Theory and Practice of ADDICTION COUNSELING

Pamela S. LASSITER
John R. CULBRETH

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I would like to thank the mentors and teachers who taught me about counseling and working with addicted families. Many of them have gone now, but their words and wisdom live on in me as a counselor and as a counselor educator. Thank you to Barry Litsey and Ron Johnson, my college psychology professors, who encouraged me to believe I could make a contribution and to realize how at home I feel in this profession. I am grateful to Jackie Doubles, who "raised me" as a therapist. Your intuitive nature, grace, and sweet heart continue to inspire me. To my mom, who taught me about kindness without attachment, how to be strong and gentle, and what it means to be truly generous. To my partner, Maddy, your support, encouragement, and kindness mean everything to me.

Pamela S. Lassiter

I would like to dedicate my work in this book to my brother, Allen Culbreth, MSgt USAF Retired. I continue to be indescribably proud of the service you have provided to our country during your active-duty career and that you still provide in the work you are doing with high school JROTC students and the CVMA. We have shared a lot of good times and memories over the years, along with some that are and were more difficult and painful. I look forward to the miles to come, both the two-wheeled kind and all the others.

Jack Culbreth

Theory and Practice of Addiction Counseling

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Preface

Nearly one in four Americans will face an addiction problem in their lifetime. This widespread problem has reached alarming heights. Likewise, nearly all the clients a professional counselor will serve have, in some way, been affected by addiction. Addiction impacts families, the workplace, friendships, and nearly all aspects of daily living. Because so many clients are impacted by addiction, all counselors, regardless of the setting, need to have skills to work effectively with addiction issues.

Addiction is a multifaceted problem supported and maintained by interpersonal, intrapersonal, social, psychological, spiritual, and biological factors. It is almost impossible to effectively understand and treat addiction issues as an isolated problem because of the complexity of its epistemology. For a given client, addiction may be a way of coping with childhood trauma such as physical or sexual abuse (psychological factors), or it may be a way of dealing with societal oppression and discrimination (sociological factors). Or biologically, a client may be more likely to become addicted due to a genetic predisposition (biological factors).

Effective counselors need a biopsychosocial perspective that examines and understands addiction and its maintenance in the lives of clients as an interaction between complex factors before they can prescribe appropriate treatment. A thorough understanding of multiple approaches to theory and practice can prepare counselors to address individualized issues that can enhance the likelihood of recovery and long-term relapse prevention. Addiction counselors must understand the theoretical epistemology of addiction before they can select the appropriate approach to treatment. Current theories such as medical, psychological, sociological, and harm-reduction models all prescribe treatment in a different way. The theory a counselor practices from will determine which type of treatment the client receives. This book is intended to be a review of existing theories of addiction that then helps counselors connect those theories to practice.

There are very few books related to addiction that focus solely on the theories of addiction. To date, most of the textbooks for this area are more survey oriented. That is, they provide a brief overview of typically four or five broad theoretical categories, such as psychological, sociological, and medical models, and only briefly mention different aspects of those theories in the chapter. They do not connect theory of addiction to practice. These survey books then go on to provide an overview of assessment issues, family issues, and 12-step approaches, with one or two chapters focused on different treatment approaches or issues. By contrast, when examining theory textbooks for the general counseling field, you find that these texts are typically focused only on counseling theories. For addictions courses, what has been lacking is a book that presents addiction theory as a focal point, similar to counseling theory texts. Currently, professors teaching a theory course must put together a collection of

textbooks, book chapters, journal articles, and such to create a working group of readings for students. This book provides all the information for an addiction theories course in one location.

We have provided an in-depth review of the current theories of addiction treatment, with each chapter devoted to a specific theory. Each chapter includes a thorough description of the basic tenets of the theory, the philosophical underpinnings and key concepts of the theory, how the theoretical approach is used by practitioners, strengths and weaknesses of the theory, and application to practice through case study responses. The authors have provided responses to a common case study that intentionally includes a multicultural focus in order to assist students in exploration of the impact of multiple identities on addiction causality, maintenance, and treatment. Our authors have been asked to respond to a common set of questions based on the theoretical perspective of their chapter's focus and the tenets of the theory. These case study responses can be used to provide readers with an opportunity to compare how the different theoretical approaches are applied to client situations. Additionally, each chapter includes boxes with classroom discussion questions or classroom activities that assist students in further exploration of the theory. Each chapter concludes with a list of resources to encourage continued learning.

The audience for this book is students taking course work in addiction counseling. There has been solid growth in these types of courses over the past 10 years. Also, with the expansion of the CACREP specialization areas into addictions counseling, there is a need for this type of textbook for programs that would like to provide training specifically for addictions counselors as a specialty track. An addictions theory course serves as a foundation for addiction counseling programs, assisting students in examining a variety of theoretical influences on addiction etiology and its influence on treatment prescription.

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We would first like to thank our editors, Abbie Rickard and Kassie Graves, who believed in this project, saw its potential, and worked hard to help us succeed. Editing a textbook is a difficult and time-consuming process. It could not have come to fruition without the help of the whole production team at Sage. We would also like to thank all our contributing authors for sharing their experience, knowledge, and wisdom in advancing the addiction counseling profession. Finally, we would like to thank the following reviewers for their thoughtful recommendations: Chaniece Winfield, Old Dominion University; Kathryn Dziekan, New Mexico Highlands University; Lia Willis, Columbia College; Ozietta D. Taylor, Coppin State University; Tiffany L. W. Bates, Louisiana Tech University; Tracy R. Whitaker, Howard University School of Social Work; Nancy E. Sherman, Bradley University; Tammara P. Thomas, Winston-Salem University; William J. Elenchin, St. Bonaventure University; An-Pyng Sun, University of Nevada Las Vegas; Diane Michaelsen, Southern Connecticut State University; and Jody

Huntington, Regis University.
We would like to thank the mentors and teachers who have taught us about counseling and working with addicted families. Many of them have gone now, but their words and wisdom live on in us as counselors and counselor educators. Some, but certainly not all, of these educators include Al Greene, Bette Ann Weinstein, Katherine Townsend, David Powell, Bettie Dibrell, Patti Mitchell, and John Edwards. Their words reverberate in our teaching and remind us every day how fortunate we were to have been their students.

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currently chairs CACREP's International Registry for Counselor Education Programs (IRCEP). His licenses and certifications include licensed professional counselor, licensed substance abuse treatment professional (both in Virginia), national certified counselor, and master addiction counselor certification. In 2007 he received the Virginia Summer Institute for Addiction Studies' Visionary Leadership Award; in 2008 he received Chi Sigma Iota's Thomas J. Sweeney National Professional Leadership Award; and in 2009, along with the CACREP staff and the other members of the 2009 Standards Revision Committee, he received the ACES Robert O. Stripling Award for Excellence in Standards.

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1 From Treatment Lore to Theory Application: *An Introduction to Addiction Theory and Practice*

John R. Culbreth
Pamela S. Lassiter

This text explores multiple theoretical approaches to both the epistemology of addiction and its treatment. It is important for the reader to understand our perspectives as editors because who we are and what we believe ultimately defines the lens through which we have edited this book. Both editors subscribe to a biopsychosocial and spiritual theoretical perspective regarding the causes and maintenance of addiction. We believe that there are crucial biological, psychological, sociological, and spiritual factors at play in the creation of addiction and in the maintenance of that addiction once it has begun. We also both believe that the treatment of addiction must necessarily include all of those aspects in order to adequately address the disease of addiction.

Additionally, we base our work on several underlying assumptions about addiction counseling. These include the following:

- Theories or models are underlying guides in clinical practice that include our beliefs about what causes problems in our lives and about how and why people change in response to those problems. In counseling, our theories reflect who we are as much as they reflect our beliefs about change. In other words, our adopted counseling theories are selected based on our own developmental process and our resulting worldview.
- We assume that counselors should be engaged in an ongoing, reflective practice concerning their biases about addiction and addicted people. Most of us have been impacted by addiction in some way. Personally speaking, after 30-plus years of practice and a strong belief that addiction is a disease that literally hijacks the person's brain, it is still difficult not to fall into moral model beliefs when a young college student is killed by a drunk driver with eight previous convictions of driving while impaired. We have to understand those judgements, accept that we will always have them (just as racism and sexism will always reside within us), and choose consciously not to act out of that place when we provide treatment.
- There is a strong connection between what a counselor believes about the causes and maintenance of addiction and how that counselor will go about treating the addicted client. Likewise, we assume that the chosen theory of counseling determines the type of treatment approach a counselor will choose to take with a client. For example, if a counselor believes family distress is a major contributing factor to a client's addiction, then the counselor may choose family therapy or a systemic approach as a primary treatment modality. If psychological issues are

seen as the underlying cause of the addiction, remedies such as stress reduction techniques or anxiety or depression medication may be sought. Regardless of the counseling theory applied to work with addicted clients, the onus is on the counselor to explore his or her own biases about addiction, addicted people, and proper treatment.

- We also assume that best practices in addiction counseling are supported by a sound theoretical approach that is evidence-based in terms of effectiveness. Whereas not all aspects of theory are "proven" to be effective, our general approaches to treatment ought to be based on empirical support for those practices.

Treatment Lore

Training to be a substance abuse counselor during the 1980s, when we came through our own counselor training programs, was quite different from addiction counseling training today. And yet there are many aspects of that early training that remain in today's addiction counseling curriculum. Much of this can be called treatment lore. This lore for working with addicted clients has its history within the development of the field through the 20th century. It is connected to Alcoholics Anonymous and the disease model in many ways. The concepts of treatment lore have been handed down in a way similar to an oral history. With this in mind, please note that we are not taking credit for these concepts and ideas. This is merely a presentation of accumulated lore that we have learned through the years by way of in-service training, our own clinical supervision as counselors, treatment program curricula, and psychoeducational materials used by counselors with clients. And our use of the word *lore* does not suggest that these concepts are untrue. They are simply a part of the accepted culture of addiction counseling, impacting the ways in which addiction counselors perceive and work with clients.

The use of treatment lore continues today, although we believe that in the classroom there has been a significant shift in focus toward empirically based approaches and theories that have solid foundations in the larger counseling and psychotherapy fields. Where treatment lore persists is in the multitude of professional development trainings, workshops, addiction counseling training institutes, and the addiction treatment agencies. Graduates of counseling programs obtain positions in treatment programs that work from this treatment lore approach. Granted, more and more programs are being required to demonstrate that treatment provided is theoretically and empirically grounded. However, this requirement is not universal, resulting in many treatment center and program addiction counselors mashing together ideas, beliefs, and personal experiences into how they work with clients on a day-to-day basis.

Although we do not advocate using treatment lore as the foundation for how counselors work with addicted clients, we believe it is important to present some of these concepts for two reasons. First, it is important that new counseling professionals entering the field understand some of the culture of their intended work environments. Many of these

concepts are held to by working addiction counselors at almost a visceral level. We believe this is due to some of these counselors having either come through their own recovery process or having a close family member in recovery. The result is that these beliefs are directly related to the fact that this professional is still alive and breathing today. Personally speaking, were it not for some or all of these ideas, some of our own family members would be dead due to their addiction. This belief makes for a "true believer" in those who have gone through this experience. And sometimes a true believer can be less open to alternative ways to conceptualize addiction and work with addicted clients.

The second reason for presenting this information is that much of it makes sense and can accurately describe some of the experiences and issues that addicted clients have to address in their process of recovery. This piece of lore helps counseling professionals understand these issues as well, allowing for a better understanding of their client experiences. If some of these ideas are accurate, which we believe is the case, then addiction counselors will be able to teach these ideas to clients and help them progress in their recovery.

In looking at what we consider to be common treatment lore, there are several groups of concepts, including a definition of addiction, descriptors of the illness and how it manifests in clients, and things to consider when working with an addicted client. We briefly discuss these concepts and provide examples of how they are used.

A common issue when beginning work with addicted clients is a resistance to the term *alcoholic* or *drug addict*. Both terms carry many negative connotations and negative stereotypical views. Often clients openly and defiantly state that they are neither one of these types. Our response is to agree with the client, stating that it is not our job to make that determination; it is the client's right to decide what levels of difficulty he or she has with chemical use. We provide a *common definition* in individual, group, or psychoeducational counseling, stating that addiction is the compulsive use of a mood-altering substance or behavior, which continues even in the face of adverse consequences. One of the best known advocates of this definition has been Father Martin, who has taught this concept in his well renowned video *Chalk Talks* (Kelly Productions, 1972). An important corollary to this definition is that it is important for counselors and clients both to understand that the chemical itself (or behavior in a process addiction) is not the primary problem. Rather, it is the behaviors, cognitions, and emotions surrounding the use and abuse of the chemical (or process) that are important. In other words, it is not the alcohol that is important in alcoholism; it is the "ism" that has to be addressed. Alcoholism, cocainism, workaholism, hypersexism, gamblingism, and perfectionism are all about the "ism." Each one of these "isms" is merely a different way for a person to alter his or her mood. Put another way, "A drug is a drug is a drug."

Another treatment lore relates to how the *nature of addiction* is explained to clients so

that they can understand what they are experiencing as they move through recovery. This description is commonly referred to as 3 *P*s and a *T*. This name stands for addiction being a primary illness that is progressive and persistent and if left unchecked is terminal. A primary illness is one that requires treatment before any other issues or concerns are addressed. In addiction counseling, this is related to clients who may focus on other psychological or emotional problems, bypassing dealing with their addiction problem, thus never addressing this issue. As counseling on the other problem progresses, often a client may begin self-medicating the pain that arises with chemicals or processes, rather than developing more appropriate and healthy coping strategies. Progress is limited at best and often very temporary. Eventually the counselor may uncover what is actually happening with the client and try to address the chemical use, with varying levels of success. Thus, a successful outcome for the client is blocked due to the primary illness overshadowing any efforts by the client or counselor to make positive changes.

Addiction as a progressive problem refers to the series of negative consequences associated with compulsive unchecked use. These consequences follow a sequence from mild to moderate to severe in nature. Examples of mild consequences include an increase in tolerance to alcohol, onset of memory blackouts, and an inability to stop drinking even once others have done so. Moderate consequences include failed efforts to control intake amount or quit altogether; negative impact on work, finances, and family and friends; and the development of tremors. Severe consequences include physical and moral deterioration, lengthy episodes of intoxication, and a decrease in tolerance to alcohol, also known as reverse tolerance. Each of these levels of severity coincide with viewing addiction through a three-stage model of progression. Jellinek (1960) created a diagram called the Jellinek Curve that displays how clients progress downward through the early, middle, and late stages of addiction. The opposite side of the curve represents steps and progress markers for clients who are working up toward recovery. The two sides create the curve, or U shape, of the progression of addiction and the progression through recovery.

The concept of persistence explains the fact that this problem cannot be ignored with the hope that it will eventually go away or resolve itself. Addiction must be addressed directly, head-on, through active participation in a treatment process. Clients must understand that their work toward recovery cannot become complacent. The idea of persistence is especially difficult for parents to accept, especially when they say to a counselor that the using behavior of a child is just a phase and that the child will grow out of it. Many times this can happen. But more often, once someone's use and abuse of chemicals comes to the attention of professionals, it is well beyond the experimentation stage or phase. At this point, the addiction is present and persistent and will not go away on its own.

The final descriptor, *T*, refers to addiction being a terminal condition. If it is left

unchecked, due to its persistent nature and the progression through increasingly severe consequences, then the final outcome is likely to be death. Death may come about in a variety of ways. It can be over the course of time through the physical deterioration of the body (although time here is relative based on the quantity and frequency of individual use). Or death can be a result of participating in risky behaviors due to impaired thinking, such as a traffic fatality. Many addicted people struggle with depression and so are at significant risk of chemically induced suicidal ideation and behaviors, sometimes resulting in a successful suicide.

A second group of descriptors about addicted clients are the three *D*s of addiction: denial, delusion, and dishonesty. Denial is probably the most commonly known of these three, although the other two appear obvious once considered by the addiction counseling student. As clients progress through addiction, they begin to deny the impact of their behaviors and subsequent consequences. Often they will look to place the blame for any negative consequences on any number of other areas rather than their use and abuse of chemicals. It is common to hear clients refer to getting arrested for driving while impaired as merely having to fill a law enforcement officer's quota of citations. Disregard the fact that the client was actually driving while impaired. Other clients will attribute their abuse of chemicals to negative or dysfunctional relationships. All of this is denial.

As the denial increases with the progression of addiction, clients will begin to develop patterns of impaired thinking, or delusions, surrounding their chemical abuse. This may include unreasonable resentments toward family and friends. As the chemical or process obsession grows, these can lead to delusional thinking. Often, this delusional thinking supports a delusional belief of persecution by people in the lives of clients.

The third characteristic, dishonesty, is connected to the first two, in that clients will often go to great lengths to avoid the truth of their addiction. This includes the dishonesty toward the self through denial and delusional thinking, as well as dishonesty in everyday interactions with the people they interact with. A system of lies is created that insulates clients from the negative consequences of their behavior. Many people close to the addicted person either openly support this dishonesty through enabling behavior or covertly support the dishonesty by creating their own "reasons" for the abusive behavior and associated consequences. Both of these compensation approaches by friends and family members share a common characteristic of not directly and honestly confronting the inappropriate abuse behavior, thus resulting in shielding, either intentionally or unintentionally, the addicted person from the appropriate negative consequences of his or her behavior. The end result of this complex level of dishonesty is usually a collapse of the delicate system of lies and alibis for the addictive behavior.

Several other treatment lore concepts should be mentioned. One of these is the idea that immediate and complete *abstinence* from all chemicals is the only way for a person to achieve recovery from addiction. Whereas there may be theoretical approaches that

support this, and many addiction counselors who profess this as true, it should not be considered an absolute. It is hard to address all of the variance in people through the use of absolute thinking. Many clients have worked through their own recovery process and rebuilt their lives successfully by way of treatment approaches that do not require abstinence.

Another piece of lore is that group counseling is the only way for clients to experience any confrontation of their behaviors and that the group process needs to break through the barrier of denial for addicted clients to finally see what they have done. This is not the case and in fact has a level of paternalistic thinking that could be quite harmful to some clients. It is important for addiction counselors to develop their other awareness of their clients and of their clients' individual circumstances. Some of this paternal thinking can be linked to some counselors bringing their own recovery experiences, or family recovery experiences, into the counseling process and assuming that if it worked for them, then it should work for their clients. This can be a very Eurocentric viewpoint that does not work well in today's diverse society. In addition, it tends to lead counselors toward their own use of the term *denial*. Some counselors will resort to labeling client resistance behaviors as client denial. The client is just not ready to listen, or admit defeat, or acknowledge his or her problem, or admit that others have been harmed. This belief releases the counselor from any responsibility in adjusting his or her approach to more readily meet clients where they are and to create a safe and accepting counseling relationship/environment that fosters honest disclosure and examination of client motivations and behavior. Clients carry enough shame on their own. They do not need more piled on them from their counselors.

There are many more aspects of treatment lore that have not been presented in this brief discussion. We are only trying to give the reader an idea of a few of the concepts and belief systems embedded in the culture of the addiction treatment community. It is important that this information not be taken as an indictment of the many substance abuse professionals and programs. It is not that at all. It is merely provided as information to help new addiction counseling professionals understand the environment that they will be working in, allowing them to integrate some of these concepts into their thinking as they work toward developing a theoretical approach to addiction treatment, similar to any other counseling professional integrating any of the more general counseling theoretical approaches into his or her own personal theoretical framework.

Overview of Book Sections and Chapters

In this text, we have organized the chapters into a biopsychosocial framework, and in the final two sections we discuss theoretical approaches to interventions or change strategies and additional issues related to addiction treatment. We begin with a historical overview of the evolution of conceptualizations of addiction and addicted people. This discussion focuses mostly on the development of the moral model, which is not an accepted theory of addiction among counseling professionals today but is rather a societal force that underlies policies and biases that may affect treatment. In this chapter, the reader will understand how Western cultures have shifted from relatively lax positions about substance use and addiction to morally condemning positions. The evolution of addiction as sin is explored, as well as its impact on treatment providers and public policy associated with laws governing drug use. Readers are invited to explore how the moral model and dominant cultural views of addiction have influenced their beliefs. Readers are also encouraged to use this awareness to become reflective and conscious addiction counselors. This discussion is followed by Chapter 3, which presents biological and genetic theories that conceptualize addiction as a product of biology. It focuses on changes in the brain and central nervous system, issues of tolerance and withdrawal, and the body's reaction to different types of drugs, including gender differences in physiological effects. Primary to the discussion is information about pharmacology, neurophysiology, and heredity. The chapter frames addiction as a disease, supporting this perspective with the latest empirical evidence. Information about innovations and uses of medication in addiction treatment are briefly discussed.

The second section of the book presents psychological theories related to the onset, maintenance, and treatment of addiction. Chapter 4 on psychoanalytic theory describes how theorists and clinicians from various points on the psychoanalytic spectrum have understood addiction and its treatment, including historical perspectives. Psychoanalytic theory generally seeks to understand the motivation or the "why" behind addictive behavior. Addiction is seen as a symptom of internal conflict, and the goal is to bring those intrapsychic conflicts into awareness, to make the unconscious conscious. Identifying the underlying cause is key to the removal of the symptom. Contemporary psychoanalytic conceptualizations and applications to treatment of addiction are presented.

Also within the psychological factors section is Chapter 5, "Self-Psychology Theory," which presents views of addiction as a developmental failure to adequately integrate certain qualities that lead to a cohesive self-structure. These qualities are crucial to later development and can be obtained through a structured experience that helps the addicted person internalize those qualities not received from earlier selfobjects. Information about the impact of trauma related to this theory is also discussed. Recovery, therefore, is conceptualized as a process of self-restoration. Next, Chapter 6 discusses the developmental nature of addiction. This perspective assumes that as

people mature or develop, they also mature in their ability to cope with the addictive process and find ways to cope with tendencies toward relapse. The chapter describes the etiology and maintenance of addiction through a developmental lens. It also explores how developmental shifts toward higher levels of consciousness impact addiction across the life span and discusses how these shifts may relate to recovery from addiction.

Also from a psychological perspective, Chapter 7 presents attachment theory as a lens to examine the relationship between attachment style and its impact on one's ability to self-regulate. Addiction is viewed as a disorder of self-regulation (emotions, self-esteem, relationships) and is perceived as a misguided attempt to self-repair. This chapter discusses attachment theory, research, and clinical applications for addicted populations. Information about the impact of trauma related to this theory is also discussed. The ways in which attachment theory is similar and dissimilar to traditional theories of addiction and how existing mechanisms in addiction treatment may be used to increase attachment style growth are explored.

The third section of the book focuses on various sociological factors related to the epistemology and maintenance of addiction. First, Chapter 8 presents addiction through the lens of external, cultural, and contextual factors. From this viewpoint, social influences determine substance use issues, and cultural attitudes toward substances influence individual behavior. Addicted individuals are links in society that are seen as part of a problem related to the whole. Sociological functions of substance use include facilitation of social interaction, release from normal social obligations, and promotion of cohesion among members of a social or ethnic group and may be used as repudiation of "establishment" values. This chapter explores various historical and contemporary sociocultural influences on the epistemology and maintenance of addiction, including sociocultural differences between the United States and other parts of the world. A second chapter in this section, Chapter 9, presents addiction through a family systems lens. This chapter examines the function of addiction within the family system and different approaches to treating the addicted family. Some approaches view addiction as a disease and encourage family members to examine their own issues. Concepts such as codependency, enabling, and family roles are discussed. Other approaches take more of a family systems approach by focusing on how the addiction functions in the family, exploring rules, boundaries, communication, problem solving, and roles. A behavioral family model looks at behaviors of the family that precede and reinforce use, tries to change what occurs before and after use, and addresses relationships in terms of themes, communication styles, and how drug use keeps the relationship stable.

A fourth section of the book explores various theoretical approaches to interventions and change strategies including the transtheoretical model, motivational interviewing, harm reduction, cognitive-behavioral approaches, 12-step facilitation, and postmodern approaches to addiction treatment. The transtheoretical model, including the stages of

change, assumes that change happens when the right process happens at the right time. From this perspective, change is both external and internal and may be viewed as transtheoretical in nature. In Chapter 10, the transtheoretical model theory is presented and discussed in detail, including how the counselor may use change process interventions (experiences and activities) that help the client move from one stage to another. The chapter shows how clients spiral in and out of these stages and how change behavior needs to be viewed within the cultural context.

Motivational interviewing is a client-centered method for enhancing internal motivation for change by exploring and resolving ambivalence within the client. In Chapter 11, motivational interviewing is presented as a style of therapeutic intervention that focuses on developing a collaborative relationship with clients, helping the counselor to roll with client resistance and enhancing client self-efficacy. This chapter is theoretical and practice focused, helping the counselor integrate the stages of change with appropriate motivational interviewing approaches.

Chapter 12 discusses harm reduction models as an approach to addiction treatment. Harm reduction is based on the notion that lifelong abstinence from substances is extremely difficult for addicted populations and that setting incremental goals toward abstinence may be more realistic. Although complete abstinence from mood-altering chemicals or behaviors may be preferred, it may not be attainable for all clients. Examples of harm reduction models are discussed as well as client presentations where it may be preferred over other approaches. An integration of a harm reduction approach with other theoretical models is also explored.

Chapter 13 reviews empirical support of cognitive behavioral theory (CBT) and surveys its application to substance use disorders and treatment. The basic assumptions of CBT are outlined as well as its assumptions about etiology and maintenance of addiction. The goals and tasks of CBT treatment are discussed along with examples of techniques that might be used in counseling.

The history of the 12-step movement is briefly explored in Chapter 14 followed by a description of its conception of the etiology and maintenance of addiction, its integration with other theoretical models (biopsychosocial/spiritual dimensions), empirical evidence of its usefulness, and a discussion of central concepts (e.g., powerlessness, acceptance, denial, spiritual dis-ease, fellowship, time binding, sponsorship, working the steps). The chapter also discusses the use of 12-step groups as an ancillary support in conjunction with counseling and treatment.

Chapter 15 describes three constructivist or postmodern approaches to addiction treatment. Postmodern approaches such as narrative, feminist, and womanist therapy share a common philosophical stance around issues of power, justice, and advocacy. They may, however, look different in clinical application. Problem-saturated stories are common among people struggling with addictions. Narrative approaches view people as separate from their problems and assume people have many competencies, beliefs,

values, and skills that will help them reduce the amount of influence problems have over their lives. Narrative concepts such as deconstructive listening, externalizing conversations, unique outcomes, thickening the plot, spreading the news, and mining for hope guide this exploration toward creating alternative stories and preferred realities in therapeutic work. Feminist and womanist approaches to addiction counseling emphasize concepts such as the intersections of personal experience and political realities, the importance of egalitarian relationships, and explorations of voice and resilience.

The fifth section presents additional issues for consideration related to addiction, including process or behavioral addictions, theory and practice of group work with addictions, and relapse prevention approaches. Chapter 16 explores theoretical approaches to process or behavioral addictions and connects the reader to treatment strategies associated with those theories. Assessment, diagnostic issues, and co-occurring issues are also discussed. Current trends and special issues in treatment of process addictions are explored.

Chapter 17 reviews the theoretical basis and efficacy for using group work in addiction treatment. It includes a discussion of the following: the roots of addiction counseling in 12-step groups and communities; the impact of vicarious learning, social support, feedback, hope for change, and how having a common problem can facilitate a common vigilance against relapse; therapeutic factors in groups; stages of group development; effective leadership styles; and special issues in addiction group work (e.g., boundaries around relapse, denial, merging honesty with respect). Practical strategies and techniques are presented that are specific to group work with addicted clients.

Chapter 18 describes relapse as a common occurrence in addiction treatment and recovery. Counselors should understand the etiology and dynamics of relapse so that they are able to design effective prevention strategies. This chapter presents an overview of varying models of relapse prevention, along with empirical support for each model. A discussion of common relapse warning signs and how relapse can be used to enhance treatment is also included.

It is important to note that the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) now combines addictive disorders from two categories in the *DSM-IV* (substance dependence and substance abuse) into a single disorder measured on a continuum from mild to severe. Because of this change in language, terms that have been commonly used in addiction counseling such as *substance abuse* and *chemical dependency* may not fit the new nomenclature of the *DSM-5*. We have chosen to include all current descriptions (not just *DSM-5* language) in the chapters presented by our authors in this book, as they are experts in addiction counseling from across the United States. Likewise, the reader may notice a variety of terms used by different authors to describe individuals struggling with addiction, such as *substance abusers*, *addicted people*, *addicts*, or *people with a substance use disorder*. We felt it was more representative of the profession to be inclusive of all current terminology, rather than be

limited by one conceptualization.
As an aid to readers in applying and comparing the various theoretical approaches described in this book, a case study is presented next. Authors respond to the case study based on the theoretical approach being presented. The reader is encouraged to reread the case study with each chapter in order to fully conceptualize the key concepts of each approach. We also encourage the reader to consult the National Association of Alcohol and Drug Abuse Counselors (NAADAC) Code of Ethics provided in the appendix and the American Society of Addiction Medicine (ASAM) placement criteria and levels of care while considering the responses to the case study by each of the chapter authors. Examining each of the responses presented within the context of the ethical guidelines will strengthen the reader's understanding of the practical application of these various clinical approaches.

Addiction Counseling Case Study

All authors were given the same case study to use as a teaching example. Our intent is to provide one set of client circumstances so that readers may see how the various addiction theories and approaches are similar and different based on application. With all authors addressing the same case study from their particular theoretical approach, readers should be able to easily identify both strengths and weaknesses of the theories, allowing for a more informed decision by addiction counselors in determining their chosen theoretical orientation(s). This is the case study, followed by questions that guide each author's response to the case study.
Gabriel is a biracial male, age 26, single, with no children. He identifies as heterosexual but also states he may be questioning his sexual orientation. His mother is African American and his father is Native American (Cherokee). He was born and raised in a small town in rural Appalachia. Gabriel states his preferred drug is either marijuana or alcohol. He says he has tried some other drugs, including cocaine variants, but has not used IV drugs. His drug use is 2 to 3 times daily; however, he does occasionally go for periods of 2 to 3 days without using. Gabriel reports that he has attempted to stop using several times, including two inpatient hospitalizations. His longest period of abstinence from all chemicals has been 7 weeks, which came after his second inpatient stay. During that time he worked with a sponsor in Alcoholics Anonymous whom he described as a "hard but caring man." He started using again and stopped going to meetings after a breakup with a girlfriend. The most Gabriel has used in a 24-hour period was a full baggie of marijuana and approximately one case of beer. He has many episodes of passing out from drinking/drugging, along with several blackouts. The longest blackout lasted approximately 36 hours.
Gabriel has one older sister who has a history of relationships with men with anger problems and who abuse substances. Her 10-year-old daughter looks up to Gabriel and has begged him to stop using many times. They enjoy playing sports together, and he tries to avoid being around his niece if he has been using. Gabriel reports a strong

family history of chemical dependence, including several aunts and uncles with substance use problems. His father has used alcohol and other drugs for as long as he has known him. When Gabriel was an adolescent, he used numerous times with his father. As a matter of fact, his father introduced him to cocaine. He remembers lots of arguing in his home and at times having to physically defend his mother and sister when his father was on a binge. Although he loves his father, he has never had a sober relationship with him and he has never felt completely accepted by him.

Since his parents' divorce 4 years ago, Gabriel has lived with his mother. He is very close to his mother, but he states she has recently started attending Al-Anon meetings and has made recent attempts at setting boundaries around his substance use behavior. Gabriel has one driving while impaired (DWI) conviction and one marijuana possession conviction. He did not serve time for these offenses, choosing to participate in court-mandated assessments and outpatient education/treatment programs. He is not currently on probation, having completed all requirements for these charges.

Gabriel describes other mental health symptoms consistent with obsessive-compulsive disorder and anxiety disorder. He describes his relationship pattern as going from one woman to the next. Relationships last up to 6 months, generally, but then end when he learns of the girlfriend's infidelity. Gabriel admits to being unfaithful in these relationships himself. He reports having sexual relationships with two women during his most recent inpatient treatment stay, while being in a "committed" relationship. He feels a great deal of shame about his earliest sexual encounter at age 15, which was with a teenage male friend. He has come for treatment again at the request of his sister and his mother.

The following questions guide authors' responses to the case study:

1. How would you conceptualize this client's problems, needs, issues, and strengths based on the theoretical approach from your chapter?
2. How would you work with this client and/or his family based on the theoretical approach from your chapter?
3. What would be some of the key techniques or strategies consistent with the theoretical approach you would use in treatment?
4. What weaknesses or challenges of your theoretical approach would be highlighted by this particular client's circumstances?
5. What strengths of your theoretical approach would be highlighted by this particular client's circumstances?

In each chapter, authors describe the basic tenets of the theory or approach, discuss the philosophical underpinnings and key concepts of the theory, present how the theoretical approach is used by practitioners, explore implications for assessment and prevention of addiction problems, define the strengths and weaknesses of the theory, apply the theory to the case study, and provide readers with sidebars that will stimulate discussion and deeper understanding of the theory. We believe this unique book expands

the understanding of diverse approaches to addiction counseling. Our hope is that it will enhance counseling services provided to individuals and families struggling with addiction.

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Appendix: National Association of Alcohol and Drug Abuse Counselors: Code of Ethics

I. The Counseling Relationship

It is the responsibility of the addiction professional to safeguard the integrity of the counseling relationship and to ensure that the client is provided with services that are most beneficial. The client will be provided access to effective treatment and referral giving consideration to individual educational, legal and financial resources needs. Addiction professionals also recognize their responsibility to the larger society and any specific legal obligations that may, on limited occasions, supersede loyalty to clients. The addiction professional shall provide the client and/or guardian with accurate and complete information regarding the extent of the potential professional relationship. In all areas of function, the addiction professional is likely to encounter individuals who are vulnerable and exploitable. In such relationships he/she seeks to nurture and support the development of a relationship of equals rather than to take unfair advantage. In personal relationships, the addiction professional seeks to foster self-sufficiency and healthy self-esteem in others. In relationships with clients he/she provides only that level and length of care that is necessary and acceptable.

Standard 1: Client Welfare

The addiction professional understands that the ability to do good is based on an underlying concern for the well-being of others. The addiction professional will act for the good of others and exercise respect, sensitivity and insight. The addiction professional understands that the primary professional responsibility and loyalty is to the welfare of his or her clients, and will work for the client irrespective of who actually pays his/her fees.

1. The addiction professional understands and supports actions that will assist clients to a better quality of life, greater freedom and true independence.
2. The addiction professional will support clients in accomplishing what they can readily do for themselves. Likewise, the addiction professional will not insist on pursuing treatment goals without incorporating what the client perceives as good and necessary.

3. The addiction professional understands that suffering is unique to a specific individual and not of some generalized or abstract suffering, such as might be found in the understanding of the disorder. On that basis, the action taken to relieve suffering must be uniquely suited to the suffering individual and not simply some universal prescription.
4. Services will be provided without regard to the compensation provided by the client or by a third party and shall render equally appropriate services to individuals whether they are paying a reduced fee or a full fee or are waived from fees.

Standard 2: Client Self-Determination

The addiction professional understands and respects the fundamental human right of all individuals to self-determination and to make decisions that they consider in their own best interest. In that regard, the counselor will be open and clear about the nature, extent, probable effectiveness and cost of those services to allow each individual to make an informed decision about his or her care. The addiction professional works toward increased competence in all areas of professional functioning; recognizing that at the heart of all roles is an ethical commitment contributing greatly to the well-being and happiness of others. He/she is especially mindful of the need for faithful competence in those relationships that are termed fiduciary—relationships of special trust in which the clients generally do not have the resources to adequately judge competence.

1. The addiction professional will provide the client and/or guardian with accurate and complete information regarding the extent of the potential professional relationship, including the Code of Ethics and documentation regarding professional loyalties and responsibilities.
2. Addiction professionals will provide accurate information about the efficacy of treatment and referral options available to the client.
3. The addiction professional will terminate work with a client when services are no longer required or no longer serve the client's best interest.
4. The addiction professional will take reasonable steps to avoid abandoning clients who are in need of services. Referral will be made only after careful consideration of all factors to minimize adverse effects.
5. The addiction professional recognizes that there are clients with whom he/she cannot work effectively. In such cases, arrangements for consultation, co-therapy or referral are made.
6. The addiction professional may terminate services to a client for nonpayment if the financial contractual arrangements have been made clear to the client and if the client does not pose an imminent danger to self or others. The addiction professional will document discussion of the consequences of nonpayment with the client.

7. When an addiction professional must refuse to accept the client due to inability to pay for services, ethical standards support the addiction professional in attempting to identify other care options. Funding constraints might interfere with this standard.
8. The addiction professional will refer a client to an appropriate resource when the client's mental, spiritual, physical or chemical impairment status is beyond the scope of the addiction professional's expertise. The addiction professional will foster self-sufficiency and healthy self-esteem in others. In relationships with clients, students, employees and supervisors, he/she strives to develop full creative potential and mature, independent functioning.
9. Informed Consent: The addiction professional understands the client's right to be informed about treatment. Informed consent information will be presented in clear and understandable language that informs the client or guardian of the purpose of the services, risks related to the services, limits of services due to requirements from a third party payer, relevant costs, reasonable alternatives and the client's right to refuse or withdraw consent within the time frames covered by the consent. When serving coerced clients, the addiction professional will provide information about the nature and extent of services, treatment options and the extent to which the client has the right to refuse services. When services are provided via technology such as computer, telephone or web-based counseling, clients are fully informed of the limitations and risks associated with these services. Client questions will be addressed within a reasonable time frame.
10. Clients will be provided with full disclosure including the guarantee of confidentiality if and when they are to receive services by a supervised person in training. The consent to treat will outline the boundaries of the client-supervisee relationship, the supervisee's training status and confidentiality issues. Clients will have the option of choosing not to engage in services provided by a trainee as determined by agency policies. Any disclosure forms will provide information about grievance procedures.

Standard 3: Dual Relationships

The addiction professional understands that the goal of treatment services is to nurture and support the development of a relationship of equals of individuals to ensure protection and fairness of all parties.

Addiction professionals will provide services to clients only in the context of a professional setting. In rural settings and in small communities, dual relationships are evaluated carefully and avoided as much as possible.

1. Because a relationship begins with a power differential, the addiction professional will not exploit relationships with current or former clients, current or former supervisees or colleagues for personal gain, including social or business relationships.

2. The addiction professional avoids situations that might appear to be or could be interpreted as a conflict of interest. Gifts from clients, other treatment organizations or the providers of materials or services used in the addiction professional's practice will not be accepted, except when refusal of such gift would cause irreparable harm to the client relationship. Gifts of value over $25 will not be accepted under any circumstances.
3. The addiction professional will not engage in professional relationships or commitments that conflict with family members, friends, close associates or others whose welfare might be jeopardized by such a dual relationship.
4. The addiction professional will not, under any circumstances, engage in sexual behavior with current or former clients.
5. The addiction professional will not accept as clients anyone with whom they have engaged in romantic or sexual relationships.
6. The addiction professional makes no request of clients that does not directly pertain to treatment (giving testimonials about the program or participating in interviews with reporters or students).
7. The addiction professional recognizes that there are situations in which dual relationships are difficult to avoid. Rural areas, small communities and other situations necessitate discussion of the counseling relationship and take steps to distinguish the counseling relationship from other interactions.
8. When the addiction professional works for an agency such as department of corrections, military, an HMO or as an employee of the client's employer, the obligations to external individuals and organizations are disclosed prior to delivering any services.
9. The addiction professional recognizes the challenges resulting from increased role of the criminal justice system in making referrals for addiction treatment. Consequently he/she strives to remove coercive elements of such referrals as quickly as possible to encourage engagement in the treatment and recovery process.
10. The addiction professional encourages self-sufficiency among clients in making daily choices related to the recovery process and self care.
11. The addiction professional shall avoid any action that might appear to impose on others' acceptance of their religious/spiritual, political or other personal beliefs while also encouraging and supporting participation in recovery support groups.

Standard 4: Group Standards

Much of the work conducted with substance use disorder clients is performed in group settings. Addiction professionals shall take steps to provide the required services while providing clients physical, emotional, spiritual and psychological health and safety.

1. Confidentiality standards are established for each counseling group by involving the addiction professional and the clients in setting confidentiality guidelines.

2. To the extent possible, addiction professionals will match clients to a group in which other clients have similar needs and goals.

Standard 5: Preventing Harm

The addiction professional understands that every decision and action has ethical implication leading either to benefit or harm, and will carefully consider whether decisions or actions have the potential to produce harm of a physical, psychological, financial, legal or spiritual nature before implementing them. The addiction professional recognizes that even in a life well lived, harm may be done to others by thoughtless words and actions. If he/she becomes aware that any word or action has done harm to anyone, he/she readily admits it and does what is possible to repair or ameliorate the harm except where doing so might cause greater harm.

1. The addiction professional counselor will refrain from using any methods that could be considered coercive such as threats, negative labeling and attempts to provoke shame or humiliation.
2. The addiction professional develops treatment plans as a negotiation with the client, soliciting the client's input about the identified issues/needs, the goals of treatment and the means of reaching treatment goals.
3. The addiction professional will make no requests of clients that are not necessary as part of the agreed treatment plan. At the beginning of each session, the client will be informed of the intent of the session. Collaborative effort between the client and the addiction professional will be maintained as much as possible.
4. The addiction professional will terminate the counseling or consulting relationship when it is reasonably clear that the client is not benefiting from the exchange.
5. The addiction professional understands the obligation to protect individuals, institutions and the profession from harm that might be done by others. Consequently there is awareness when the conduct of another individual is an actual or likely source of harm to clients, colleagues, institutions or the profession. The addiction professional will assume an ethical obligation to report such conduct to competent authorities.
6. The addiction professional defers to review by a human subjects committee (Institutional Review Board) to ensure that research protocol is free of coercion and that the informed consent process is followed. Confidentiality and deceptive practices are avoided except when such procedures are essential to the research protocol and are approved by the designated review board or committee.
7. When research is conducted, the addiction professional is careful to ensure that compensation to subjects is not as great or attractive as to distort the client's ability to make free decisions about participation.

II. Evaluation, Assessment and Interpretation of Client Data

The addiction professional uses assessment instruments as one component of the counseling/treatment process taking into account the client's personal and cultural background. The assessment process promotes the well-being of individual clients or groups. Addiction professionals base their recommendations/reports on approved evaluation instruments and procedures. The designated assessment instruments are ones for which reliability has been verified by research.

Standard 1: Scope of Competency

The addiction professional uses only those assessment instruments for which they have been adequately trained to administer and interpret.

Standard 2: Informed Consent

Addiction professionals obtain informed consent documentation prior to conducting the assessment except when such assessment is mandated by governmental or judicial entities and such mandate eliminates the requirement for informed consent.

When the services of an interpreter are required, addiction professionals must obtain informed consent documents and verification of confidentiality from the interpreter and client. Addiction professionals shall respect the client's right to know the results of assessments and the basis for conclusions and recommendations. Explanation of assessment results is provided to the client and/or guardian unless the reasons for the assessment preclude such disclosure or if it is deemed that such disclosure will cause harm to the client.

Standard 3: Screening

The formal process of identifying individuals with particular issues/needs or those who are at risk for developing problems in certain areas is conducted as a preliminary procedure to determine whether or not further assessment is warranted at that time.

Standard 4: Basis for Assessment

Assessment tools are utilized to gain needed insight in the formulation of the most appropriate treatment plan. Assessment instruments are utilized with the goal of gaining an understanding of the extent of a person's issues/needs and the extent of addictive behaviors.

Standard 5: Release of Assessment Results

Addiction professionals shall consider the examinee's welfare, explicit understanding of the assessment process and prior agreements in determining where and when to report assessment results. The information shared shall include accurate and appropriate interpretations when individual or group assessment results are reported to another entity.

Standard 6: Release of Data to Qualified Professionals

Information related to assessments is released to other professionals only with a signed release of information form or such a release from the client's legal representative. Such information is released only to persons recognized as qualified to interpret the data.

Standard 7: Diagnosis of Mental Health Disorders
Diagnosis of mental health disorders shall be performed only by an authorized mental health professional licensed or certified to conduct mental health assessments or by a licensed or certified addictions counselor who has completed graduate level specific education on diagnosis of mental health disorders.

Standard 8: Unsupervised Assessments
Unless the assessment instrument being used is designed, intended and validated for self-administration and/or scoring, addiction professional administered tests will be chosen and scored following the recommended methodology.

Standard 9: Assessment Security
Addiction professionals maintain the integrity and security of tests and other assessment procedures consistent with legal and contractual obligations.

Standard 10: Outdated Assessment Results
Addiction professionals avoid reliance on outdated or obsolete assessment instruments. Professionals will seek out and engage in timely training and/or education on the administration, scoring and reporting of data obtained through assessment and testing procedures. Intake data and other documentation obtained from clients to be used in recommending treatment level and in treatment planning are reviewed and approved by an authorized mental health professional or a licensed or qualified addiction professional with specific education on assessment and testing.

Standard 11: Cultural Sensitivity Diagnosis
Addiction professionals recognize that cultural background and socioeconomic status impact the manner in which client issues/needs are defined. These factors are carefully considered when making a clinical diagnosis. Assessment procedures are chosen carefully to ensure appropriate assessment of specific client populations. During assessment the addiction professional shall take appropriate steps to evaluate the assessment results while considering the culture and ethnicity of the persons being evaluated.

Standard 12: Social Prejudice
Addiction professionals recognize the presence of social prejudices in the diagnosis of substance use disorders and are aware of the long term impact of recording such diagnoses. Addiction professionals refrain from making and/or reporting a diagnosis if they think it would cause harm to the client or others.

III. Confidentiality/Privileged Communication and Privacy
Addiction professionals shall provide information to clients regarding confidentiality and any reasons for releasing information in adherence with confidentiality laws. When providing services to families, couples or groups, the limits and exceptions to

confidentiality must be reviewed and a written document describing confidentiality must be provided to each person. Once private information is obtained by the addiction professional, standards of confidentiality apply. Confidential information is disclosed when appropriate with valid consent from a client or guardian. Every effort is made to protect the confidentiality of client information, except in very specific cases or situations.

1. The addiction professional will inform each client of the exceptions to confidentiality and only make a disclosure to prevent or minimize harm to another person or group, to prevent abuse of protected persons, when a legal court order is presented, for purpose of research, audit, internal agency communication or in a medical emergency. In each situation, only the information essential to satisfy the reason for the disclosure is provided.
2. The addiction professional will do everything possible to safeguard the privacy and confidentiality of client information, except where the client has given specific, written, informed and limited consent or when the client poses a risk of harm to themselves or others.
3. The addiction professional will inform the client of his/her confidentiality rights in writing as a part of informing the client of any areas likely to affect the client's confidentiality.
4. The addiction professional will explain the impact of electronic records and use of electronic devices to transmit confidential information via fax, email or other electronic means. When client information is transmitted electronically, the addiction professional will, as much as possible, utilize secure, dedicated telephone lines or encryption programs to ensure confidentiality.
5. Clients are to be notified when a disclosure is made, to whom the disclosure was made and for what purposes.
6. The addiction professional will inform the client and obtain the client's agreement in areas likely to affect the client's participation including the recording of an interview, the use of interview material for training purposes and/or observation of an interview by another person.
7. The addiction professional will inform the client(s) of the limits of confidentiality prior to recording an interview or prior to using information from a session for training purposes.

IV. Professional Responsibility

The addiction professional espouses objectivity and integrity and maintains the highest standards in the services provided. The addiction professional recognizes that effectiveness in his/her profession is based on the ability to be worthy of trust. The professional has taken time to reflect on the ethical implications of clinical decisions and behavior using competent authority as a guide. Further, the addiction professional recognizes that those who assume the role of assisting others to live a more responsible

life take on the ethical responsibility of living a life that is more than ordinarily responsible. The addiction professional recognizes that even in a life well-lived, harm might be done to others by words and actions. When he/she becomes aware that any work or action has done harm, he/she admits the error and does what is possible to repair or ameliorate the harm except when to do so would cause greater harm. Professionals recognize the many ways in which they influence clients and others within the community and take this fact into consideration as they make decisions in their personal conduct.

Standard 1: Counselor Attributes

1. Addiction professionals will maintain respect for institutional policies and management functions of the agencies and institutions within which the services are being performed, but will take initiative toward improving such policies when it will better serve the interest of the client.
2. The addiction professional, as an educator, has a primary obligation to help others acquire knowledge and skills in treating the disease of substance use disorders.
3. The addiction professional, as an advocate for his or her clients, understands that he/she has an obligation to support legislation and public policy that recognizes treatment as the first intervention of choice for non-violent substance-related offenses.
4. The addiction professional practices honesty and congruency in all aspects of practice including accurate billing for services, accurate accounting of expenses, faithful and accurate reporting of interactions with clients and accurate reporting of professional activities.
5. The addiction professional recognizes that much of the property in the substance use disorder profession is intellectual in nature. In this regard, the addiction professional is careful to give appropriate credit for the ideas, concepts and publications of others when speaking or writing as a professional and as an individual.
6. The addiction professional is aware that conflicts can arise among the duties and rights that are applied to various relationships and commitments of his/her life. Priorities are set among those relationships and family, friends and associates are informed to the priorities established in order to balance these relationships and the duties flowing from them.
7. When work involves addressing the needs of potentially violent clients, the addiction professional will ensure that adequate safeguards are in place to protect clients and staff from harm.
8. Addiction professionals shall continually seek out new and effective approaches to enhance their professional abilities including continuing education research, and participation in activities with professionals in other disciplines.
9. Addiction professionals have a commitment to lifelong learning and continued

education and skills to better serve clients and the community.

10. The addiction professional respects the differing perspectives that might arise from professional training and experience other than his/her own. In this regard, common ground is sought rather than striving for ascendance of one opinion over another.
11. Addiction professionals, whether they profess to be in recovery or not, must be cognizant of ways in which their use of psychoactive chemicals in public or in private might adversely affect the opinion of the public at large, the recovery community, other members of the addiction professional community or, most particularly, vulnerable individuals seeking treatment for their own problematic use of psychoactive chemicals. Addiction professionals who profess to be in recovery will avoid impairment in their professional or personal lives due to psychoactive chemicals. If impairment occurs, they are expected to immediately report their impairment, to take immediate action to discontinue professional practice and to take immediate steps to address their impairment through professional assistance. (See Standard 2, item 3 below.)

Standard 2: Legal and Ethical Standards

Addiction professionals will uphold the legal and ethical standards of the profession by being fully cognizant of all federal laws and laws that govern practice of substance use disorder counseling in their respective state. Furthermore, addiction professionals will strive to uphold not just the letter of the law and the Code, but will espouse aspirational ethical standards such as autonomy, beneficence, non-malfeasance, justice, fidelity and veracity.

1. Addiction professionals will honestly represent their professional qualifications, affiliations, credentials and experience.
2. Any services provided shall be identified and described accurately with no unsubstantiated claims for the efficacy of the services. Substance use disorders are to be described in terms of information that has been verified by scientific inquiry.
3. The addiction professional strives for a better understanding of substance use disorders and refuses to accept supposition and prejudice as if it were the truth.
4. The impact of impairment on professional performance is recognized; addiction professionals will seek appropriate treatment for him/herself or for a colleague. Addiction professionals support the work of peer assistance programs to assist in the recovery of colleagues or themselves.
5. The addiction professional will ensure that products or services associated with or provided by the member by means of teaching, demonstration, publications or other types of media meet the ethical standards of this code.
6. The addiction professional who is in recovery will maintain a support system outside the work setting to enhance his/her own well-being and personal growth as well as promoting continued work in the professional setting.

7. The addiction professional will maintain appropriate property, life and malpractice insurance policies that serve to protect personal and agency assets.

Standard 3: Records and Data

The addiction professional maintains records of professional services rendered, research conducted, interactions with other individuals, agencies, legal and medical entities regarding professional responsibilities to clients and to the profession as a whole.

1. The addiction professional creates, maintains, disseminates, stores, retains and disposes of records related to research, practice, payment for services, payment of debts and other work in accordance with legal standards and in a manner that permits/satisfies the ethics standards established. Documents will include data relating to the date, time and place of client contact, the services provided, referrals made, disclosures of confidential information, consultation regarding the client, notation of supervision meetings and the outcome of every service provided.
2. Client records are maintained and disposed of in accordance with law and in a manner that meets the current ethical standards.
3. Records of client interactions including group and individual counseling services are maintained in a document separate from documents recording financial transactions such as client payments, third party payments and gifts or donations.
4. Records shall be kept in a locked file cabinet or room that is not easily accessed by professionals other than those performing essential services in the care of clients or the operation of agency.
5. Electronic records shall be maintained in a manner that assures consistent service and confidentiality to clients.
6. Steps shall be taken to ensure confidentiality of all electronic data and transmission of data to other entities.
7. Notes kept by the addiction professional that assist the professional in making appropriate decisions regarding client care but are not relevant to client services shall be maintained in separate, locked locations.

Standard 4: Interprofessional Relationships

The addiction professional shall treat colleagues with respect, courtesy, fairness and good faith and shall afford the same to other professionals.

1. Addiction professionals shall refrain from offering professional services to a client in counseling with another professional except with the knowledge of the other professional or after the termination of the client's relationship with the other professional.
2. The addiction professional shall cooperate with duly constituted professional ethics committees and promptly supply necessary information unless constrained by the demands of confidentiality.
3. The addiction professional shall not in any way exploit relationships with

supervisees, employees, students, research participants or volunteers.

V. Working in a Culturally Diverse World

Addiction professionals understand the significance of the role that ethnicity and culture plays in an individual's perceptions and how he or she lives in the world. Addiction professionals shall remain aware that many individuals have disabilities which may or may not be obvious. Some disabilities are invisible and unless described might not appear to inhibit expected social, work and health care interactions. Included in the invisible disabled category are those persons who are hearing impaired, have a learning disability, have a history of brain or physical injuries and those affected by chronic illness. Persons having such limitations might be younger than age 65. Part of the intake and assessment must then include a question about any additional factor that must be considered when working with the client.

1. Addiction professionals do not discriminate either in their professional or personal lives against other persons with respect to race, ethnicity, national origin, color, gender, sexual orientation, veteran status, gender identity or expression, age, marital status, political beliefs, religion, immigration status and mental or physical challenges.
2. Accommodations are made as needed for clients who are physically, mentally, educationally challenged or are experiencing emotional difficulties or speak a different language than the clinician.

VI. Workplace Standards

The addiction professional recognizes that the profession is founded on national standards of competency which promote the best interests of society, the client, the individual addiction professional and the profession as a whole. The addiction professional recognizes the need for ongoing education as a component of professional competency and development.

1. The addiction professional recognizes boundaries and limitations of their own competencies and does not offer services or use techniques outside of their own professional competencies.
2. Addiction professionals recognize the impact of impairment on professional performance and shall be willing to seek appropriate treatment for oneself or for a colleague.

Working Environment

Addiction professionals work to maintain a working/therapeutic environment in which clients, colleagues and employees can be safe. The working environment should be kept in good condition through maintenance, meeting sanitation needs and addressing structural defects.

1. The addiction professional seeks appropriate supervision/consultation to ensure conformance with workplace standards.

2. The clerical staff members of the treatment agency hired and supervised by addiction professionals are competent, educated in confidentiality standards and respectful of clients seeking services.
3. Private work areas that ensure confidentiality will be maintained.

VII. Supervision and Consultation

Addiction professionals who supervise others accept the obligation to facilitate further professional development of these individuals by providing accurate and current information, timely evaluations and constructive consultation. Counseling supervisors are aware of the power differential in their relationships with supervisees and take precautions to maintain ethical standards. In relationships with students, employees and supervisees he/she strives to develop full creative potential and mature independent functioning.

1. Addiction professionals must take steps to ensure appropriate resources are available when providing consultation to others. Consulting counselors use clear and understandable language to inform all parties involved of the purpose and expectations related to consultation.
2. Addiction professionals who provide supervision to employees, trainees and other counselors must have completed education and training specific to clinical and/or administrative supervision. The addiction professional who supervises counselors in training shall ensure that counselors in training adhere to policies regarding client care.
3. Addiction professionals serving as supervisors shall clearly define and maintain ethical professional, personal and social relationships with those they supervise. If other professional roles must be assumed, standards must be established to minimize potential conflicts.
4. Sexual, romantic or personal relationships with current supervisees are prohibited. Supervision of relatives, romantic partners or friends is prohibited.
5. Supervision meetings are conducted at specific regular intervals and documentation of each meeting is maintained.
6. Supervisors are responsible for incorporating the principles of informed consent into the supervision relationship.
7. Addiction professionals who serve as supervisors shall establish and communicate to supervisees the procedures for contacting them, or in their absence alternative on-call supervisors.
8. Supervising addiction professionals will assist those they supervise in identifying counter-transference and transference issues. When the supervisee is in need of counseling to address issues related to professional work or personal challenges, appropriate referrals shall be provided.

VIII. Resolving Ethical Issues

The addiction professional shall behave in accordance with legal, ethical and moral standards for his or her work. To this end, professionals will attempt to resolve ethical dilemmas with direct and open communication among all parties involved and seek supervision and/or consultation as appropriate.

1. When ethical responsibilities conflict with law, regulations or other governing legal authority, addiction professionals should take steps to resolve the issue through consultation and supervision.
2. When addiction professionals have knowledge that another counselor might be acting in an unethical manner, they are obligated to take appropriate action based, as appropriate, on the standards of this code of ethics, their state ethics committee and the National Certification Commission.
3. When an ethical dilemma involving a person not following the ethical standards cannot be resolved informally, the matter shall be referred to the state ethics committee and the National Certification Commission.
4. Addiction professionals will cooperate with investigations, proceedings and requirements of ethics committees.

IX. Communication and Published Works

The addiction professional who submits for publication or prepares handouts for clients, students or for general distribution shall be aware of and adhere to copyright laws.

1. The addiction professional honestly respects the limits of present knowledge in public statements related to alcohol and drug abuse. Statements of fact will be based on what has been empirically validated as fact. Other opinions, speculations and conjectures related to the addictive process shall be represented as less than scientifically validated.
2. The addiction professional recognizes contributions of other persons to their written documents.
3. When a document is based on cooperative work, all contributors are recognized in documents or during a presentation.
4. The addiction professional who reviews material submitted for publication, research or other scholarly purposes must respect the confidentiality and proprietary rights of the authors.

X. Policy and Political Involvement

Standard 1: Societal Obligations

The addiction professional is strongly encouraged to the best of his/her ability to actively engage the legislative processes, educational institutions and the general public to change public policy and legislation to make possible opportunities and choice of service for all human beings of any ethnic or social background whose lives are impaired by alcoholism and drug abuse.

1. The addiction professional understands that laws and regulations exist for the good ordering of society and for the restraint of harm and evil and will follow them, while reserving the right to commit civil disobedience.
2. The one exception to this principle is a law or regulation that is clearly unjust, where compliance leads to greater harm than breaking a law.
3. The addiction professional understands that the determination that a law or regulation is unjust is not a matter of preference or opinion but a matter of rational investigation, deliberation and dispute, and will willingly accept that there may be a penalty for justified civil disobedience.

Standard 2: Public Participation

The addiction professional is strongly encouraged to actively participate in community activities designed to shape policies and institutions that impact on substance use disorders. Addiction professionals will provide appropriate professional services in public emergencies to the greatest extent possible.

Standard 3: Social and Political Action

The addiction professional is strongly encouraged to understand that personal and professional commitments and relationships create a network of rights and corresponding duties and will work to safeguard the natural and consensual rights of each individual within their community. The addiction professional understands that social and political actions and opinions are an individual's right and will not work to impose their social or political views on individuals with whom they have a professional relationship.

This resource was designed to provide an ethics code and ethical standards that will be used by counseling professionals. These principles of ethical conduct outline the importance of having ethical standards and the importance of adhering to those standards. These principles can help professionals face ethical dilemmas in their practice and explore ways to avoid them.

2 Historical Perspectives and the Moral Model

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Substance use and addiction has a long and colorful history in the United States. The alcohol and drug cultural evolution has shifted from attitudes of complacency to demonization, criminalization, and mass incarceration. From the colonial era to the present day, the emphasis has vacillated between treatment and prevention programs to criminalization and harsh punishments for users and offenders. The moral model is one of the key underpinnings found throughout the evolution of the alcohol and drug culture in the United States. Often discussions of the history of addiction and treatment are framed within the context of opposing ends of this moral spectrum: good versus bad, abstaining versus drunkenness, upper class versus lower class, religious versus nonreligious, and disease versus immoral conduct (Thombs, 2006). In this chapter, we explore the historical and cultural perspectives of substance use and addiction in the United States, including the evolution of the moral model.

Colonial Era (1492–1763)

During the colonial era as Europeans began arriving in the New World, Native Americans were introduced to the use of alcohol. Also during this time, Native Americans introduced Europeans to nicotine and tobacco. Settlers and Europeans began to heavily use tobacco and tobacco products, such as snuff. Over time tobacco became so addictive, people found they could not stop smoking. As a cash crop, tobacco had a huge impact on the New World economy. Tobacco was used as legal tender and was also a contributing factor that led to the slave trade in colonial America (Spurling & Leonard, 1993).

According to Spurling and Leonard (1993), rum was also used as legal tender in the early days of the United States. Because there were no water purification systems, water was often not healthy to drink, so alcohol was used as a form of water purification in colonial America. As a result, almost every person in colonial America drank some form of alcohol. As a matter of routine, most Americans began their day by drinking alcohol with breakfast and continued to drink all day long. Eventually, when the British cut off molasses supplies needed to make rum, the American colonists began making whiskey out of converted grains. Because of the large amount of grain available, whiskey was relatively inexpensive and easy to make. In fact, whiskey was cheaper than coffee. Thus, in colonial America, whiskey became the drink of choice, and there were few moral judgments about its use and the user (Spurling & Leonard, 1993).

American Revolution and Young Republic (1763–1820s)

Despite the widespread use of alcohol and tobacco among the early American settlers, there were those who started to realize the negative impacts of alcohol. Dr. Benjamin

Rush, a founding father of the United States and signer of the Declaration of Independence, was one of the first to draw attention to the possible negative effects of alcohol on the human body. Dr. Rush warned that the drinking of alcohol could cause mental and physical health issues that could lead to death (Thombs, 2006). In 1790, Dr. Rush included the "moral thermometer" in his book titled *An Inquiry Into the Effects of Spirituous Liquors on the Human Body*. Dr. Rush's (1790) moral thermometer is a visual scale (represented by a thermometer) showing the progress from temperance to intemperance caused by the effects of liquor on humans. The categories on the temperance portion of the thermometer ranged from water to strong beer and from weak punch to pepper in rum on the intemperance portion of the thermometer. The scale also visually depicts the consequences humans might experience as they move down the intemperance portion of the thermometer. Those consequences ranged from vices to suicide, diseases to death, and punishments to gallows (Rush, 1790). Dr. Rush is known as one of the original advocates for the concept of humane treatment for addicted people (Durrant & Thakker, 2003; Thombs, 2006). The consumption of alcohol continued to increase in the United States, and the dangers of alcoholism slowly began to creep into the American consciousness. In 1791, the "whiskey tax" was passed. Despite the heightened awareness of the excessive use of alcohol, the passage of the excise tax was more about paying down the national debt than it was about curbing the use of alcohol by Americans. This terribly unpopular excise tax was repealed in 1801 (Durrant & Thakker, 2003).

Alcohol was also used as a form of control. According to Spurling and Leonard (1993), slaves were given alcohol to keep them on the plantations, and Native Americans were often provided with alcohol during trade and treaty negotiations in an effort to hinder their negotiation abilities. With alcohol literally flowing through all aspects of American life, public drunkenness was not uncommon. As Dr. Rush had predicted, alcohol-related illnesses and deaths were on the rise. American consumption led to a number of societal issues. One issue was an explosion in the population of debtor prisons. Some estimates show there were as many as 50,000 people per year entering these prisons (Spurling & Leonard, 1993). There was no social safety net such as welfare or social security during this time for those experiencing social and personal ills (Spurling & Leonard, 1993).

Temperance Movement (1826–1919)

Because the use of alcohol was so prominent in early American society and the lack of understanding of what effect excessive alcohol use could have on the human body, there was little concern about drinking or even public drunkenness. Excessive drunkenness led to domestic violence and the abuse of women and children, which resulted in a call for moderation. It was becoming more evident that there was an alcohol issue in America and something had to be done.

The temperance movement was born out of the acknowledgment that the issue of

drinking had to be addressed. This movement was originally led by clergy in the United States (Spurling & Leonard, 1993). The goal was to curb excessive drinking and public drunkenness through gentle moral persuasion. Originally, the key message of the temperance movement was to view alcohol use through the lens of moderation. This concept was tied directly to linking moderation to the importance of one's personal relationship with God. The key message of the movement was that each individual was a servant of God, and using alcohol often led to becoming a drunk, and drunkards could not serve God well. In other words, drinking prevented the formation of a positive relationship with God and therefore was considered bad (Spurling & Leonard, 1993; Thombs, 2006). A number of organizations were born out of the temperance movement, from the Washingtonians to the Women's Christian Temperance Union and the Anti-Saloon League. As the movement grew, the message soon became one of abstinence rather than moderation (Durrant & Thakker, 2003). According to Hanson (1999), by the late 1830s, there were more than 1.5 million people belonging to more than 800 temperance-related organizations in the United States.

Ironically, one of the fathers of the temperance movement, the Reverend Lyman Beecher, had put himself through school selling alcohol on the side. Unlike the original moderate messaging, Reverend Beecher preached a message of abstinence. Reverend Beecher's work shifted the tone of the message from one of moderation to a message that any use of alcohol was bad. This was the beginning of what became and is still known today as the moral model (Spurling & Leonard, 1993).

During this period, people were asked to take a pledge of abstinence by signing their name and placing a *T* next to their signature. The *T* indicated the individual had agreed to become a teetotaler and had promised to avoid all consumption of alcohol. Not everyone accepted the teetotaler approach. Many within the movement did agree to avoid all alcohol whereas others only agreed to avoid hard alcohol but decided to continue to indulge in drinking wine. As a result of these efforts, Americans were drinking far less than they had in the previous decade (Spurling & Leonard, 1993). By 1840, Americans were drinking roughly 3.1 gallons per person per year compared with 7.1 gallons per person per year in the early 1830s (Goode, 1993).

Whereas there was a focus on the harmful effects of alcohol and ways to stop it, America was simultaneously seeing a dramatic increase in the number of opioids being imported. From 1840 to 1870, opioid imports grew at 7 times the rate of the population (Spurling & Leonard, 1993). The main reason for the increase in opioids was that physicians were using them for a number of medicinal purposes. During this time, opioids were often used as painkillers. With the isolation of morphine and hypodermic medications, doctors began prescribing opioids for all kinds of health issues. The unregulated and seemingly unlimited use of opioids by doctors resulted in a whole new era of addiction. During this era, many doctors and their patients became addicted to drugs. These substances were legal, and many were accessible over the counter. No

governmental regulations existed during this time (Durrant & Thakker, 2003). Hypodermic needles were also readily available, and in fact, hypodermic kits were available in the 1897 Sears Roebuck catalog for under $2.00 (Spurling & Leonard, 1993).

Opioids were seen as a "cure-all" and used by most of society. Some ads depicted mothers describing how their crying children would calm down after being given their medicine. Little did they know, their children were probably suffering from withdrawal, so of course, a little more medicine would help calm their children down. Because so little was understood about the long-term effects of these medications, many people did not realize they had become addicted until it was too late (Spurling & Leonard, 1993). Like alcohol, the widespread use of opioids had huge societal implications. Opioid addiction crossed all socioeconomic boundaries. According to Durrant and Thakker (2003), the typical user of opiates by the 1920s was over the age of 30, Caucasian, female, and middle class. Often these women became addicts as the result of being prescribed an opioid to combat some type of medical condition or physical pain. However, no one was immune from the use of and subsequent addiction to opioids. According to Spurling and Leonard (1993), the upper class frequented opioid dens, which were originally viewed as exotic and tended to indicate a certain social status. Simultaneously, the lower classes used opioids to cope with everyday stresses. Cocaine was also widely used as a recreational drug and stimulant. It was during this period that the intersection of drug use and ethnicity in America became visible. For example, African American males who worked as longshoremen often used cocaine as a stimulant to help them get through their long shifts of loading and unloading container ships (Spurling & Leonard, 1993). The Chinese immigrants who came to America to work on the transcontinental railroad and in mining often turned to opioids as a means of escaping their harsh realities. For many Chinese immigrants, opium dens were accepted in their cultures and in fact were seen as a source of cultural and racial identity (Spurling & Leonard, 1993).

By the 1880s, many Americans started to realize there was a problem with drug and alcohol addiction in the United States. Americans began to enter treatment facilities and hospitals for periods of time as they went through the withdrawal process. In 1879, the Keeley Institute opened its doors as one of the first organizations to serve those suffering from alcoholism (Spurling & Leonard, 1993).

Many people who either attempted to treat themselves at home or checked themselves into a treatment center found they were still yearning for drugs and alcohol upon completion of their treatment program. They simply could not seem to wean themselves from the addictive substances. It was during this time that the public, helped by the American media, pushed for assistance in fighting substance use disorders (Spurling & Leonard, 1993).

In 1906, after 27 years of debate, the Pure Food and Drug Act passed in Congress. The

law required all manufacturers of patent medicines to place ingredients known to be addictive or dangerous on the product label. The law included alcohol, morphine, opium, and cannabis on the list of ingredients known to be addictive or dangerous. The Pure Food and Drug Act did not prevent these medications from being sold over the counter. However, this act was one of the first steps in the regulation of drugs in the United States. By 1909, the Smoking Opium Exclusion Act was passed. This law made it a criminal offense to be in possession of opium for nonmedicinal purposes (Durrant & Thakker, 2003).

By 1900, there were an estimated 1 million addicts in the United States (Spurling & Leonard, 1993). Even though addiction was prevalent across all socioeconomic levels, how addiction was depicted by social class and race differed tremendously. For example, the African American longshoremen and Chinese laborers were depicted negatively and labeled as drug users. Opium smoking had become associated with the Chinese laborers, and there was a fear among some in white society that cocaine would empower African Americans to fight against the oppression and discrimination they were experiencing at the hands of the dominant white leaders (Musto, 1999). It was during this era when the dangers of drug use and the prejudices associated with minorities were linked. It is a connection that still permeates our society today. It was also during this period that messaging about substance use disorders started being manipulated by lawmakers for political purposes.

One of the first bills passed by Congress during the early 1900s was the Harrison Narcotics Act of 1914. It ushered in tighter regulations on opiates and cocaine. After the passage of the law, many doctors came under scrutiny for prescribing heroin and other drugs to addicts (Sharp, 1994; Spurling & Leonard, 1993). In fact, according to Sharp (1994), “There is some evidence that between 1915 and 1938, more than 25,000 physicians came under the scrutiny of federal agents enforcing the Harrison Act and about 5,000 were convicted and fined or jailed” (p. 20). This governmental crackdown was further supported by the Supreme Court ruling in *Webb et al. v. United States* (1919), which stated that doctors could not prescribe opiates to addicts as a form of treatment. This effectively halted the existence of maintenance treatment programs for addicts. The Supreme Court ruled the Harrison Narcotics Act was constitutional and that because addiction was not considered a disease, doctors could no longer prescribe opiates to addicts (Sharp, 1994).

This Supreme Court ruling is often viewed as the beginning of the criminalization of drug users and the basis upon which much of the drug policies of the United States have been built. In one ruling, the Supreme Court in essence criminalized an entire group of people. This ruling also reinforced the narrative that substance users were criminals and deviants simply looking for self-gratification and pleasure (Sharp, 1994; Spurling & Leonard, 1993).

Prohibition (1919–1933)

The Prohibition era was ushered in partly due to a number of new technologies that allowed for the faster and cheaper manufacturing of alcohol. The amount of grain available in the United States and the ease of making alcohol only led to the continued increase in alcoholism in America. By 1913, many Americans began to consciously acknowledge the impact alcohol abuse was having on society. The temperance movement and Prohibition efforts were a strong political force between the 1840s and the 1930s. The temperance movement had led to over 50% of Americans living in dry counties, which are counties that do not allow the sale or distribution of alcohol (Spurling & Leonard, 1993).

Prohibition really began to take shape during World War I in the years after the United States joined the Allies against Germany in April 1917. During the First World War, it became unpatriotic to drink alcohol in the United States. Grain that had been used for making alcohol was now needed to support the American troops. Ironically, World War I ended before Prohibition was fully enacted across the United States. In 1919, the Eighteenth Amendment of the Constitution was passed, and Prohibition became the law of the land on January 18, 1920. The constitutional amendment banned the sale, production, importation, and transportation of all alcoholic beverages. Prohibition was repealed 13 years later in 1933 (Spurling & Leonard, 1993).

Prohibition is often credited with creating the environment that allowed an entire new class of criminals to be born. Organized crime rings began to pop up, and an entire black market was created for the production, sale, and transportation of alcoholic beverages in the United States. Storefronts, which became known as speakeasies, sold cigars and magazines in the front and illegally sold alcoholic beverages at a bar in the back of the store (Spurling & Leonard, 1993).

Enforcing Prohibition was a difficult task for the United States government. During this time, the alcohol produced in the United States was of inferior quality. It was often referred to as bathtub gin because of the poor quality of the homemade spirits. Better-quality alcohol was illegally imported from Canada, which only perpetuated the increase in organized crime (Spurling & Leonard, 1993).

Prohibition had a big impact on American culture. American alcohol consumption decreased by 50%, and overall alcohol-related health problems also saw a decrease (Spurling & Leonard, 1993). However, these two decreases were offset by an increase in violence due to organized crime and accidental deaths from poisoning from black market alcohol. The economic toll on the United States was significant. Originally, approximately $5 million was budgeted by the United States Congress to ensure compliance with Prohibition. By the time Prohibition was repealed, the budget had increased to over $300 million (Spurling & Leonard, 1993). Instead of continuing to increase the budget of the United States to control the production and sale of alcohol, Congress moved toward a regulation and tax model. The repeal of Prohibition gave people access to much-needed jobs during the Depression as well as a much-needed tax

base for the United States government. Once again, political forces were at work in terms of how drug and alcohol abuse were being portrayed by the United States government and in the American media.

World War II Era (1939–1945)

Perhaps one of the greatest influencers on shaping America's drug policy was Harry Jacob Anslinger. He served as the first commissioner of the U.S. Treasury Department's Federal Bureau of Narcotics (FBN), which was formed in 1930. Anslinger was a staunch supporter of Prohibition and the criminalization of drugs. He held office for an unprecedented 32 years, and his impact can still be felt on America's drug policies today (Sharp, 1994). His philosophy was a very simple, straightforward view of addiction—drug and alcohol use was bad. He believed all drugs, users, and pushers should be eliminated from society. Anslinger's efforts resulted in the first American "war on drugs" (Spurling & Leonard, 1993). He was a master of leveraging organized groups like the General Federation of Women's Clubs, the Women's Christian Temperance Union, and the World Narcotic Defense Association to support his cause (Sharp, 1994).

During the early Cold War era, drug sales and use were often depicted as a Communist plot to place fear in the minds of many Americans. The war on drugs only increased during this period and resulted in several significant legislative acts. In 1951, the Boggs Act was passed, which required mandatory jail sentences for marijuana and narcotic trafficking (Sharp 1994; Spurling & Leonard, 1993). The Boggs Act "mandated a combination of fines of up to $2000 and a minimum sentence of two to five years for first offenders and five to ten years for second offenders, with no possibility for probation or a suspended sentence" (Sharp, 1994, p. 22). The Narcotics Drug Act of 1956 further tightened the penalties for selling drugs. Members of Congress who supported this act had sought a mandatory death penalty for drug smuggling. However, the death penalty was not included in the final bill. But the act did require the death penalty be imposed for those found guilty of selling heroine to minors (Sharp, 1994). According to Spurling and Leonard (1993), substance use by African Americans, Hispanics, and Asians was being portrayed as criminal, and the use of alcohol and tobacco by the middle and upper class was at times being portrayed as sophisticated and sexy. Actors and actresses were often seen in movies and on television smoking and drinking in a number of social settings. The use of alcohol and tobacco had steadily increased since the repeal of Prohibition (Spurling & Leonard, 1993).

Nixon Era (1969–1974)

The first antismoking warnings started to be published by doctors in the early 1950s (Spurling & Leonard, 1993). By 1964, the first surgeon general warning about cigarette usage appeared. Despite the surgeon general warnings, cigarette sales continued to increase. During the sixties, marijuana and pot smokers became symbols of the peace

movement. It was President Richard Nixon who declared total war on public enemy number one—drugs. There was concern about the amount of drug use among Vietnam veterans returning to the United States after such a long and unpopular war. By the 1970s, the perception was that many local law enforcement agencies and police departments were not actively investigating and arresting recreational drug users. To combat the growing concern over the availability of drugs in America, the U.S. government created the Drug Enforcement Administration (DEA) in 1973 under the Department of Justice (Spurling & Leonard, 1993). The DEA was formed by combining two agencies—the Bureau of Narcotics and Dangerous Drugs (BNDD) and the Office of Drug Abuse Law Enforcement (ODALE) (Sharp, 1994).

These agencies and their missions provide another example of the politicization of the American approach to drug users and sellers. Sharp (1994) documented that both agencies were created as a result of an executive order issued by President Nixon. With both agencies under the direct control of the White House, Nixon could control his message about drug use and drug users and hoped to curb the efforts of those resistant to his drug policy goals (Sharp, 1994). Sharp (1994) points out that the mission of ODALE was "simply the escalation of arrests against street-level dealers" (p. 26). The BNDD's mission was to focus on the capture of higher-level drug dealers, which was in direct conflict with the Nixon administration's current approach of focusing on the lower-level street dealers and users (Sharp, 1994). As Sharp (1994) points out, this approach placed an enormous strain on the criminal justice system. Yet there was little disruption to the overall drug trafficking issue it had been implemented to address. As lower-level street dealers were captured and arrested, they were simply replaced by higher-level drug dealers (Sharp, 1994). The increased number of people coming through the criminal justice system "led to coping devices such as plea bargaining, dropped charges, and early release from prison, thus turning the massive-arrest strategy into meaningless 'revolving-door' justice" (Sharp, 1994, p. 27).

During this time, the depiction of the use of marijuana and cocaine continued to be seen in popular culture. Many upper- and middle-class Americans were often portrayed as indulging in the use of these substances in movies and on television. It was as if the collective memory of America had faded and the issues of addiction experienced a generation ago were front and center again in American culture (Spurling & Leonard, 1993).

President Nixon did not focus only on the law enforcement aspect of substance addiction in the United States. Sharp (1994) suggests that perhaps one of the most interesting aspects of Nixon's war on drugs was his focus on drug treatment. In June 1971, in a Special Message to the Congress on Drug Abuse Prevention and Control, Nixon asked Congress to amend his 1972 budget and to provide an additional $155 million (bringing the total designated for drug control programs to $371 million) (Woolley & Peters, 1999). Even though Nixon was asking Congress for money to

support drug treatment, he continued to describe America's drug problem as a national emergency and framed drug addicts as less than and often as the dregs of society (Woolley & Peters, 1999).

Carter Era (1977–1981)

President Jimmy Carter deviated from Nixon's very public depiction of drug users as criminals who must be dealt with swiftly and harshly. For example, the Carter administration's drug policy was based on a wellness rather than a criminal approach (Sharp, 1994). The drug policy during the Carter years was rooted in prevention and treatment programs and focused on improving existing policies and programs. One of the leaders of Carter's new drug policy was Peter Bourne. Bourne, a physician who had worked in the field of mental health and substance use, was a longtime supporter of Jimmy Carter. After Carter's election in 1976, Bourne became his chief drug policy adviser and was named director of the Office of Drug Abuse Policy (ODAP) (Sharp, 1994).

Peter Bourne's work experience and educational background brought a very different perspective regarding how to approach the nation's drug policy (Sharp, 1994). There were three main themes to Carter's drug policy agenda: (a) a balanced approach to the drug issue, (b) a focus on research and less focus on creating a public frenzy around drug use in America, and (c) a reorganization of the nation's approach to creating drug policy (Sharp, 1994). The Carter administration's more balanced approach shifted the focus onto the problem of prescription drug use and abuse as much as the Nixon administration had focused on illegal drug use.

Perhaps the largest shift in drug policy during the Carter years was the push for the decriminalization of marijuana (Sharp, 1994). In March 1977, the U.S. House of Representatives Select Committee on Narcotics Abuse and Control heard testimony on the topic of the decriminalization of marijuana. The Carter administration supported reviewing the potential medical uses of marijuana and addressed the harsh penalties imposed on marijuana drug offenders.

A number of changes were made to existing laws from 1967 to 1970 (Sharp, 1994). According to a summary of the House Select Committee on Narcotics Abuse and Control hearings, there were stiff federal penalties already in existence for certain federal drug offenses. For example, some first offenses carried from 5 to 20 years in prison, and second offenses resulted in 10 to 40 years in prison (U.S. House of Representatives, Select Committee on Narcotics Abuse and Control, 1977). However, when the Controlled Substance Act was passed by Congress in 1970, it repealed all prior federal legislation and allowed for reduced penalties for federal drug offenses. The new federal penalty for a first offense of simple possession and/or distribution was a maximum 5 years in prison and a fine of no more than $15,000. For a second offense, the penalties were doubled. Also, a first offender could be placed on probation for 1 year for simple possession without a guilty verdict (U.S. House of Representatives,

1977).
Despite these reductions in federal penalties that had taken place prior to Carter's election and the focus on medicinal uses of marijuana, the Carter administration failed to decriminalize marijuana (Sharp, 1994). A number of contributing factors led to Carter's failed drug policy. One factor often cited is that of the resignation of Peter Bourne as Carter's chief drug policy adviser under a cloud of controversy. He was accused of using cocaine at a Washington, DC, party, and he was also accused of writing a prescription for a colleague under a false name. As a result of these two incidents, Bourne's credibility was shattered, and along with it, so was the credibility of the Carter drug policy (Sharp, 1994). The Carter administration found it difficult to overcome all the years of portraying drug use and abuse in such a negative light. The grip was so tight that public opinion could not be changed as quickly and easily as some in the Carter administration had hoped (Sharp, 1994).

Reagan Era (1981–1989)

After the failed attempt of the Carter administration to shift the drug conversation away from one focusing on criminalization to one focusing on treatment and prevention, the Reagan years ushered in a reemphasis of criminalizing drug offenders (Sharp, 1994). Even though the drug problem in America was not a key issue debated in the 1980 election, President Ronald Regan began his presidency with a renewed interest in America's drug policy focusing on public awareness and law enforcement (Sharp, 1994).
Several issues drew the American public back into the conversation about drug use. The introduction of a new form of cocaine, crack cocaine, really changed the conversation (Sharp, 1994). By 1986, cocaine was often thought of as the drug of choice among the upper class. Numerous stories appeared in the media describing cocaine use by athletes and celebrities. Because crack cocaine was less expensive than regular cocaine, the use of cocaine crossed all socioeconomic boundaries because it was more readily available to the masses (Sharp, 1994; Spurling & Leonard, 1993). The media images of drugs being used by the wealthy, athletes, and celebrities were replaced with images of "impoverished black and Hispanic individuals" (Sharp, 1994, p. 53). Like the Chinese and African American laborers of the 1920s and 1930s, drug users were once again being depicted as criminals and ethnic minorities (Sharp, 1994). By the mid-1980s, when Americans were polled about their concerns about the biggest threats to America, drug use often polled as the number one concern (Spurling & Leonard, 1993).
Another contributing factor to Americans' increased fear of drugs and drug use was the spread of the newly identified disease acquired immune deficiency syndrome (AIDS) (Sharp, 1994). Because so little was known about the spread of this deadly disease, a lot of fear and social stigma was associated with it. The fact that AIDS was known to spread among intravenous drug users only fueled the growing fears of drug use in America (Sharp, 1994). These fears became interwoven into the overall drug narrative

of the late 1980s.

In order to address what was being dubbed a drug epidemic, the Just Say No campaign was born. First Lady Nancy Reagan began to make a number of public appearances with the sole purpose of bringing an awareness of illegal drugs and drug use to the American public (Sharp, 1994). In September 1986, President Reagan and the first lady gave a nationally televised speech during prime time to reach as many Americans as possible. The speech was intended to increase the public's awareness of the current drug issues facing America (Sharp, 1994). Excerpts of the speech were printed in the *New York Times* the following morning. Nancy Reagan was quoted as saying, "Drugs take away the dream from every child's heart and replace it with a nightmare. … There's no moral middle ground. Indifference is not an option. … Our job is never easy because drug criminals are ingenious" ("Excerpts From Speech," 1986).

Despite the increased emphasis on public awareness, critics of the Reagan administration point out that no new funding was sought to develop treatment and prevention programs during this time. The emphasis had once again shifted to abstinence, law enforcement, and criminalization of users (Sharp, 1994). To boost the law enforcement portion of the approach, harsher laws were passed in Congress, including the Anti-Drug Abuse Act of 1986. This law required minimum sentences for the distribution of cocaine and crack cocaine. First-time offenders for possession or intent to sell were to receive a minimum of 5 years in prison. These harsher penalties continue to contribute to the high incarceration rates found in the United States (Capuzzi & Stauffer, 2016).

The 1990s and 2000s

Despite all the Just Say No efforts, by the 1990s there was a sharp increase in drug use among 13- and 14-year-olds (Spurling & Leonard, 1993). The most popular drugs of choice were still marijuana and cocaine. Often the experimentation with marijuana by teens led to more frequent use and a desire to explore other, more dangerous drugs over time (Spurling & Leonard, 1993).

One of the tangible results of the war on drugs that has gained national attention in recent years is the issue of mass incarceration. By the early 2000s, and after 9 decades of trying to combat drugs, the United States had one of the highest incarceration rates related to drug use in the world. According to a press release from the Department of Justice, Bureau of Justice Statistics (2003a), the "growth in the federal system from 1995 to 2001 (up 61 percent) is attributed largely to the increase in drug offenders (accounting for 48 percent of the growth)" (p. 1). The 2002 statistics are staggering in that "1 in every 143 U.S. residents were incarcerated in State or Federal prison or a local jail" (Department of Justice, Bureau of Justice Statistics, 2003b, p. 2). And the high rate of incarceration has continued throughout the mid-2000s. The latest Bureau of Justice Statistics report, *Prisoners in 2014*, shows that "6% of all black males ages 30–39 were in prison, compared to 2% of Hispanic and 1% of white males in the same age

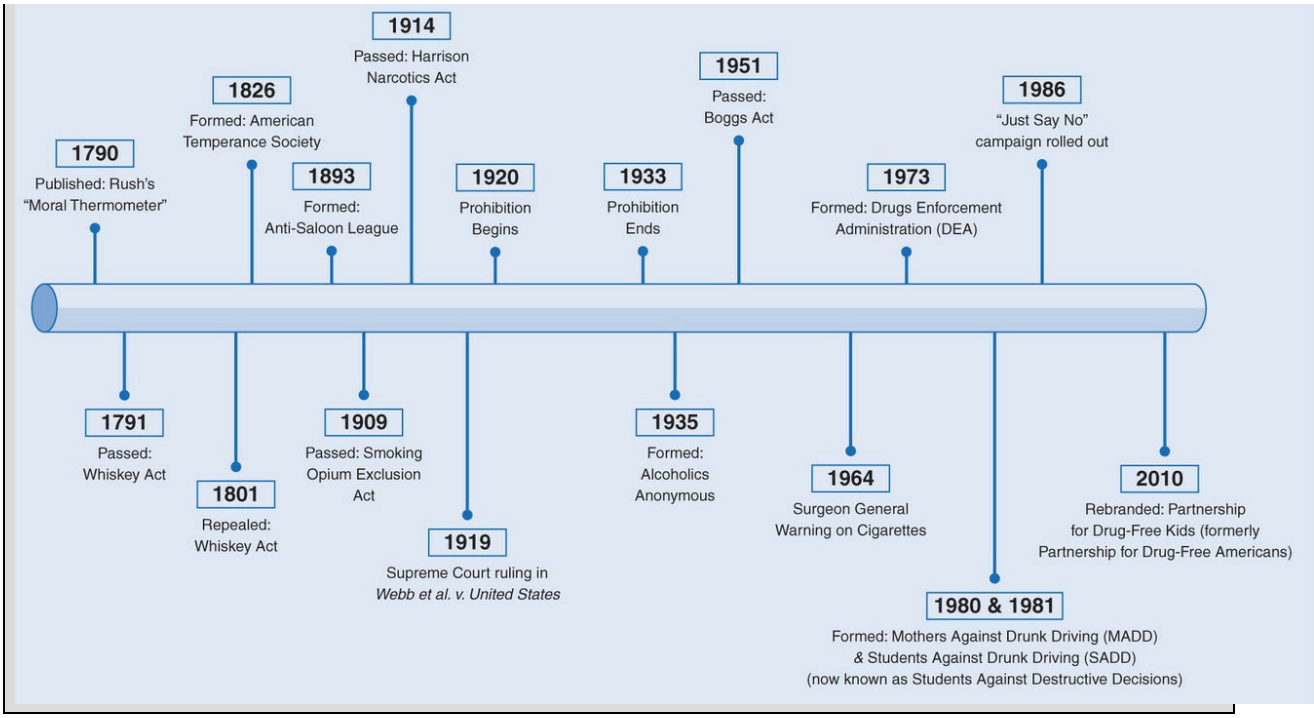
group" (Department of Justice, Bureau of Justice Statistics, 2015, p. 1). As of September 2014, 50% of all males and 59% of females serving time in federal prison are there because of a drug offense (Department of Justice, Bureau of Justice Statistics, 2015).

As America's war on drugs continues, now more than ever, the statistics show that those belonging to lower socioeconomic and minority ethnic groups represent those feeling the effects of the criminalization of substance use offenders. According to the United States Sentencing Commission (1998), possession of powder cocaine is a state offense. However, possessing an equal quantity of crack cocaine carries a minimum of 10 years in federal prison if convicted. Ever since this distinction was first made in 1988, 95% of those sentenced for crack offenses have been African American (Caulkins, Rydell, Schwabe, & Chiesa, 1997). These conviction rates are despite the fact that according to the nonprofit human rights organization Human Rights Watch, illegal drug use is proportionally higher among whites than blacks. One of the key areas of focus on the war on drugs has been the possession and sale of crack cocaine by African Americans (Human Rights Watch, 2000, p. 2). According to Human Rights Watch (2000), "Crack cocaine in black neighborhoods became a lightning rod for a complicated and deep-rooted set of racial, class, political, social, and moral dynamics" (p. 2).

The racial divide continues as black males in urban areas are often targeted for drug offenses. This marginalized population is often an obvious target of law enforcement because it is easy for police to find offenders on the streets in urban areas, and it is easy for the media to capture footage of these types of arrests compared with drug offenders living in suburban, predominately white neighborhoods (Spurling & Leonard, 1993). These specific drug issues are often more visible in predominately poor urban minority neighborhoods than they are in middle- to upper-class white neighborhoods (Human Rights Watch, 2000).

Whereas so much focus has been given to the selling and use of illegal drugs in the United States, the two most legal drugs are still arguably the most lethal—alcohol and tobacco. Despite stronger driving while intoxicated (DWI) laws, and the ongoing focus on prevention and awareness programs about the dangers of tobacco use, it must not be forgotten that these two legal drugs still account for large numbers of deaths each year in the United States. From 2005 to 2009, smoking was responsible for more than 480,000 premature deaths annually among Americans 35 years of age and older (U.S. Department of Health and Human Services, 2014). According to the Centers for Disease Control, there were approximately 87,000 deaths from 2006 to 2010 that can be attributed to the excessive use of alcohol (Centers for Disease Control and Prevention, 2013).

Box 2.1 Substance Use Historical Milestones



This historical journey of drug use and addiction within American culture has been reflective of changing attitudes and social constructions across various eras. It is clear that there has been no essential truth about what addiction is and about how we as a culture should treat the problem. When one considers the tapestry of cultures that make up American society, this epistemology of addiction becomes even more complex.

Cultural Views of Addiction

Cultural and ethnic views regarding alcohol and drug use are interwoven with cultural and ethnic identities. Alcohol and drug use are often associated with specific racial groups, and these stereotypes can be difficult for these groups to overcome. For many cultures, alcohol and drug use is a part of normal social activities that often bind a group of people together.

Alcohol was introduced to the Native American culture by Europeans coming to the New World. For many Native Americans, alcoholism has had long and devastating effects on their population. According to Porter and Teich (1995), the alcoholism rate among Native Americans is "5.4 times higher than it is for all races in the United States" (p. 133). There are several theories regarding why alcoholism is so high among Native Americans, and most of those theories focus on the significance of drinking in social settings. For example, many older Native American men have incorporated drinking as part of traditional ceremonies as well as during parties held in Native American homes (Porter & Teich, 1995). Another often-cited reason for high rates of alcohol use by Native Americans is that the rates are due to their acculturation process and are a result of their way of dealing with stressors such as poverty and other social issues (Porter & Teich, 1995).

The impact of alcohol on Native American culture should not be underestimated no

matter what the root cause. Also, the diversity that exists between Indian people in terms of age, gender, tribal culture, and social organization must also be considered when looking at the use of alcohol among Native American population subgroups (Porter & Teich, 1995; Straussner, 2001). Even though alcohol use among Native Americans should not be associated with old stereotypes, the use of alcohol in this population has become a part of the Native American cultural identity, and those associated stereotypes are difficult to overcome (Heath, 2000).

Alcohol also plays a key role in Jewish culture. Drinking is largely done at home with family and as part of family celebrations. For many Jewish people, one's ability to use alcohol in moderation is often seen as a form of self-control and is not necessarily considered a vice (Thombs, 2006). According to Heath (2000), for many Jewish people, part of celebrating the traditional Sabbath involves having a glass of wine before and after the Sabbath meal. Heath (2000) suggests that within the Jewish culture, "we have a population with no abstainers but also one with virtually no problem drinkers" (p. 90). Perhaps this can be explained due to the fact that often drunkenness within the Jewish culture is viewed as negative and inexcusable (Thombs, 2006). Straussner (2001) found that in fact, "Jews appear to have a lower rate of alcoholism or alcohol dependence than is found among the general population in the United States" (p. 302).

According to Vaillant (1983), of all the ethnic groups, the Irish are almost 7 times more likely to suffer from alcoholism than people from Mediterranean cultures. Thombs (2006) suggested that "although on one hand drinking is viewed as the 'curse of the Irish,' on the other it is seen as the quintessential Irish act, one embodying all that is 'Irish.' In a symbolic way, drunkenness connects the Irish to all of their similarly anguished ancestors" (p. 239).

According to Heath (2000), alcohol consumption varies from culture to culture as does the type of most desired alcoholic beverage. For example, the countries of Russia, Portugal, Spain, France, Italy, and Greece can be classified as "wet" cultures based on the annual alcohol consumption and the social norms associated with drinking in those countries. "Dry" countries include India, Israel, and Saudi Arabia as well as some Hopi and Cantonese cultures.

Heath (2000) also suggests that based on a culture's predominant beverage, certain countries can be classified as wine, beer, or hard liquor (spirits) cultures. Beer cultures include England, Australia, Austria, and Germany. He suggests that Portugal, Chile, Argentina, and France are wine cultures. Japan, Russia, some Scandinavian countries, and the Gaelic and Eskimo cultures tend to drink spirits. Heath (2000) also states that people in any culture may partake in all three types of alcoholic beverages or none at all depending on the social and cultural context in which they live.

Similar to the way drinking is often associated with the Irish culture, opium smoking is often associated with the Chinese culture (Durrant & Thakker, 2003). As discussed

earlier, opium smoking among Chinese immigrants in the United States had a large social aspect to it. The cultural aspect of Chinese opium usage was often "at odds with the American orientation toward productivity, action and settling the West" (Thombs, 2006, p. 241). As a result, even though opium smoking was considered acceptable by Chinese Americans, it was frowned upon by the dominant American culture and viewed within the racist context of foreigners who were corrupting American culture (Durrant & Thakker, 2003).

Substance use and abuse cannot be viewed solely through a historical lens but must also be viewed through the lens of what is considered acceptable cultural and social norms within unique populations. As has been discussed here, what some cultures consider immoral, other cultures consider to be perfectly acceptable.

Basic Tenets of the Moral Model

As we can see, the moral model of conceptualizing addiction evolved from historical use/abuse and attempts to remedy its impact on society. The moral model assumes that addicted people refuse to abide by ethical or moral proscriptions of conduct and that their behavior is freely chosen. Excessive drinking or other drug use is viewed as an expression of irresponsibility, sinful behavior, and even evil possession. The addict is defined as a transgressor who is engaged in morally wrong behavior. Because this position assumes that people are free to choose their behaviors, addicted people are not seen as being literally "out of control" of their addiction as in other models. They instead are seen as choosing to create suffering in themselves and family members and can therefore be justifiably blamed for their behavior. Because the behavior is seen as freely chosen, the most logical way to treat the problem is to punish the transgressor. Therefore from this perspective, the best remedy is to create legal sanctions, provide stricter jail sentences, and increase fines to control and punish the user. Punishment is preferred over providing care or help to the addicted person. Relapse is considered evidence of the enduring evil and sin present in the person and a sign that further, more intense punishment is needed.

Strengths and Weaknesses of the Theory

There are several advantages and disadvantages of the moral model perspective on addiction. One positive aspect of this theoretical perspective is that it is straightforward, simple, and clear. There is little ambiguity or complexity about the causes or nature of addiction, and the remedy is clear. There is no need to examine social, biological, psychological, or spiritual factors related to the epistemology of addiction. Addiction is not seen as a complex issue with many influences and underpinnings. The behavior is seen simply as wrong or sinful, and the application of punishment can be clearly applied. From this perspective, increases in rates of addiction throughout our society are attributable to widespread "moral decay," and calls for a return to "traditional family values" are made to remedy the problem.

One of the disadvantages of the moral model is that scientific research has shown that addiction is an extremely complex problem with multiple contributing factors. In many ways we have just begun to understand the complex nature of addiction from biological, social, psychological, and spiritual perspectives. Scientific evidence suggests that contributing factors to the development and maintenance of addiction are apparently related to genetic predispositions, environmental factors such as family structure, and biological changes in the brain after use over a prolonged time. Another disadvantage to the moral model is that it is not clear at all that addictive use is freely chosen and a matter of free will. In fact, many models discussed later in this book take opposite positions and offer evidence that addictive behavior is out of the control of the individual and that the brain is actually hijacked by the introduction of chemicals. Likewise, in terms of sociological factors, various social policies in U.S. history have contributed to the systemic addiction of populations such as the use of alcohol to control slaves and Native Americans to make them more compliant. In contrast to the freely chosen tenets of the moral model, these external contributing factors to the onset and maintenance of addiction are outside of the control of individuals. Another disadvantage to the moral perspective is that punishment has not been shown to decrease rates of addiction. In fact, an emphasis on societal sanctions and prohibitions against drug use and drug users have historically resulted in increases in organized crime, created lucrative and dangerous underground markets, and overloaded prisons at significantly higher costs than providing treatment.

Whereas the moral model is not an organized and officially adopted model for addiction treatment, it is present in our history and our belief systems both culturally and personally. This makes it difficult to research as a treatment model, but the evidence mentioned earlier does not support its usefulness. Despite questions about the efficacy of this model, this view of addiction as immoral conduct has tremendous influence over social policies.

Influences on Social Policy

The moral model emerges during each political season and can be seen in political campaigns of conservative groups who attempt to appeal to public sentiment by proposing tougher penalties to stop the moral decay and widespread impact of addiction. This sentiment appeals to the general population likely because many still view addiction and drug use as sinful, and many have been personally harmed by addicts. Any promise to control what feels out of control morally is attractive despite repeated failed attempts by the government to eliminate addiction with legal crackdowns (e.g., Chinese opium smokers of the 1800s, Prohibition). Richard Nixon called drugs “public enemy number one” in the 1970s, which eventually influenced the creation of the Just Say No campaign of the 1980s. In the mid-1980s, polls showed that the American people believed that drugs and drug use was the biggest problem in the country. The Just Say No campaign has been seen as a contributor to the prevalence of

the moral model in that drugs were framed as bad and drug users were framed as bad people. The message was clear that addictive behavior was seen as a choice and a problem to be punished. It was actually another oversimplification of the problem that insinuated that if people were morally strong enough they could avoid addiction. Ronald Reagan kept saying "we are going to take back America." From this view, addiction has nothing to do with social context, growing up in poverty, being raised by addicted parents, or the effects of oppression; it is just a matter of having the moral fortitude to say no. Those who cannot say no become one of "them" or the "other," and you do not want to be one of "them."

It is important to acknowledge that our history heavily influences modern-day policies. In terms of public drug policy, our history has brought us to vacillating and often contradictory assumptions involving morality and disease. As a society we believe on the one hand that addiction is a disease, but we punish the addict for the behaviors associated with the disease. Peele (1996) called this the "disease law enforcement model." For example, the temperance movement created a combined disease-moral model that can be seen in the way punishment is given by drug courts to DWI offenders (Thombs, 2006). Offenders are often forced to participate in treatment or 12-step groups in addition to fines and incarceration depending on the number of offenses. Further, employers require addicted employees to attend treatment under the threat of job loss. As a society, we are left with a confusing conceptualization about the nature of addiction and how we must treat it, as well as social norms about what is acceptable and unacceptable substance use.

Box 2.2 Activity—Self-Exploration

1. What was the first reference to addicted people you ever remember hearing?
2. What do you remember about the first person you ever saw or met whom you identified as addicted?
3. What messages did you get from your parents or family about addicted people? How have those messages influenced your beliefs?
4. Some things about addicted people that concern me are _____.
5. Morally I think addicted people are _____.
6. Some things I anticipate I might struggle with when counseling a person who is addicted are _____

Influences on Clinicians

Clinicians often bring their own experiences with addiction into their work. Many have been either directly or indirectly affected by addiction. Some are adult children of

alcoholics, some have struggled with their own addictions, and some have had relatives and friends who have suffered with addiction. Most of us carry some preconceived ideas about addicted people, and many of those perceptions come out of painful feelings associated with those we know. We are naturally judgmental beings, and those judgments can closely resemble the notions at the core of the moral model. How we view addiction and its causes directly affects how we choose to treat it. If we have witnessed someone close to us struggle with addiction, we may judge them based on our personal feelings. If you have unfinished business around an addicted person in your life, you may project those feelings onto your addicted clients. We may believe that they are just not trying hard enough or that they should have more willpower.

Depending on our background, we may believe that the addicted person can find a cure for his or her problems in the context of religion. If you are in recovery yourself and religion or spirituality helped you, you may impose that same path on your clients. Regardless of your beliefs in what causes and maintains addiction, it is difficult not to feel judgmental when someone with eight arrests for DWI kills an innocent college student on the way home from school. Likewise, it is difficult to work nonjudgmentally with a recidivist client who has attended several rounds of treatment without any success. An angry client in extreme denial who proclaims his drinking is not affecting his children may bring up frustration and anger in a clinician. Just as racism, sexism, and homophobia are internalized in us all, the moral model is all around us and in us. Acknowledging and embracing this potential is the only way for these biases to not have undue influence on our interactions with addicted clients. It is important to be able to separate the person from the problem. Examining their own personal vulnerabilities to the negative effects of addiction can help clinicians focus on what is best for their clients. Being politically correct and claiming not to operate from the moral model can in the end be detrimental to our work as addiction counselors.

> Box 2.3 Activity—Common Myths About Addicted People
> As a group, brainstorm a list of common myths that you have heard about addicted people. What does society generally believe about addicted people? What are the stereotypes? After making the list as a group, deconstruct some of those myths to discover the underlying beliefs or assumptions. For example, if "addicted people lack willpower" is on your list, what is the underlying assumption? It may mean that the myth is based on the idea that addiction is a choice. It may be particularly useful to explore conceptions of denial and resistance in this discussion as well. Discuss how these myths are connected to how we might prescribe treatment for addicted people.

Additionally, clinicians who are working with addicted clients with legal involvement may need to educate probation and parole officers to mediate the influences of the moral

model as a form of advocacy for clients. Clients may have their legal status and recovery compromised by a system that may not perceive addiction as a disease or be educated about the effects of drugs on the brain. For example, many probation officers are unaware that marijuana stays in the system for 30 days so any drug screens administered during this time would produce a positive result and place the client in violation of probation. The more clients can be treated from an educated perspective and not a judgmental one, the more likely recovery efforts can be supported.

Case Study Responses

Gabriel seems to be struggling with addiction because of guilt and shame associated with his infidelities and his confusion about his sexual orientation. His irresponsible behavior of dating multiple women while being in a committed relationship reinforces his guilt and shame. Because he was raised in a home that lacked strong family values, he was never afforded the benefits of a strong moral foundation. He seems to struggle with the notions of right and wrong and lacks the personal values to help guide his life choices. Although we don't know much about his childhood, his parents did not appear to provide a religious or spiritual environment to help guide his decision making. The cultural backgrounds of his parents (Native American and African American) may help him find a moral compass through tradition and find support from church and cultural communities. Gabriel lacks the personal willpower to stop using for long periods of time and has not fully grasped the implications of his use and illegal behavior. His legal punishments have apparently not been significant enough to keep him from further transgressions. The penalties have not been harsh enough to convince him to make the choice to change. He also does not fully understand that his misbehavior has impacted his family and his ongoing deliberate use of drugs is out of control, causing the suffering of his family members. His actions are being controlled by evil forces in his life, and his salvation may lie in his acceptance of God's help and a church community. He should stop choosing to use.

The moral model treatment approach to working with Gabriel is very straightforward. It would emphasize a return to traditional or family values and a strong religious component. We would recommend to Gabriel that he find a religious community that would provide a peer mentor and an environment that could guide him in creating a more morally just lifestyle. Daily prayer, devotion, and meditation would be crucial to his recovery. It would also emphasize stronger punishment and legal consequences for his behavior. We would also emphasize his need to find and keep a job to support his family. He would need to place his relationship with God above all else in his life. He needs to explore the relationship between his drug use and his sexual promiscuity, which separate him from serving God well. His confusion about his sexual orientation will be resolved as he becomes stronger in his faith and finds his moral compass.

From the moral model perspective, Gabriel would benefit from more severe punishments for his poor decisions and misbehavior with substances. Through

counseling he would be encouraged to place his family first in his priorities and return to the traditional values of his culture. He would also be encouraged to take full responsibility for his misbehavior and immaturity, acknowledging and accepting that his troubles are of his own making. He would be guided to incorporate structures in his life that would provide a moral compass for his behavior.

From the moral model perspective, no attention is given to the biological, psychological, or social contributing factors in Gabriel's life. For example, from this perspective his many attempts to stop using are not attributable to changes in his brain chemistry, and his predisposition to addiction genetically may be seen as an excuse rather than a factor in his struggles. Likewise, the environmental factors present in his childhood and in his family of origin relationships would not be viewed as contributors to his issues, nor would they be seen as an important part of treatment. The oppression he likely experienced as a biracial person of color would not be perceived as relevant to his psychological issues but rather as an excuse for his bad behavior. Another weakness of the moral model is that there is no scientific evidence that supports the notion that addiction is the result of freely chosen or willful misconduct. Additionally, punishment has not been shown to be an effective means of curtailing substance use.

Some of the strengths of viewing Gabriel's substance use problems from the moral model perspective include that his problems are straightforward and clear. There is no need to overphilosophize or theorize about the causes and maintenance of his issues. His misbehavior and moral deficits are all that need to be addressed if he is willing to address them. He must choose a better life for himself by stopping his use of substances, accepting the consequences of his behavior, and perhaps finding a faith community that will guide him in living a life centered on strong moral values.

Summary

The moral model perspective of drug use and addiction has a long and complex history. Early Americans used alcohol regularly and were complacent about its impact on individuals and society. Attitudes have shifted in extremes from this complacency to demonization and criminalization of users and addicted people. Social and political controls aimed at curbing abuse have contributed to the strength of the moral model and resulted in oversimplification of a very complex problem. Addiction counselors may carry internalized biases that reflect moral model attitudes and should work to increase their awareness so that they do not influence their work with clients. Whereas public sensitivity to the struggles of addicted people has increased, many challenges and barriers continue to prevent some from accessing needed treatment.

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3 Biological Theory: *Genetics and Brain Chemistry*

Kathleen Brown-Rice
Regina R. Moro

Overview of Empirical Research Findings on the Addictive Process

The effect of drugs on a person's physiological functioning is multifaceted. As a drug enters the body it impacts numerous systems (e.g., immune, digestive) with the most severe effect being on the central nervous system (CNS). In particular, the brain's reward pathway is hijacked by the chronic use of alcohol and other drugs that results in risky drug seeking and drug-using behaviors. Thus, professional counselors need to have a basic understanding of the neurobiology of addiction regarding how drugs alter brain chemistry.

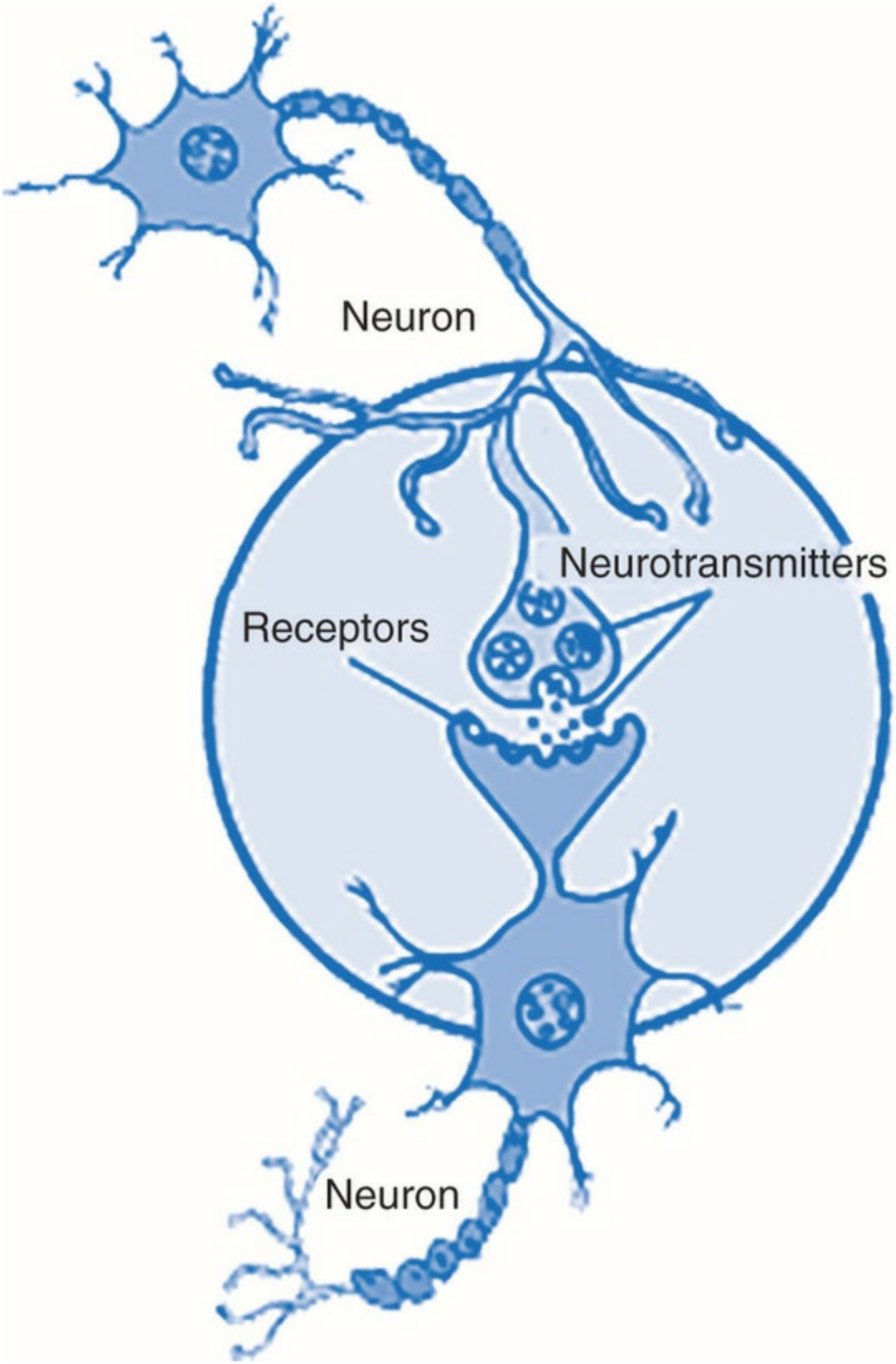
Neurotransmitters

The human brain contains 100 billion neurons or nerve cells (see Exhibit 3.1) that communicate with each other via chemicals called neurotransmitters that transmit signals across the synapses (Koob, Arends, & Le Moal, 2014). Neurotransmitters attach to the receptor of a receiving neuron to unlock these signals. The exact number of neurotransmitters is not known, but it is estimated there are more than 100 (Koob et al., 2014). The neurotransmitters found to be the most involved in the addictive process are dopamine, serotonin, gamma-aminobutyric acid (GABA), and glutamate (Lovinger, 2011). Dopamine is a chemical the brain releases in order to experience pleasure. Dopamine production is stimulated by alcohol, nicotine, opiates, and cannabis. Serotonin is produced to assist in regulation of bodily rhythms, appetite, sexual behavior, and emotional states, and its production is promoted by amphetamines and cannabis.

The most common neurotransmitters in the brain are glutamate and GABA. Over 50% of all brain synapses use glutamate, and 20% to 30% use GABA (McKim & Hancock, 2013). GABA is an inhibitory neurotransmitter that inhibits the transmission of nerve impulses that contribute to motor control and vision, and glutamate is an excitatory neurotransmitter that is associated with learning and memory. Because GABA inhibits neural communication and glutamate mediates neural signals, these neurotransmitters work in tandem to control many brain processes. Drugs change the stability of glutamate and GABA by having sedating or stimulating effects on the brain. Drugs that increase GABA or decrease glutamate are depressants or tranquilizers, and those that decrease GABA or increase glutamate are stimulants (Lovinger, 2011). Overstimulation of glutamate receptors can result in neural cells dying (McKim & Hancock, 2013). The

impact on these neurotransmitters (i.e., dopamine, serotonin, GABA, glutamate) is categorized as either being agonistic or antagonistic (Nutt & Nestor, 2013). Agonistic effects will increase neurotransmitter production, increase neurotransmitter release, or activate receptor sites that respond to neurotransmitters. For example, delta-9-tetrahydrocannabinol (THC) in marijuana binds to cannabinoid receptors and turns off the release of inhibitory neurotransmitters including GABA, which allows excess dopamine to flood the synapse. Antagonistic effects interfere with the release of neurotransmitters, occupy neurotransmitter receptor sites as a false signal, or cause neurotransmitter leakage from vesicles. For example, phencyclidine (PCP) blocks the receptor, which keeps glutamate from being released.

Exhibit 3.1 Neuron Diagram



Source: National Institute on Drug Abuse, National Institutes of Health, U. S. Department of Health and Human Services. (2009). Mind over matter: Prescription drugs. Retrieved from https://teens.drugabuse.gov/educators/mind-over-matter/prescription-drugs.

Brain Reward Pathway

Most drugs of abuse directly or indirectly target the brain's reward system by flooding the circuit with dopamine. This system, known as the reward pathway, contains the prefrontal cortex, which functions in personality expression, decision making, and moderating behavior; the nucleus accumbens, which mediates dopamine release to control desire and inhibition; and the ventral tegmental area (VTA). The VTA is a group of neurons at the very center of the brain that is connected to the prefrontal cortex and nucleus accumbens, and it receives information to see if a person's biological needs are getting met. When the VTA gets information that something is satisfying the body, the VTA will then forward this information by the dopamine neurotransmitter. The increase in the level of dopamine overwhelms the nucleus accumbens and tells the prefrontal cortex, "Do that behavior again; it feels good." This pathway is a natural process and is activated by behaviors that are pleasurable (e.g., eating our favorite food, enjoyable sex). Through the amygdala and hippocampus, our brains remember which behaviors will result in us feeling pleasure. Drugs overstimulate this reward system by producing large amounts of dopamine that create euphoric effects, which generates a powerful reinforcement (Solof, 2013) (see Exhibit 3.2). Positive reinforcement strongly motivates people to engage in drug-taking behaviors and creates a cycle of addiction (Koob & Le Moal, 2005).

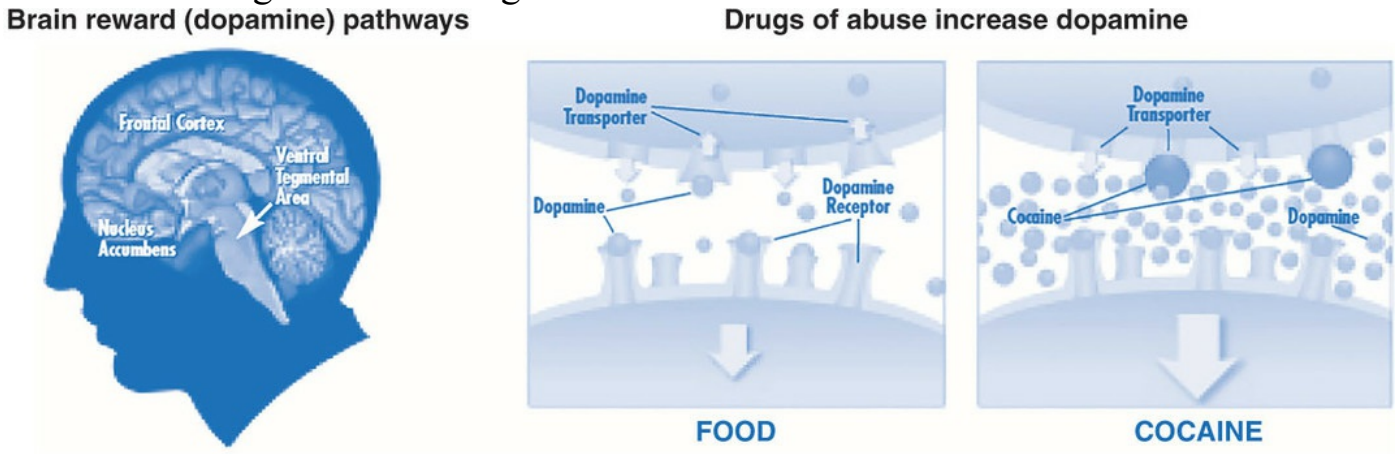
The type of drug will impact the amount of dopamine that floods the reward pathway, and how the drug is taken will affect how quickly the euphoria is felt by an individual. Oral consumption of a drug results in the drug being absorbed into the bloodstream through the stomach and results in a high in approximately 30 minutes (McKim & Hancock, 2013). A suppository results in the substance being absorbed through the mucus membrane in the rectum with a high resulting in generally 15 minutes. When snorting, 30% to 60% of the drug enters the bloodstream through the mucus membrane in the nose and the remainder is swallowed and reaches the bloodstream through the stomach (McKim & Hancock, 2013). Generally, the high occurs within about 15 minutes from the time of snorting. Smoking a drug causes fast absorption into the bloodstream through the lungs, which results in a faster high. Injecting the drug directly into the bloodstream creates an almost immediate high, typically within 3 to 5 seconds (McKim & Hancock, 2013).

The *reward* that a drug produces in the brain can be 2 to 10 times stronger than a reward that chocolate or good sex can produce. Thus, the brain needs to maintain homeostasis and will self-regulate. After the unnatural flood of dopamine the drug creates, the brain will naturally produce less dopamine, which can result in a person who abuses substances having abnormally low dopamine levels. The consequence of these lower levels can be a reduced ability to experience pleasure unless the person takes the substance, which may negatively condition a person to continue using.

Cycle of Addiction

Jellinek (1960) is considered to be the originator of developing behavioral cues that show the progression of addiction. He developed a U-shaped model, called the Jellinek Curve, to define the course of alcohol addiction for an individual. However, the reliability of Jellinek's model has been found to be reduced in samples that were diverse in gender and other cultural characteristics (Venner & Miller, 2001). Koob and Volkow (2010) found that animal and human brain imaging studies have led to us having a greater understanding of the cycle of addiction, which can be described in three stages: *binge/intoxication*, *withdrawal/negative affect*, and *preoccupation/anticipation* (i.e., craving, relapse). "From a neurobiological perspective, progression through the three stages of the addiction cycle induces plasticity in neural circuitry that drives compulsive drug taking, narrowing the behavioral repertoire to drug seeking" (Koob & Le Moal, 2005, p. 1442).

Exhibit 3.2 Drugs of Abuse Target the Brain's Pleasure Center



Source: National Institute on Drug Abuse, National Institutes of Health, U. S. Department of Health and Human Services. (2014). Drugs and the brain. Retrieved from www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drugs-brain.

The nucleus accumbens and VTA are activated in the binge/intoxication stage. As discussed earlier, the reward pathway results in a positive reinforcement to keep engaging in a behavior. The nucleus accumbens and amygdala are important in the withdrawal/negative affect phase. Constant exposure to drugs results in a reduction in the number of dopamine receptors in the nucleus accumbens; thus more drug-taking behavior is needed for a person to feel *normal*. It has been found that changes to the amygdala have been related to drug withdrawal symptomatology (i.e., irritability, anxiety, stress) (Logrip, Koob, & Zorrilla, 2011). In this process, negative reinforcement is at work facilitating drug-taking behavior. The main brain structures involved in the preoccupation/anticipation stage are the frontal cortex and hippocampus.

Researchers hypothesize that the altered frontal cortex and hippocampus functioning found in individuals with severe substance use problems results in these individuals engaging in drug-seeking behaviors even if they have negative consequences (Lubman, Yücel, & Pantelis, 2004; Schoenbaum & Shaham, 2008).

Basic Tenets of the Theory

The concept of addiction being a disease is not a new concept. Benjamin Rush in 1784 was the first to provide recommended treatments for chronic alcohol inebriation, and Dr. William Sweetser in 1829 was the first to provide that chronic intoxication directly and indirectly resulted in a dysfunctional change of the major functions and structures of the human body (White, 2001). Today, the disease model of addiction suggests that addiction is a progressive and chronic condition that is not curable but can be managed (Thombs & Osborn, 2013). Clinicians working from the disease model perspective believe that defining addiction as a disease assists in taking away the moral stigma of addiction (Buchman, Skinner, & Illes, 2010).

The general disease concept seeing addiction as a chronic, incurable condition that can be managed only through abstinence has a long history that has been reinforced through 12-step organizations (e.g., Alcoholics Anonymous, Narcotics Anonymous) (Meurk, Carter, Partridge, Lucke, & Hall, 2014). The disease theory of addiction has been strengthened by advances in genetic testing, neurobiology, and neuroimaging (e.g., positron emission tomography, PET; functional magnetic resonance imaging, fMRI). PET records brain activity through mapping water, glucose, or any number of other chemicals via an extremely complex statistical computing system (Hickman, 2014). fMRI records blood flow and oxygen levels that are correlated with the brain's neural activity. Active areas of a brain will *light up* and can be detected through fMRI imaging. Consequently, the disease model of addiction is currently categorized by two separate models: the dispositional model and the neurobiological model.

Philosophical Underpinnings and Key Concepts of the Theory

Dispositional Model

The dispositional disease model provides that some people are somehow genetically or biologically different; thus, they are susceptible to developing an addiction. The human genome is believed to contain 30,000 genes, and from 50 to 100 genes have been found to influence addiction (Snow & Lu, 2012). Twin and familial studies have consistently found that alcohol use is genetically influenced. Kendler, Maes, Sundquist, Ohlsson, and Sundquist (2014) examined environment and genetic risk factors in the etiology of drug abuse using twin sibling modeling and found that heritability predicted drug abuse in males (55%) and females (73%) (see Exhibit 3.3).

When determining if a person is at risk of becoming addicted, epigenetics (see Box 3.1)

should be considered. Changes in how genes are expressed in brain reward regions can contribute to cause and continuance of drug addiction (Renthal & Nestler, 2014). For example, animal research has found that repeated exposure to cocaine results in a certain set of genes being expressed, and these genes will remain activated for days to weeks after the last ingestion of cocaine (Bowers et al., 2004; Grimm et al., 2003; McClung & Nestler, 2003). These genes appear to be related to brain regions "involved in regulating behavioral responses to drugs of abuse," which has important implications for understanding how recreational drug use becomes a chronic disease (Renthal & Nestler, 2013, p. 346). These altered genes may explain why all twins do not become substance abusers. These genes may not be activated or expressed in some twins and may be immediately expressed in other twins following their first or concurrent drug use. The introduction of the drug into the body alters how a person's genetic code is expressed, which results in them developing the disease of addiction. Vassoler, Byrnes, and Pierce (2014) suggest "that [parental] exposure to drugs of abuse produce[s] transmissible epigenetic changes that result in profound alterations" in the genetic makeup and drug behaviors of their children (p. 273). However, research is needed to determine if the alteration in a substance user's genetic code results in a permanent change in the genetic makeup of subsequent generations.

Neurobiological Model

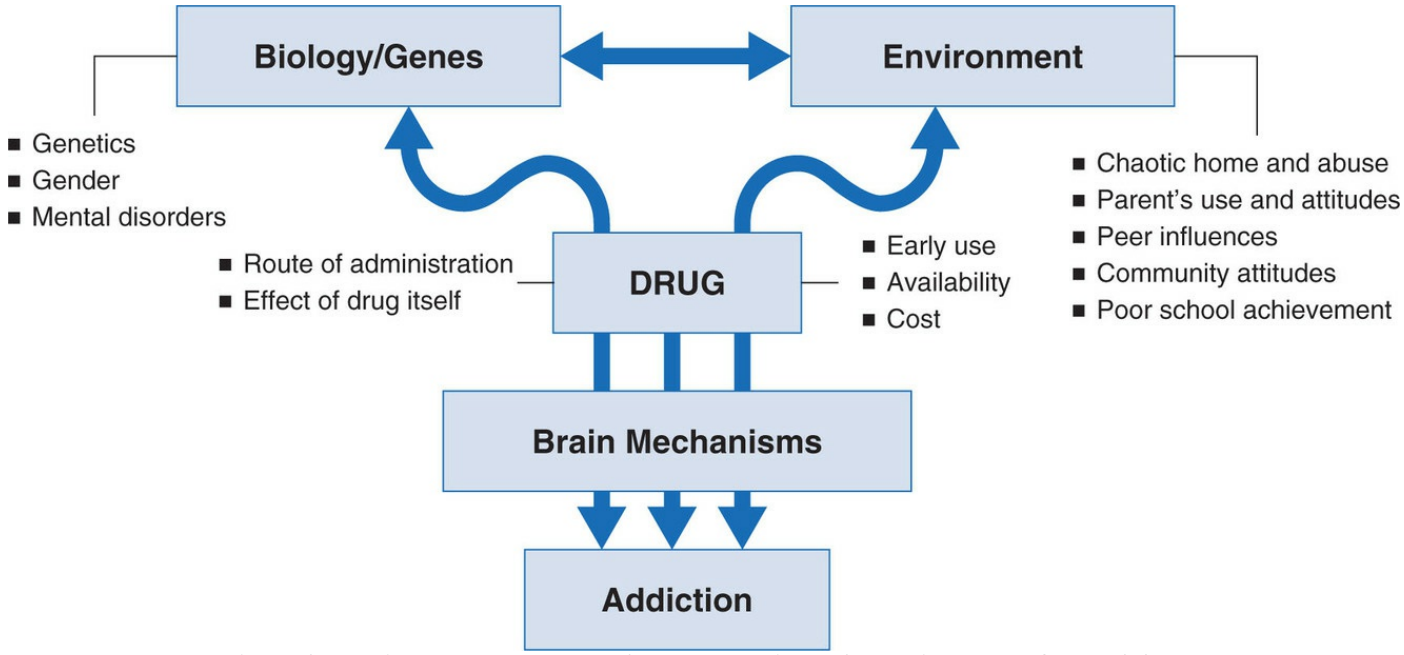
The neurobiological model provides that addiction is a result of a brain's structure and function being changed by exposure to alcohol and other drugs. As discussed, drugs interfere with how neurotransmitters function. According to the neurobiological theory, chronic use of drugs alters the functioning of the neurotransmitters and receptors, which changes brain functioning (Nutt & Nestor, 2013). This model of addiction provides an explanation regarding why addiction continues and relapse occurs. These neurobiological changes to the brain produce several effects: (a) They impact how the prefrontal cortex functions so that judgment is impaired, (b) they alter the brain circuitry leaving a person vulnerable to relapse, and (c) they block dopamine receptors leading to the development of drug dependence (Koob & Simon, 2009). In fact, structural and functional brain differences in certain regions (i.e., temporal, parietal, occipital frontal lobes) have been found in adults and adolescents who drink large amounts of alcohol (Fein & McGillivray, 2007; Fein, Shimotsu, & Barakos, 2010; Sullivan, Harris, & Pfefferbaum, 2010). In particular, abnormalities have been found in prefrontal brain function in individuals who are addicted to substances that relate to having a loss of control (Luijten et al., 2014; Moeller et al., 2014).

Box 3.1 Defining Epigenetics

In a human cell there are many genes. Some genes are inactive and do not do anything (not expressed); other genes are activated (expressed) by certain conditions that occur naturally in our body. Epigenetics is the study of how

environmental factors change the way genes are expressed (Francis, 2009). Genes that would naturally stay inactive are made active by environmental factors (e.g., drugs, nutrition, abuse, neglect, poverty, oppression).

Exhibit 3.3 Risk Factors



Source: National Institute on Drug Abuse, National Institutes of Health, U. S. Department of Health and Human Services. (2014). Drugs and addiction. Retrieved from www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-abuse-addiction.

Hijacked Brain Theory

Dr. Alan Leshner was the director of the National Institute of Drug Abuse from 1994 to 2001 and is credited with being at the forefront of the theory that drugs hijack the brain. Leshner (1997) was one of the first researchers to state that addiction is "a chronic, relapsing brain disorder characterized by compulsive drug seeking and use," and "prolonged drug use causes pervasive changes in brain function that persist long after the individual stops taking the drug" (p. 45). Consequently, the addicted brain is vastly different on a molecular, cellular, structural, and functional level from the nonaddicted brain. This alteration of the brain is due to how alcohol and other drugs disrupt and hijack the brain mechanisms that trigger the cycle of addiction (binge/intoxication, withdrawal/negative affect, and preoccupation/anticipation) (Koob & Volkow, 2010). This hijacking of the brain may be especially dangerous during adolescence. The prefrontal cortex of the brain is not completely developed until around the age of 25; subsequently, adolescents' and young adults' ability to make healthy decisions, control impulses, and understand the consequences of their actions are impaired (Sowell et al., 2003). Thus, adolescents may be more inclined to engage in risky drug use, which in turn can alter how the prefrontal cortex develops (Volkow & Li, 2004). Blum and

colleagues (2015) completed an extensive review of the literature regarding epigenetic factors, prefrontal cortex dysregulation, and adolescents' predisposition to engage in addictive behavior and found that “early life alcohol exposure or adversity may modulate … proper neurodevelopment, thereby predisposing a person to addictive behaviors at adulthood” (p. 290).

Addictive Substances

As mentioned earlier, the type of substance is correlated with the impact on an individual's brain reward pathway. Therefore, professional counselors should be versed in the names of drugs, including common street names and how use of these drugs affects a person's psychological and physiological functioning. Exhibit 3.4 provides a quick reference guide to the drugs, long-term and short-term effects, and possible withdrawal symptoms. More detail related to the major drugs of addiction is provided next.

Box 3.2 Wernicke's Syndrome
Wernicke's syndrome is a neurological disorder that affects heavy drinkers. The symptoms are being undernourished, jerkiness, involuntary eye movements or paralysis of the eye muscles, poor balance or being unsteady on your feet, and confusion or mild memory loss.

Box 3.3 Korsakoff's Syndrome
Korsakoff's syndrome is a brain disorder usually correlated with heavy alcohol consumption over a long period. It is a result of a loss of B1, and a symptom is loss of short-term memory.

Depressants

Depressants are drugs that inhibit a person's central nervous center by suppressing GABA neurotransmitters. Basically, a person's brain functioning is slowed down and/or sedated. Some depressants (e.g., Valium) may be beneficial to a client who has symptoms of anxiety or sleep issues when the medication is taken as prescribed. However, when the substances are abused they can have detrimental effects on a person's overall functioning.

Substance	Possible Short-Term Effects	Possible Long-Term Effects	Possible Withdrawal Symptoms
Tobacco (cigarettes, chewing tobacco, cigars, bidis, hookahs)	Increased blood pressure, breathing, and heart rate	Increased risk of cancer, chronic bronchitis, emphysema, heart disease, leukemia, cataracts, pneumonia	Irritability, attention and sleep problems, increased appetite
Alcohol (beer, wine, hard liquor)	Slurred speech, drowsiness, vomiting, diarrhea, headaches, distorted vision, impaired judgment, decreased coordination and perception, loss of consciousness, anemia, blackouts, and coma	Kidney and liver damage (e.g., hepatitis, cirrhosis), high blood pressure, stroke, Wernicke's syndrome (see Box 3.2), Korsakoff's syndrome (see Box 3.3), sexual dysfunction	Anxiety or nervousness, depression, fatigue, irritability, jumpiness or shakiness, mood swings, nightmares, unclear thinking, clammy skin, dilated pupils, headache, insomnia, loss of appetite, nausea, vomiting, rapid heart rate, sweating, and hand and other body part tremors
Marijuana (pot, grass, reefer, weed, ganja, hash, chronic, gangster)	Enhances sensory perception and euphoria followed by drowsiness/relaxation; slowed reaction time; problems with balance and coordination; increased heart rate and appetite; problems with learning and memory; hallucinations; anxiety; panic attacks; psychosis	Mental health issues, chronic cough, frequent respiratory infections	Irritability, trouble sleeping, decreased appetite, anxiety
Cocaine (coke, blow, snow, flake, toot, crack, candy, C, bump, rock)	Narrowed blood vessels; enlarged pupils; increased heart rate, temperature, and blood pressure; headaches; anxiety; erratic and violent behavior; panic attacks; paranoia; psychosis; heart attack; stroke; seizure; coma	Nosebleeds, nasal damage, poor nutrition, decreased appetite, weight loss	Depression, tiredness, increased appetite, insomnia, vivid unpleasant dreams, slowed thinking and movement, restlessness
Amphetamines (speed, Ritalin, ecstasy, X, diet pills, crystal meth, ice, crank)	Increased alertness and energy, increased blood pressure and heart rate, decreased appetite, narrowed blood vessels, increased blood sugar	Heart problems, psychosis, anger, confusion, paranoia, insomnia, violent behavior, problems with attention and memory, loss of appetite, hallucinations, intense itching, severe dental problems	Depression, anxiety, tiredness, sleep problems, loss of appetite, trouble concentrating
Inhalants (glue, correction fluid, gasoline, butane, paint thinner, lighter fluid, spray paint, poppers, snappers, Rush, Locker Room, nitrous oxide, laughing gas, whippets)	Confusion, nausea, slurred speech, lack of coordination, euphoria, dizziness, drowsiness, disinhibition, hallucinations/delusions, headaches, death from heart failure or asphyxiation, convulsions, seizures, coma, choking	Liver and kidney damage; bone marrow damage; nerve damage that can cause spasms; brain damage that can cause problems with thinking, movement, vision, and hearing	Nausea, loss of appetite, sweating, tics, problems sleeping, mood changes
Sedatives (Valium, Xanax, Librium, Dalmane, Ativan, Halcion, Miltown, Thorazine, Mellaril, Restoril, Rohypnol, roofies, GHB, Liquid X, Liquid E, Mebaral, Nembutal, Seconal, Fiorinal, Amytal, Phenobarbital, Placidyl, Doriden, downers, barbs, phennies, red birds, reds, tooies, yellow jackets, candy, tranks, rope, R2)	Drowsiness, slurred speech, poor concentration, confusion, dizziness, problems with movement and memory, lowered blood pressure, slowed breathing	Unknown	Insomnia, anxiety, tremors, sweating, increased heart rate and blood pressure, psychotic thoughts, seizures
Hallucinogens (LSD, blotter, acid, mushrooms, PCP, angel dust, THC, wet, illy, ketamine, Special K, vitamin K, 2C-B)	Hallucinations, altered perception of time, inability to tell fantasy from reality, panic, memory loss, confusion, muscle relaxation or weakness, problems with movement, enlarged pupils, nausea, vomiting, drowsiness	Risk of flashbacks, memory problems, paranoia, mood swings	Headaches, sweating. All withdrawal symptoms are not known at this time.
Opioids (Codeine, OxyContin, Darvon, Vicodin, Dilaudid, Demerol, Lomotil, Percodan, Talwin NX, heroin, morphine, methadone, Cody, Lean, Schoolboy, Sizzurp, Purple Drank, Doors & Fours, Loads, China Girl, China White, Dance Fever)	Pain relief, drowsiness, nausea, constipation, euphoria, confusion, slowed breathing, death	Unknown	Restlessness, muscle and bone pain, insomnia, diarrhea, vomiting, cold flashes, leg movements

Source: National Institute on Drug Abuse, National Institutes of Health, U.S. Department of Health and Human Services. (2016). *Drug Facts*. Retrieved from www.drugabuse.gov/publications/finder/t/160/DrugFacts.

Alcohol

Alcohol (ethanol) is the most commonly abused substance. The National Institute on Alcohol Abuse and Alcoholism (NIAAA; 2015) reports that 71% of people 18 years and older in the United States in 2013 consumed alcohol within the previous 12 months. In fact, drinking to excess is the third leading cause of injury and preventable death (NIAAA, 2015). The amount of pure ethanol in a drink is called *proof*. The key to an alcohol beverage is not the type (e.g., wine, beer, hard liquor) but the percentage of ethanol. The higher the concentration of ethanol, the greater the amount the body has to process.

The higher the concentration of alcohol, the faster the body absorbs it, and the faster the absorption, the quicker a person's blood alcohol concentration (BAC) will peak. If something causes the alcohol to stay in the stomach, then absorption is delayed (see Exhibit 3.5). Even a person's mood can delay absorption of alcohol. When the BAC rises faster than the body can eliminate the alcohol, intoxication occurs. BAC is decreased by the water in the body, in that the water will cause the alcohol to be diluted, which results in a lower BAC. Muscle has more water than fat, and women have more fatty tissues than muscle; therefore, women generally will achieve a higher BAC and a quicker and greater level of intoxication. One standard drink (see Exhibit 3.6) is usually metabolized by a person's body in 1 hour. Only time will lower a person's BAC. Cold showers, caffeinated drinks, and exercise will do nothing to lower the BAC.

Alcohol has the most obvious effect on the CNS. Basically, alcohol slowly puts the brain to sleep. The first part of the brain impacted is the prefrontal cortex, which is responsible for a person's critical thinking and decision making. A person who is drinking may engage in behaviors or say things that are not appropriate. With the prefrontal cortex napping, the limbic system (i.e., emotional center of the brain) takes over, and some people become unpredictable: inappropriately laughing; crying; or becoming angry, hostile, and even violent. The next part of the brain to be affected by alcohol is the cerebellum (i.e., motor coordination). Consequently, coordination is impacted when a person drinks too much. The last part of the brain that alcohol affects is a person's involuntary systems. Too much alcohol at one time can cause a person's vital functions (e.g., respiration, heart pumping) to slow and then stop. Binge drinking is so dangerous because consuming a large amount of alcohol in a short period of time impacts these vital functions to a point where a person goes into a coma or dies.

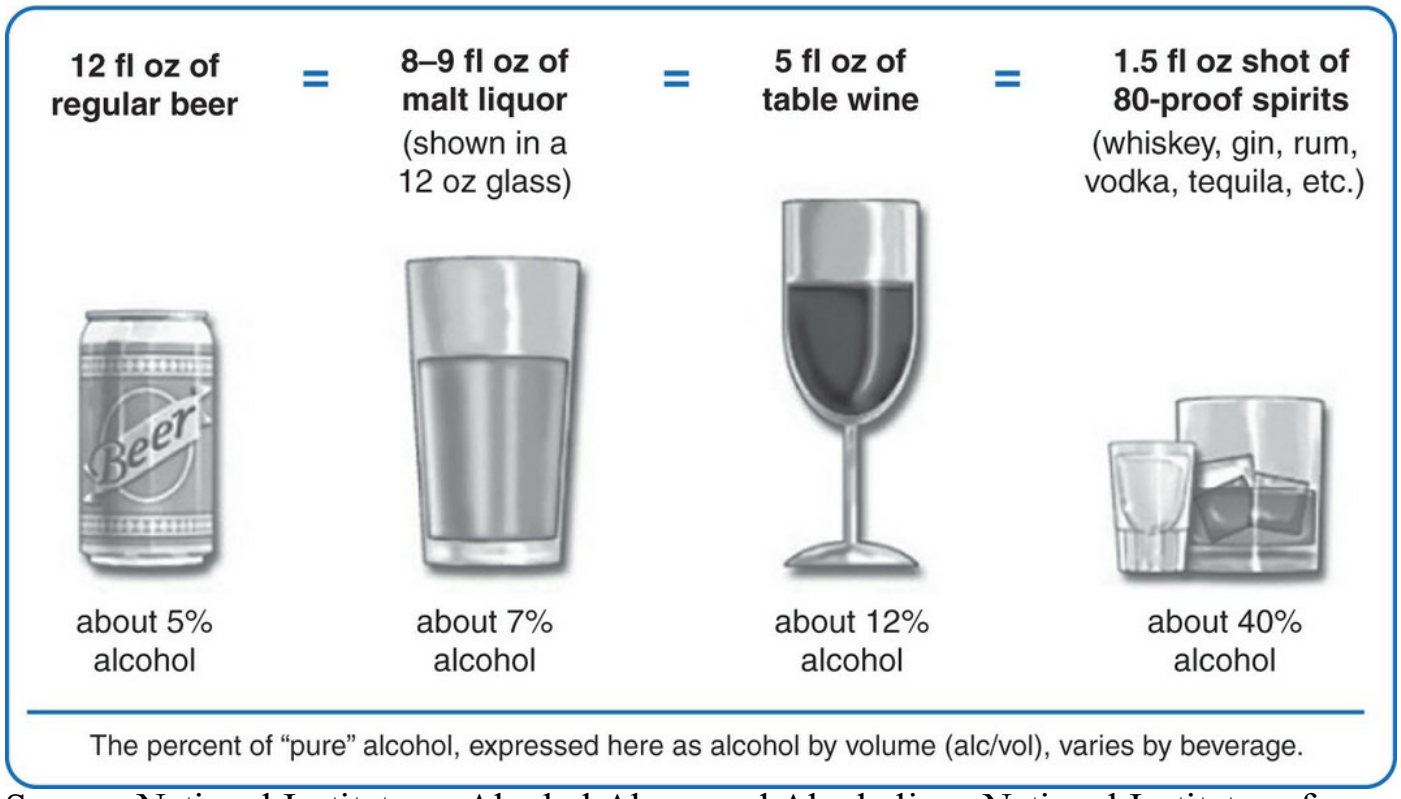
Sedatives

Sedatives are usually prescribed to treat anxiety and problems sleeping. Because they increase the GABA neurotransmitter, this inhibits brain activity, which causes

drowsiness and gives an individual a feeling of calm (Lovinger, 2011). The most common type of drug in this category is benzodiazepines (i.e., chlorodiazepoxide, Valium, Xanax, Halcion), barbiturates (i.e., pentobarbital, phenobarbital), and sleep medications (i.e., Ambien, Lunesta, Sonata) (National Institute on Drug Abuse [NIDA], 2014). See Exhibit 3.4 for a list of sedatives. Benzodiazepines are also related to drug-facilitated sexual assaults. Flunitrazepam (Rohypnol) has been found to be slipped into the food or drink of a person (Jansen & Theron, 2006). As a result, the person becomes incapacitated to the point he or she cannot move or becomes unconscious and is victimized.

What Slows Alcohol Absorption?	What Speeds Alcohol Absorption?
Mixing alcohol with another nonalcoholic liquid (mixed drinks)	Straight liquor (shots)
Food in the stomach	Chugging drinks
Feeling angry, fearful, stressed, or fatigued	Feeling happy, excited

Exhibit 3.6 What Is a Standard Drink?



Source: National Institute on Alcohol Abuse and Alcoholism, National Institutes of Health, U.S. Department of Health and Human Services. (n.d.). *What is a standard drink?* Retrieved from www.niaaa.nih.gov/alcohol-health/overview-alcohol-consumption/what-standard-drink.

Men abuse prescription drugs more than women except for 12- to 17-year-old females (NIDA, 2014). A person abusing sedatives usually begins taking the medication as

prescribed. However, as one's body adjusts to the effects of the sedative, tolerance (see Box 3.4) can develop. Long-term use can result in a person becoming dependent on the drug, and he or she will have withdrawal symptoms when not getting a sufficient amount of the drug. These symptoms can be severe (e.g., seizures). Because withdrawal from barbiturates can be life-threatening, medical monitoring is recommended.

Opioids

Also known as narcotics, opioids can be naturally occurring (e.g., opium, morphine, codeine), semisyn-thetic (e.g., heroin, hydromorphone), or synthetic (e.g., methadone, Demerol) (NIDA, 2014). Naturally occurring opioids protect us when we sustain an injury. Semisynthetic and synthetic opioids are typically prescribed to decrease the perception of pain and cause sleepiness (McKim & Hancock, 2013). See Exhibit 3.4 for a list of opioids. Opioids attach themselves to opioid receptors found in the CNS and gastrointestinal tract (McKim & Hancock, 2013). As a result, a person will become drowsy and light-headed and will fall asleep for short periods of time. Opioids affect the body's respiratory system; thus, large doses will result in impaired breathing and overdose due to respiratory failure. In fact, deaths by opioid pain relievers exceed those for all other illicit drugs (Centers for Disease Control and Prevention [CDC], 2011).

> Box 3.4 Tolerance
> Tolerance is when a drug no longer has an effect on a person.

Individuals who abuse opioids might have started using the substance to relieve pain or obtain a euphoric feeling. However, given opioids' highly addictive properties, physical dependence can occur. It is estimated 2.1 million people in the United States have substance use disorders related to prescription opioid pain relievers (Substance Abuse and Mental Health Services Administration [SAMHSA], 2013), and one fourth of users of nonmedical opioids are 12 to 17 years old (Wu, Ringwalt, Mannelli, & Patkar, 2008). Wu, Woody, Yang, Pan, & Blazer (2011) examined National Survey on Drug Use and Health data from 2005 to 2008 from 72,561 adolescents aged 12 to 17 years and found that after marijuana, opioids are the most commonly used illicit drug (see Box 3.5) among all racial/ethnic groups, with Native American, white, and multiracial youth showing significantly higher rates of use.

Heroin is a particularly addictive opioid. It is estimated that 467,000 people in the United States are addicted to heroin (SAMHSA, 2013). Heroin mimics the body's natural opiates and turns off dopamine inhibition, which floods dopamine into the body's reward pathway. The body cannot re-create this initial flood of dopamine during subsequent uses, and a person will continually use trying to *chase* the initial high. Consequently, heroin is a highly addictive substance. Individuals who abuse heroin are also at risk of HIV and hepatitis infection due to sharing needles (CDC, 2011).

Stimulants

Stimulants have the opposite effect of depressants, in that these drugs excite a person's

central nervous center by increasing glutamate neurotransmitters. Thus, stimulants increase dopamine and can create a euphoric feeling when not taken as medically prescribed. Using stimulants as prescribed can increase an individual's alertness, responsiveness, and energy. Abusing stimulants can result in developing not only an addiction but also cardiovascular problems due to the fact that stimulants elevate the user's blood pressure, respiration, and heart rate (NIDA, 2014).

Amphetamines

Prescriptions written for stimulants have grown from 4 million in 1991 to 45 million in 2010 (NIDA, 2014). Stimulants are mainly prescribed to treat attention-deficit/ hyperactivity disorder (ADHD) to decrease hyperactivity. However, prescription stimulants (e.g., Concerta, Adderall, Ritalin) are increasingly being abused. A particular at-risk population appears to be college students. Varga (2012) completed an extensive literature review on the use of Adderall on college campuses and found students reporting illicit use is increasing, possibly due to the pressures regarding academic performance. One study found that 34% of college students reported using an amphetamine without a valid prescription, with men abusing more than women (DeSantis, Webb, & Noar, 2008).

> Box 3.5 Illicit Drugs
> An illicit drug is a drug that is illegal to make, sell, or use.

Illicit amphetamines, such as methamphetamine (meth), are alternatives to pharmaceutically produced amphetamines. Meth can be smoked, snorted, injected, or ingested. See Exhibit 3.4 for a list of effects and withdrawal symptoms. These substances are highly addictive because they hijack the brain's reward pathway by not only blocking the reuptake of dopamine but increasing the flood of dopamine, which results in an extremely intense feeling of pleasure for the drug user (NIDA, 2012a). As with heroin, the initial rush of euphoria cannot be re-created, and the individual addicted to this substance is continually chasing the high. These substances are typically created in home-based *meth labs*, which results in the substance costing less than prescribed medications. Meth abuse also raises the risk of contracting or transmitting HIV, hepatitis, and other infections by the sharing of needles (NIDA, 2012a). Even noninjecting meth users are at risk because the drug affects a person's judgment and inhibition and may lead him or her to engage in risky behaviors (e.g., unprotected sex).

Cocaine

Forms of cocaine (see Exhibit 3.4) can be smoked or injected. The use of cocaine in the United States has been found to be diminishing over the last 30 years (Drug Enforcement Agency [DEA], 2015). Adults aged 18 to 25 years are reported to have the highest rate of cocaine use (NIDA, 2010). Research regarding differences in gender and race/ethnicity and cocaine use found women have higher rates of cocaine addiction then men; however, no difference was found related to race/ethnicity (Wu et al., 2010).

Cocaine is typically snorted or injected. It interferes with the brain's natural reward pathway by blocking the uptake of dopamine to produce a short-term feeling of euphoria; this is why cocaine is so addictive. It also affects the part of the brain responsible for controlling movements (i.e., cerebellum). As a result, individuals abusing cocaine are fidgety and have an inability to be still. Neural imaging has shown continued cocaine use affects the dopamine receptors in the brain. This is believed to be responsible for diminished sensitivity to the brain reward pathway being naturally activated, which results in individuals craving the unnatural high that cocaine provides (Volkow et al., 2014).

Marijuana

According to a study conducted in 2013, marijuana is the most commonly used illicit drug (see Box 3.6) (SAMSHA, 2014). Specifically, marijuana was used by 81% of individuals using drugs in the last 30 days and was the only drug used by 65% of respondents. Adolescents use marijuana more often than any other drug, including alcohol (Wu et al., 2011). There also appears to be a quicker transition from experimental use of marijuana to regular use in females when compared with males (Schepis et al., 2011). Marijuana can be used in various forms (see Exhibit 3.4).
The active agent in marijuana is THC. THC blocks neurotransmitters that inhibit dopamine release, and excess dopamine is allowed to be released (NIDA, 2015). As a result, people who use marijuana have a sense of relaxation, which can result in a person continuing to take the drug to sustain this feeling. THC can stay in a person's system for up to 6 weeks; however, the high generally dissipates after 1 to 3 hours when smoked or several hours when consumed in food or drink (NIDA, 2015). The use of marijuana has also been associated with psychotic symptoms. However, the degree of symptomatology is related to the type and strength of the plant, usage patterns, and individual characteristics of the user (Guimarães Silva, Queiroz Balbino, & Moura Weiber, 2015).

> Box 3.6 Marijuana
> Although medical and recreational marijuana have been legalized in some jurisdictions, it is still considered an illicit drug because it is a violation of federal law to make, sell, or use it.

Neural imaging studies of chronic marijuana users have found abnormal functioning in the prefrontal cortex. Decreased activity has been found in the regions of the brain that integrate affective and cognitive information (i.e., anterior cingulate cortex) (Wesley, Hanlon, & Porrino, 2011); are responsible for working memory (i.e., dorsolateral prefrontal cortex) (Bolla, Eldreth, Matochik, & Cadet, 2005); are important in decision making (i.e., ventromedial prefrontal cortex) (Li, Lu, D'Argembeau, Ng, & Bechara, 2010); and responsible for controlling cognitive-motor skills and coordinating movement (Weinstein et al., 2008). This decreased activity can impact a person's

motivation, critical thinking, memory, and motor coordination.

Tobacco

Tobacco stimulates the CNS and increases blood pressure, heart rate, respiration, and constriction of the arteries. See Exhibit 3.4 for more information on the long-term and short-term effects and possible withdrawal symptoms of tobacco. Tobacco is the single largest preventable cause of death and disease in the United States (CDC, 2014). Men are more inclined to use tobacco than women, with 20 of every 100 men and 15 of every 100 women using a form of tobacco (CDC, 2014). The percentage of high school students who smoke cigarettes has dropped significantly in the last 15 years; however, the use of e-cigarettes has grown from 4.7% in 2011 to 17.2% in 2014 for high school seniors (Office of Adolescent Health, 2015).

Nicotine is the substance in tobacco the causes the product to be so addictive. Similar to cocaine and heroin, nicotine affects the brain's reward pathway by flooding it with dopamine. Long-term tobacco use alters the reward pathway and clients become addicted (McKim & Hancock, 2013). Tobacco use has been linked to use of other addictive drugs. Individuals who smoked cigarettes were far more likely to use cocaine, heroin, crack, and marijuana regardless of age, race, or gender (Lai, Lai, Page, & McCoy, 2000). Thus, it appears cigarette smoking is a gateway drug to other illegal drug use. Further, tobacco use has been associated with poorer short-term outcome of outpatient treatment for clients who have a cocaine addiction (Harrell, Montoya, Preston, Juliano, & Gorelick, 2011).

Latest Trends

Just as many other professional fields see emerging trends, so does the substance abuse and addiction field. One of the most prevalent current trends is increased abuse of synthetically manufactured substances. Many of the creators of these substances seek to mimic the effects of other substances of abuse examined earlier. The following three substances are only a sample of the emerging drugs, with more being created weekly.

Molly

In 2012 the legendary musical performing artist Madonna was quoted as saying, “How many people in this crowd have seen Molly?” during an outdoor music festival in Miami, Florida (Diaz, 2012, para. 4). The drug *Molly* has recently grown in popularity as emphasized by Madonna's quote, although the substance has been around for quite some time. Molly refers to the pure form of MDMA, also known as Ecstasy (NIDA, 2013). Users of Molly are generally seeking increased energy and feelings of euphoria. These feelings are a result of the substance increasing the activity of three neurotransmitters: serotonin, dopamine, and norepinephrine (NIDA, 2013). Users also report an elevated mood and positive social interactions. These side effects are mostly due to the release of serotonin, which also triggers the release of oxytocin and vasopressin, two hormones responsible for feelings of love, trust, and overall social

bonding (NIDA, 2013). With the large release of serotonin during use, the brain becomes depleted, which later results in feelings of confusion and often drug craving to return to the euphoric state in the following days and weeks (NIDA, 2013).

K2/Spice

The substance K2 or Spice is part of a newly emerging synthetic substance trend, the main purpose of which is to mimic marijuana. For many years, these substances were sold legally by placing the label "not for human consumption" on the packages (NIDA, 2012b). These packages look like incense, although the substance is typically composed of dry plant material and chemical substances, which have been created to mimic cannabinoids in the brain. Users report elevated mood, relaxation, and altered sense of perception, similar to marijuana users (NIDA, 2012b). There have been extreme cases of users seeking medical attention for rapid heartbeat, vomiting, agitation, and hallucinations (NIDA, 2012b). In 2010, approximately 11,406 visits to emergency departments were due to the use of synthetic cannabinoids, yet this more than doubled in 2011 with a reported 28,531 visits involving complications from the substance (Bush & Woodwell, 2014).

Flakka

The substance named Flakka is also known as "gravel" or "Alpha-PVP." This drug is a stimulant, although it is synthetically created in laboratories, most commonly overseas (United Way of Broward County Commission on Substance Abuse [UWBCCSA], 2014). According to the UWBCCSA (2014), users are typically seeking a euphoric state, although severe side effects such as accelerated heart rate, paranoia, agitation, and psychosis are common. In addition, users are at risk for developing excited delirium, a "syndrome of violent behavior often accompanied by seriously elevated body temperature (or hyperthermia), as well as a breakdown of muscle tissue that leads to the release of muscle fiber contents into the blood (or rhabdomyolysis) and kidney failure" (UWBCCSA, 2014, para. 2). The instances of death following Flakka use are rising across the United States.

Polysubstance Use

When individuals use and abuse multiple substances, the biological effects can be dangerous and life threatening. A person concurrently using depressants (e.g., alcohol, sedatives) and stimulants (e.g., amphetamines, cocaine) sends contradicting messages to his or her body. Consequently, immense pressure is placed on the person's central nervous, cardiovascular, and respiratory systems. This tug and pull on these systems can result in slowed breathing, cardiac arrest, heart attack, heart failure, coma, or death. In fact, when individuals who survived overdose were interviewed, 67.5% of these participants reported polysubstance use during their last overdose event (Martin et al., 2014).

A common trend has been to consume highly caffeinated energy drinks with alcohol.

Khan, Cottler, and Striley (2016) assessed the alcohol and energy drink use of 4,905 youth, 13 to 18 years of age from 10 U.S. cities. They found that 28% reported past 30-day alcohol use, and among these alcohol users, 27% reported having alcohol mixed with energy drinks. When college students were assessed for their concurrent use of alcohol and energy drinks, similar percentages were found (27%) (Rutledge, Bestrashniy, & Nelson, 2016). Energy drinks are designed to increase alertness and stimulation, whereas consuming alcohol sedates the CNS. When taken together, energy drinks "mask the depressant effects of alcohol, reducing physiological and psychological sedation-based effects (e.g. fatigue), while increasing stimulation (e.g. alertness, energy)" (Peacock, Pennay, Droste, Bruno, & Lubman, 2014, p. 1613). As a result, an individual will underestimate his or her level of intoxication. This can result in more hazardous drinking and increased risk-taking behaviors (Peacock et al., 2014). The previous reviewed substances are only a sample of substances abused in today's society. In addition, it is important to consider that many users may use a combination of substances, creating a confusing picture of side effects for the counselor attempting to understand a client's use patterns and resulting biological effects. It is important for counselors to attend continuing education sessions on emerging drugs in order to stay up to date.

How the Theoretical Approach Is Used by Practitioners

Neuroscience is increasingly becoming an important focus of clinical counseling in general, not only for the addiction specialty. There is an increased recognition of the role biology/genetics plays in human behavior and an increased interest in learning about the brain's structure and chemistry. Within the addiction counseling field, understanding the specific contributions of neuroscience has been around since the initial description of addiction as a disease, yet as research improves, the role of neuroscience in addiction counseling evolves. The two primary uses of neuroscience for professional counselors are for conceptualization and psychoeducation purposes.

Conceptualization

The process of conceptualization is extremely important for professional counselors, because this is the mechanism for identifying how the client came to his or her current state of functioning. Conceptualization also informs our treatment approach. As a counselor operating from a biological theory, the theory would be used to explain how the client's addiction developed. Let's pretend you are an addictions counselor working at an intensive outpatient program. You are referred a new client, a 28-year-old Latina female named Maria. Maria has been referred to your program after her second driving while intoxicated arrest. Maria previously completed an alcohol assessment and outpatient counseling as mandated by the court from her first arrest and informs you that her mother and sister have both been in and out of treatment for years for problems associated with alcohol. You begin by introducing yourself to Maria, and throughout

your initial meeting, you hear Maria say numerous times, “I just don't know how I ended up drinking again. I was working my program, and doing well, and then one day it was as if I opened my eyes and just saw myself pouring the end of the wine bottle. How do you explain this?”

Maria's story is not uncommon, and her brain can explain this! One may assume Maria has a predisposition to an alcohol use disorder, because there is a family pattern, and from her report, Maria has established neuropathways that only know to drink alcohol as opposed to engaging in other activities (e.g., yoga, drawing mandalas). As a counselor, you would be able to conceptualize her case with an understanding of the brain chemistry responsible for Maria's current functioning. Whether you believe it is in part responsible or fully responsible depends on your embracing the theory as a stand-alone theory or in combination with an alternate theory.

Psychoeducation

The other primary application of the biological theory when working with clients is psychoeducation. Psychoeducation occurs with the client and the client's family and also is used to discuss treatment options (e.g., pharmaceutical interventions). To begin, we discuss psychoeducation with clients.

Unfortunately, for many individuals, the terms *neuroscience*, *brain chemistry*, and *neurobiology* may conjure up feelings of confusion. It is important for counselors to help convey to clients that they do not need advanced degrees or to be brain scientists but only open to discussing the brain. It is the counselor's responsibility to make this topic engaging and not as complex as your high school biology teacher, Mrs. (I'm-An-Actual-Brain-Scientist) Jones.

Client psychoeducation can begin by discussing the brain's structure and then move into talking more about the neurons and how signals are transmitted. For clarity, it is important to give examples throughout the discussion. By providing a foundation, counselors equip clients to hear more complex information, such as about the human genome and how that influences brain structure. Much of what is currently discussed with clients in addiction treatment is actually based in neuroscience, yet it is not known or discussed in that context. For instance, triggers are a common discussion with clients in addiction settings, yet it is not always explained that triggers are associated with neuropathways. We all have established neuropathways, our common ways of acting in certain situations or when we have certain feelings. It is important to talk with clients about their neuropathways, or their preferred ways of acting. Counselors can talk about needing to put one's brain under construction and the importance of establishing new pathways. The context of biological theory can help clients understand why it is important to talk about triggers. Once clients understand the foundation of the brain, the counselor can discuss more about the etiology of addiction through a biological lens. The hope of this is that it will reduce feelings of self-shame and increase one's desire to become active in recovery.

Another main focus of psychoeducation is for family members. Education about addiction at the public level is almost nonexistent. The moral model of addiction largely dominates, with the belief that it is the individual's choice to act in immoral ways. Educating family members about the biological components of addiction can have many outcomes. First, understanding addiction as a biological process reduces the moral judgment (White, 2001). Family members are equipped with knowledge about the biology of the addiction in order to shift the anger and resentment they are often feeling away from the individual living with addiction. In addition, family members may become aware of their own predisposition to addiction, which may either mean seeking treatment for themselves or being aware in order to reduce the likelihood of developing into addiction. Because addiction affects everyone within the systemic context of the addicted person (e.g., significant other, family, friends), it is important to provide addiction education to all.

The counselor can also use psychoeducation to discuss treatment options. Certainly treatments such as cognitive-behavioral therapies are rooted in the brain (as discussed with the triggers earlier), but newer research has seen more advancements made in pharmaceutical interventions. Psychoeducation can be used to discuss how the medication works, what brain components it interacts with, and so on. It is important for addictions counselors to be knowledgeable about these other therapies, although they cannot prescribe them if they are not medical professionals, in order to provide more information to the client.

Influences on Social Policy

Social policies in general are significantly affected by society's understanding of addiction, both the etiology and diagnosis and treatment. Sadly, addiction is often categorized as a character flaw of the individual (Dackis & O'Brien, 2005), rather than as a disease worthy of treatment. Social policies provide support for research funding, as well as for policies related to our criminal justice system. It is crucial that policymakers have an understanding of the neurobiological processes involved in addiction in order to make more informed decisions about public policy.

The etiology of addiction is examined through research that is primarily funded and regulated through government organizations (e.g., National Institute on Drug Abuse [NIDA], National Institute for Alcohol Abuse and Alcoholism [NIAAA], Substance Abuse and Mental Health Services Administration [SAMHSA]). With the acceptance of the disease model, addiction-related research can be funded by the National Institutes of Health (NIH) as are all other diseases. The 2015 fiscal year budget has projected funding for alcoholism research at $476 million, with $1.016 billion budgeted for drug abuse research (NIH, 2015). These numbers are encouraging compared with other medical diseases such as the $685 million budgeted for breast cancer research and $255 million budgeted for lung cancer research (NIH, 2015). It is important to note that many other disease categories are either directly or indirectly impacted by addiction (e.g.,

liver cancer, Hepatitis C), and therefore the actual funding number for addiction-supported research is significantly larger than looking solely at the two categories mentioned.

Changes in public policy in the arenas of criminal justice and health care would benefit not only people living with addiction but also society in general. The U.S. criminal justice system has been criticized for its high numbers of prisoners for an industrialized nation (Gopnick, 2012). Overrepresented in the prison system are those individuals serving time for drug-related crimes, for they represent approximately 48% of prisoners (Federal Bureau of Prisons, 2015). Individuals who serve time are often in need of treatment for addiction yet are not provided this in prison or are not given an option for treatment (Dackis & O'Brien, 2005). President Barack Obama recently made headlines when he commuted the sentences of 46 nonviolent drug offenders from prison (Horwitz & Eilperin, 2015). This move was both supported and criticized. One might wonder what the responses may have been if the public had more of an understanding of the biology of addiction and addictive processes.

The other U.S. system significantly affected by addiction is the health care system, yet there is often very limited screening or treatment for these disorders (Dackis & O'Brien, 2005). Risky alcohol use is responsible for a large hit to the health care system with approximately 24% to 31% of all emergency department patients being admitted due to risky drinking (D'Onofrio & Degutis, 2004–2005). Up to 50% of all trauma patients are injured due to their or another individual's risky drinking (American College of Surgeons Committee on Trauma, 2003), and 15% to 20% of primary-care patients are reported to have alcohol-use disorders (McQuade, Levy, Yanek, Davis, & Liepman, 2000). Although addiction permeates the health care system either directly or indirectly, the addiction education provided to medical staff is extremely limited (Dackis & O'Brien, 2005; Rasyidi, Wilkins, & Danovitch, 2012). Neurobiological addiction education could help reduce stigma in medical settings and may ultimately improve treatment outcomes. More educational policies mandating addiction education not only at the resident-specialty level but also in medical school would be helpful to expand treatment in the health care arena. Policies are influenced largely by public opinion, and currently perceptions of addiction are predominantly negative (Dackis & O'Brien, 2005). Educating the public on the neurobiology of addiction and implementing policies aimed at alleviating addiction is drastically needed (Dackis & O'Brien, 2005).

Assessment and Prevention Implications

The biological and brain chemistry theory has implications directly related to prevention efforts. If the ability to identify a biomarker for addiction was available, which it currently is not (Hammer et al., 2013), prevention efforts could be individually focused, as opposed to the current population-focused efforts (Gartner, Carter, & Partridge, 2012). For example, education for individuals may discuss personalized risk, and hopefully, if an individual is aware of a predisposition he or she will be more

likely to avoid risky behavior that would lead to addiction. As research funding increases there may also be development of advanced preventative efforts such as vaccines (Gartner et al., 2012).

Additionally, biological theory has implications for assessment procedures. As mentioned, there is no current molecular test for addiction, yet there are other issues to consider. Addiction and addictive behavior has a stigma attached to it, which can be detrimental for the individual living with the disease. Due to stigma and the judgments of others, it is likely that individuals living with addiction are hesitant to open up and trust others they encounter. Counselors may carry some of these biases as well, yet it is imperative to be able to build a relationship with clients in order to establish trust and openness. Embracing the biological theory of addiction can help counselors conceptualize the addiction as separate from the individual, thereby allowing the judgment to dissipate. Biases are a part of life, but we do not have to let them control us. As treatment professionals, we can significantly alter our own biases by owning them and confronting them. Embracing the biological theory as either a stand-alone theory or in combination with another will allow counselors a platform to conceptualize addictive behavior that reduces judgment and stigma within the assessment process in order to create a therapeutic alliance.

Strengths and Weaknesses of the Theory

As does any theory, the biological theory of addiction has both strengths and limitations. The following sections outline these opposing perspectives and invite the reader to brainstorm additional strengths and weaknesses that may have been overlooked. Readers are invited to consider how they might explain the strengths and weaknesses of the biological theory to clients and to consider how these factors might influence their work as addiction counselors.

Strengths

One of the strengths most commonly associated with the biological theory is the reduction in moral judgment (Hammer et al., 2013; White, 2001). Individuals living with addiction, family members, and friends are often bombarded with strong feelings of anger and resentment when having to deal with the consequences of the problematic use. These strong feelings will not disappear due to the biological theory, but it helps refocus the anger not on the individual but on the brain chemistry. Hammer et al. (2013) found that individuals living with addiction who were exposed to the biological theory during treatment reported this approach reinforced their need to take responsibility for their condition and the need for them to seek services. Reducing moral judgment is a key strength of this model, for the blame and shame associated with addiction tend to stymy clients into continued detrimental use.

Another strength of the biological model in recent years is the new knowledge of neurogenesis and neuroplasticity. Neurogenesis refers to the potential to grow newer

brain cells, and neuroplasticity to the potential for current brain pathways to be reconstructed and new pathways to be formed (Arden, 2015). This research is encouraging because it highlights the ability to alter one's future. A critique of the biological theory, elaborated on in the next section, is that it could be fatalistic (i.e., that if one is born with a genetic predisposition to addiction, one will be predestined for that life) and that one therefore has little to no options for either not becoming addicted or once addicted, a life of recovery. Yet this recent research is encouraging and provides a counterargument to this critique.

Finally, the biological theory of addiction does not have to be used as a stand-alone model and works well with other common approaches. The well-known biopsychosocial model (Engel, 1977) draws heavily on biological, psychological, and sociological components when considering one's diagnosis and treatment options. The biological component of addiction is difficult to ignore, yet the theory needs additional support through consideration of psychological components (e.g., historical trauma, co-occurring diagnoses) and/or sociological components (e.g., sociopolitical climate, family dynamics) (Morphett & Meurk, 2013).

Weaknesses

Although the strengths outlined earlier have received wide acclaim from all invested stakeholders, there are still identifiable weaknesses of the model. For one, critiques of the theory strongly argue against the scientific credibility (White, 2001). There have been efforts to identify a biomarker of addiction, yet these efforts have not produced fruitful results (Hammer et al., 2013). In addition, the diagnosis of addiction rests purely on behavioral description, gained mostly through the clinical interview with the individual living with addiction (Hammer et al., 2013). For example, when an individual complains of symptoms of fatigue and tiredness, a medical practitioner will often order a series of laboratory tests and many times will look at the thyroid gland to examine the functionality. This is not the case with addiction symptomatology because there is no molecular exam. “Although addiction is posited as a brain disease with a molecular basis, the lack of a molecular diagnosis is a point of criticism for opponents and a source of frustration for scientists” (Hammer et al., 2013, p. 4). It is difficult to identify the biological etiology of the disease without the diagnostic tools to do so.

Another weakness or criticism is that the model may encourage a fatalistic mind-set (Morphett & Meurk, 2013) or in other words, decrease one's perceived self-efficacy to quit and maintain abstinence (Gartner, Carter, & Partridge, 2012). For example, if you were born with a predisposition to addiction, it may be that instead of working to avoid this by actively preventing yourself, you become absorbed with the idea that becoming an addict is your destiny and believe you have no control over it. The fatalistic mind-set is not adopted by all clients (or we would have none in our offices), and the findings of Hammer et al. (2013) support that an understanding of the neurobiology of addiction can assist clients to accept more responsibility in their treatment, yet this is still used as a

critique of the model.

As mentioned previously, the biological theory of addiction can be used in conjunction with other theories. However, Luke (2016) argues that as a stand-alone theory it does not account for behavior, which the author believes is necessary for addiction to develop. For example, in order to become addicted to cocaine, one must first use cocaine. Peer pressure has been widely studied in relation to why individuals use initially, yet more may be gained from examining the failed Just Say No campaign of the 1980s. Why is it that some individuals just can't say no? The disease model is not synonymous with the biological theory, yet it is intertwined. The notion that addiction is a *disease* has been around for a long time (White, 2001). Supporters of the disease model perceive one of its strengths to be reduction of stigma for people living with addiction, because it is no different than any other biological disease. However, this argument is flawed, for disease and individuals living with diseases are not immune to stigma (Hammer et al., 2013). One can just think of the HIV/AIDS epidemic of the late 1980s and early 1990s and be flooded with memories of the stigmatization of individuals diagnosed with the disease. Diseases in general are thought of as *abnormal* and due to this are susceptible to stigmatization.

Case Study Responses

According to the biological theory, Gabriel's substance use has resulted in his brain being hijacked by the chemical substances. Both alcohol and marijuana (Gabriel's drugs of abuse) have altered his brain chemistry, and Gabriel seeks different effects from each substance due to their differing classifications and effects on the brain and body. Gabriel's needs include understanding his drug use in terms of his body's cravings and expectant results from use and also the need to understand how his brain structure has been altered by the substance use. In addition, Gabriel needs to understand the concepts of neurogenesis and neuroplasticity. These concepts may help explain why treatment and counseling are important, for they have shown that the brain can generate new neuropathways, which can result in new ways of being. This knowledge can help instill hope in Gabriel, who may be feeling his life is going to be a series of stints between abstinence and relapse.

Working with Gabriel from the biological theory position would first involve a thorough assessment of his use patterns. In order to gain Gabriel's respect and trust, it is important for the counselor to adopt a client-centered nonjudgmental framework, focusing on building rapport and empathic listening to Gabriel's story. The counselor engaging in this behavior will assist with helping Gabriel disclose his accurate use amounts. According to the information given in the case study, Gabriel reports using two to three times daily. His counselor would want to know what this means specifically. Is he combining marijuana and alcohol every time he uses, or is he using marijuana twice per day and using alcohol once per day? This information is important to decipher in order to examine the effects of the substance on the brain. Because alcohol is a CNS

depressant and marijuana is a CNS stimulant, combining these two substances may cause confusion within the user's body. The counselor would also want to discuss in detail the effects Gabriel reports following his use. For example, he might be invited to remember periods of using and to recall the feelings and sensations he has experienced throughout his body during these times. The counselor would also want to discuss Gabriel's cocaine use, even though he does not report this as his main drug of abuse. This assessment is important to help the counselor understand which side effects Gabriel dislikes from cocaine use, as opposed to the use of marijuana and alcohol. It also may not be the side effects but the stigma of cocaine (possibly seen as a more severe drug), which the counselor will be able to understand by discussing this openly with Gabriel.

In addition to Gabriel's use of alcohol and marijuana, the counselor needs to also assess his use of prescription medication. Gabriel has symptomatology consistent with obsessive-compulsive disorder and anxiety disorder, yet the counselor may be unsure if he has received a formal diagnosis of these mental health issues in the past. If he has, the counselor should be curious about any medications he was prescribed and their reported side effects.

Once the counselor gains a clear history of drug use from Gabriel, he or she would also want to assess his knowledge about the biological component of chemicals and how they interact with the brain. Psychoeducation about substances is common within treatment programs, and because Gabriel has received both inpatient and outpatient services it is important to know what he has learned, what he remembers, and what he believes. The counselor may proceed under the assumption Gabriel has learned some things but is open to revisiting understanding the biological components of his addiction. Gabriel will benefit from understanding the chemical reactions occurring in his brain and entire body following his use of substances. The counselor should be able to discuss with Gabriel what happens and also help explain his cravings due to the effect of neurotransmitters on the brain reward pathway. It is likely that Gabriel may report not knowing how he ended up using or not remembering making a decision to use. In the event of hearing this, the counselor could talk to Gabriel about neuropathways and the hijacked brain, including information about the established road maps the brain uses even though one may not be conscious of the decisions. Overall, much of a counselor's work with Gabriel will involve psychoeducation, along with assessing his understanding of the discussion. It is important for the counselor to be empathic and examine whether the client agrees with this biological theory. If the client appears reluctant to believe in the model, the counselor can validate the client and explore his or her experience.

As mentioned, it is very important that the counselor adopt a nonjudgmental stance when working with Gabriel. It is a difficult process to come to counseling, and it is the counselor's job to ensure Gabriel feels as comfortable as possible. Overall, the

biological theory emphasizes a great deal of psychoeducation, the process of educating clients about the symptoms and the disorder. In the case of Gabriel, the counselor should educate him about the brain process, discussing such concepts as the hijacked brain, the role of neurotransmitters, and the hopeful concept of neuroplasticity. Gabriel may benefit from understanding that he can change his brain structure in a way that will result in less craving of his drugs of abuse, just as he altered his brain structure when he became hooked. Throughout the psychoeducational process, the counselor should emphasize the use of foundational counseling skills. If Gabriel looks confused about what is being discussed, the counselor might offer a reflection of feeling: "Gabriel, you look a little confused by what I am saying. Could you repeat back what you heard from me?" Strong reflecting skills will invite Gabriel to be a part of the process. Instead of the counselor talking *to* Gabriel, the discussion should be *with* Gabriel. Further, the counselor would want to affirm that Gabriel is not *responsible for* his addiction, but he is *responsible to* it.

One particular challenge with using the biological theory with Gabriel may be actual use of the terms *brain* and *biology*. Whereas it is true that one does not need to be a brain surgeon to understand the role of neurotransmitters, just the idea is often enough to scare people away. It also is important for counselors to have an understanding of the client's educational background. For example, the counselor may need to know what Gabriel's highest level of education is and perhaps how he has done in the biological sciences. The case history gives limited information about Gabriel's education—he may have a master's degree in biology, a bachelor's degree in sociology, or have completed his GED after dropping out of high school because he was unable to pass chemistry. Based on Gabriel's educational level, the counselor may want to tailor discussions in a way that engages and creates interest for him in the topic.

Like many other individuals living with addiction, Gabriel may be feeling confused with his use, possibly wondering why he continues to use despite his negative consequences. The biological theory has an ability to help explain this question, providing concrete objective facts about the chemical properties and effects on the brain. The objective nature of this discussion may help Gabriel feel more compassion for himself. This awareness may also help inspire hope for his future, that with newer research related to neurogenesis and neuroplasticity there is hope that he can restructure his brain to decrease his cravings and increase his ability to remain abstinent.

Summary

With the increase of neural imaging our understanding of the neuroscience of addiction has grown. This technology has bolstered the biological perspective that addiction is a chronic disease where the brain's function and structure are hijacked by the drugs that enter the body and reduced the stigma that it is due to moral turpitude. Professional counselors working from this theoretical orientation and those integrating the tenets with other theories should have a basic understanding of the neurological underpinnings

related to addiction in order to be able to conceptualize how clients developed their disease of addiction and how it relates to their current state of functioning. As with any disease, clients are not *responsible for* their addiction; however, they are *responsible to* it. Clinicians can provide psychoeducational information to clients and their support systems regarding the etiology of the disorder and identifying how triggers are connected to neuropathways to assist clients in being empowered in their recovery.

Resources for Continued Learning

Books

Arden, J. B. (2015). Brain2Brain: Enacting client change through the persuasive power of neuroscience. Hoboken, NJ: Wiley.

Doidge, N. (2007). The brain that changes itself: Stories of personal triumph from the frontiers of brain science. New York: Penguin Books.

Luke, C. (2016). Neuroscience for counselors and therapists: Integrating the sciences of mind and brain. Thousand Oaks, CA: Sage.

Websites

Commonly Abused Drugs: www.drugabuse.gov/drugs-abuse/commonly-abused-drugs-charts-0.

Drugs, Brains, and Behavior: The Science of Addiction: www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/preface.

Heads Up: Real News About Drugs and Your Body for Students: http://headsup.scholastic.com.

The Hijacked Brain: http://gailpellettproductions.com/the-hijacked-brain.

History of the Disease Concept, a series of papers authored by William L. White: www.williamwhitepapers.com/pr/2000HistoryoftheDiseaseConceptSeries.pdf.

NIDA for Teens: Brain and Addiction: http://teens.drugabuse.gov/drug-facts/brain-and-addiction.

NIDAMED: Medical & Health Professionals: www.drugabuse.gov/nidamed-medical-health-professionals.

The Science of Addiction: Genetics and the Brain: http://learn.genetics.utah.edu/content/addiction.

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4 Psychoanalytic Theory of Addiction

Leigh F. Holman

Psychoanalytic theory has developed over the course of time from Freud's one-person model of intrapsychic conflict to a widened scope of psychoanalytic theory, eventually to include a two-person interpersonal model of client functioning (Wachtel, 2008). In contemporary practice, psychoanalysis is relational and incorporates the entirety of psychological factors described in this text.

Basic Tenets of the Theory

Psychoanalytic theory, like all theories, is based on a set of assumptions that guide clinicians' practice. The most important may be the assertion that human beings are dynamic in that they change based on context and experience; therefore, psychoanalysis is a dynamic theory. Because it is dynamic, the theory has continued to change and develop over time. Clinicians have used Freud's theoretical foundation and integrated concepts consistent with new psychoanalytic thought such as object relations; interpersonal, relational, and developmental adaptations of Freud's theory; and integration of new neurobiological findings (Kaufman, 1994; Keller, 1996; Khantzian, Halliday, & McAuliffe, 1990; Wachtel, 2008).

Psychoanalytic therapists believe that early life experiences impact personality development and functioning (Freud, 1960; Wachtel, 2008). The most impactful experiences are either traumatic experiences or our relationships with caregivers early in life before we have developed the ability to cognitively process the emotional aspects of these experiences (Wanigaratne & Keaney, 2002). They are stored in whole or in part in nondeclarative or implicit memory outside of conscious awareness (LeDoux, 2002). In other words, individuals do not possess the ability to talk about these memories because they are stored as sensory experiences or dissociated memories in the limbic system (Fonagy, 1999; Van der Kolk, McFarlane, & Weisaeth, 1996).

As Siegel (2012) describes, early in development, a person does not have the ability to talk about his or her experiences, and therefore memories of these experiences are sensory in nature. Emotion is a sensory experience. It isn't until the ability to speak is developed that one can label emotions with feeling words. As we develop, we are able to connect sensory emotional experiences with higher-level cognitions in order to understand those emotional experiences. If a traumatic event happens later in life, after speech and cognition have developed, but the event is overwhelming to the individual, then the individual will dissociate parts or all of the memory so that the effect is essentially a sensory nondeclarative memory of those events (Van der Kolk et al., 1996). Parts or all of the memory will be stored in the unconscious, outside of the person's present awareness.

When unconscious memories and their emotional counterparts begin to move into conscious awareness, individuals experience anxiety (Horney, 1945, 1950). Because

these emotions and experiences are nondeclarative, a person may have difficulty finding words to verbally process the emotional experiences in order to gain a better understanding of them. This further exacerbates the individual's anxiety. In order to guard against what can sometimes be felt as intense and overwhelming anxiety, people form defense mechanisms to block the past unconscious emotional experiences from present awareness (Bromberg, 2001). As illustrated by Petrucelli and Stuart (2001), presenting symptoms, such as addictions, are often manifestations of defense mechanisms formed to deal with these troubling sensory or emotional triggers.

Box 4.1 Key Tenets of Psychoanalytic Theory

1. Psychoanalysis has an interpersonal and intrapsychic process orientation.
2. Early relational templates impact later behavior.
3. Behavior is adaptive to context.
4. Unconscious emotional and sensory motivating drives trigger addictive behavior.
5. Anxiety results from the unconscious becoming conscious.
6. The goal is to increase conscious awareness.
7. Defense mechanisms block the unconscious from conscious awareness.
8. The interpersonal therapeutic relationship involves working through early relational templates and traumatic experiences resulting in corrective emotional experiences.

Clients may use predominantly one defense mechanism or they may use a constellation of defense mechanisms to deal with their anxiety. Common developmental defense mechanisms are described in Exhibit 4.1. Defense mechanisms are all interpersonal maneuvers that can be addressed through the therapeutic relationship. They can be divided into four categories: pathological, immature, neurotic, and mature. Pathological defenses allow individuals to avoid dealing with reality to the point that they appear insane or psychotic. Immature defenses allow a person to distort reality such that the distress experienced by anxiety-producing stimuli may be avoided. These defenses are often exhibited by people with mental health diagnoses. Neurotic defenses are commonly used by adults to deal with distressing situations in the short term. However, if these defenses become the preferred coping modality across situations and relationships, then they may cause functional impairment. Finally, mature defense mechanisms are commonly found in functional adults and are often associated with resilience. These include acceptance, altruism, respect, patience, tolerance, courage, emotional self-regulation, gratitude, humility, and humor.

An example of a client's use of defense mechanisms to manage anxiety is when a court-mandated client who has had multiple drug arrests for possession and intoxication experiences intense fear of giving up the substances he has used for years to regulate his

emotions. He may have few or no other emotional coping resources upon entry to treatment. So giving up the substance in a controlled treatment environment may result in intense, possibly overwhelming, anxiety. He may be angry with the court for mandating his treatment, but because the court is an entity that is not present or could further punish him, he instead *projects* his anger onto staff and his therapist for "making" him come to treatment. He may have a number of reasons for why he was caught with substances, like he was holding it for a friend, or for being intoxicated, like he did not know that the coke someone gave him had a drug in it. These are examples of *rationalizations*. He may be able to clearly articulate the problems with his behavior and the reasons why he needs to stop, but he is completely unable to demonstrate emotion while discussing these issues and cannot answer any questions about his feelings aside from responding that he is feeling fine or is angry. This would be evidence of *intellectualization*. He may state that although he may like to "party," he is no different than any other 21-year-old guy other than being unlucky because he got caught. This would be complete *denial* of any addiction problem. These are just some of the potential manifestations of defense mechanisms that a client may use when entering addiction treatment. All of these would be addressed by the psychoanalytic therapist in a manner that was appropriate to the particular client, be it an experiential intervention, an interpersonal process intervention, or an analytical intervention.

Level I: Pathological Defenses		
Defense Mechanism	**Description**	**Example**
Denial	A client is unable to consciously accept the truth of her behavior and therefore states or acts as if it is not true.	A client has four DUIs in the past year and is referred for inpatient treatment, but she states she does not have a problem.
Psychotic denial	A break from reality. Attending to primary-process thinking over secondary-process thinking (reality).	A psychotic break.
Undoing	An attempt to erase bad choices by doing something good.	An abuser attempts to be overly loving and nice to his girlfriend by buying her an expensive gift after beating her up.
Splitting	A client creates a situation where her perception of someone or something as all good or all bad is played out relationally.	A residential client may split staff by idealizing one staff member and devaluing another (see Idealization below).
Idealization	A client views a counselor as being "all good" or idealized.	A client tells his individual counselor that she really understands him when no one else does, that she is so much smarter or more perceptive/ empathic than the other staff.
Devaluation	A client views a counselor as being "all bad" or less than.	A client frequently asserts that the group counselor is "just an intern" who still has a lot to learn, that she is not in recovery so she can't possibly understand his struggle, thus devaluing her experience and ability.

Level II: Immature Defenses		
Defense Mechanism	**Description**	**Example**
Fantasy	Channeling unacceptable urges into an acceptable form.	A client with a gambling problem fantasizes that he will hit it big with his next trip to the casino.
Projection	Attributing a quality about self or another person in one's life onto someone who is perceived as less threatening.	A client is angry about being court-ordered into residential treatment, so during the initial stages of therapy she repeatedly tells you that she is angry because you are keeping her from her kids by putting her in residential.
Projective identification	Identifying with another person's projections.	A client blames her father because she is placed in detox. He feels guilty and takes responsibility, resulting in agreeing to sign her out of the treatment center.
Acting out	Rather than experiencing an emotion and labeling it with a feeling word, a client acts out the emotion. Often these clients do not have an adequate feelings vocabulary or are alexithymic.	A client feels powerless when he is placed in a controlled environment where he cannot use. However, rather than verbally processing the emotion, he acts aggressively toward the group counselor in order to assert some power. It is key to empathically understand the client's experience in order to understand how best to address this behavior in a therapeutic manner.

Level III: Neurotic Defenses		
Defense Mechanism	**Description**	**Example**
Intellectualization/ isolation of affect	Using only cognitive skills to process a situation, avoiding feelings.	A client is able to identify and discuss her distorted thoughts, but she is unable to identify any feelings associated with the situations where she exhibits distorted thinking. She may look like a successful client in cognitive therapy settings.
Rationalization	A client has a seemingly reasonable explanation for why something happened in order to avoid exploring the full reality of the situation.	A client was picked up for DUI twice in one month. He explains that he lives in an area where there is a DUI checkpoint, so he is more likely to be caught and that the only reason he even drank is that he's a salesperson, and it is expected that he go out drinking with clients in order to soften them up for the big sell.
Reaction formation	Acting in a manner inconsistent with one's feelings.	A client who is homosexual but also is active in his Southern Baptist church has sex with strangers multiple times each week in order to "prove" to himself and others that he is not gay.
Dissociation	The reality of a situation is so threatening that the client completely blocks awareness of the situation.	A client has a complete memory loss when asked about middle school other than to remember that she started using at that age. However, in reality, she was sexually abused by her stepfather beginning at age 12.
Repression	The reality of a situation is threatening to a client's beliefs about self or an important other, so she pushes the reality out of conscious awareness.	A client is unable to explore certain aspects of her history such as family relationships during an intake interview because her father was a violent alcoholic, but she also experienced him as loving when he was not drinking and psychologically "needs" to believe he is the ideal man.
Displacement	Feelings about a person or situation are placed onto an alternative safer target.	A client is confronted by his counselor during a group session. He feels angry at the counselor but fears he may be penalized for expressing his anger, so he goes back to the unit and begins arguing with his roommate about being a "sloppy pig."

Level IV: Mature Defenses		
Defense Mechanism	**Description**	**Example**
Humor	Finding humor in something that is clearly not humorous.	A client jokes about her brother being at their family's annual haunted house by saying, "Can you imagine anything scarier than an actual pedophile at a haunted house?"
Sublimation	Displacing feelings into a constructive activity.	Following an argument, a client goes back to his room and writes a rap song about his frustration.
Compensation	Attempting to make up for doing something perceived as wrong or bad.	Having stayed sober for 7 years, a client in recovery decides to become a substance abuse counselor to give back.
Suppression	Choosing not to focus on one situation or feeling until another more important one is dealt with.	A client chooses to work on her recovery while her kids are in protective custody, understanding that she will need to address parenting issues once she is stable.
Altruism	Focusing on helping others to deal with aspects of self that are felt to be unacceptable.	A client volunteers at a homeless shelter to deal with his own feelings of worthlessness that trigger his drinking.
Anticipation	Realistic planning for future anxiety.	Working on a relapse prevention plan that realistically identifies stressors and attempts to develop healthier alternative coping mechanisms than using.

Psychoanalytic therapists believe that clients must increase conscious awareness of the unconscious motivational driving force for their addictions in order to be empowered to make conscious choices about their behaviors (Hassin, Ulemann, & Bargh, 2006; Horney & Bernard, 1999). Therefore, it is imperative that clinicians understand the client's life story and the emotional impact of significant relationships and events discussed. Psychoanalytic therapists facilitate clients' ability to emotionally and cognitively process these experiences and integrate them into conscious awareness. Part of this process involves the therapist observing how early relational templates currently manifest in the client's life (Fosshage, 2005). They do this through exploring the client's perception of past and present relationships and events and by observing how clients act out relational templates within the treatment milieu or with the therapist (Wachtel, 2008). By doing this, the therapist is able to identify a pattern of defense mechanisms that are significant for a particular client.

These patterns inform the therapist's interventions, including the use of process comments about how the client may be acting out these defenses within the therapeutic setting (Teyber & McClure, 2011). Process comments about behavioral patterns are often helpful in bringing unconscious material into conscious awareness and subsequently facilitating the client's ability to verbally and emotionally process those experiences. It is crucial to do this because these are often triggers for the client. For many addicts, the neural pathways connecting the limbic system (emotion and sensation) and executive functioning areas of the brain (problem solving and impulse control) are not optimally developed. Therefore unconscious, sensory triggers in the environment motivate addictive behaviors and undermine a client's potential for lasting recovery. Bromberg (2001) states that addictive behavior "may be the end result of prolonged necessity … to control physiological and affective states without an experience of human relatedness *and its potential for* reparation that mediates it" (p. 73). For this reason, it is crucial to attend to unconscious or preconscious (limbic system) material through sensory, experiential/behavioral, and/or interpersonal processing of emotion. In this manner, the therapist helps the client build and strengthen new neural pathways connecting the limbic system and executive functioning areas of the brain. This occurs through consistent corrective emotional experiences over time within the context of a therapeutic relationship (Teyber & McClure, 2011).

In facilitating the client's process of making the unconscious conscious, psychoanalytic therapists may use process comments about the therapist's observations of the client's interpersonal interactions with the therapist, with other clients or staff in group or in the therapeutic milieu, and/or with family members. Therapists may also use other experiential methods, such as art, music, psychodrama, or sand, or behavioral methods, such as guided visualization and progressive muscle relaxation, which evoke similar sensory or emotional experiences to those that trigger the client's addictive behaviors. Interpersonal processes or other creative experiential interventions are often more

successful in helping the client to access unconscious feelings of vulnerability, loss, loneliness, fear, and being misunderstood that underlie more obviously acted out emotions such as anger or that the client is otherwise numb to due to the effects of long-term addiction.

Psychoanalysis is process orientated and values building sustained interpersonal therapeutic interactions between therapist and client (Horney & Bernard, 1999; Wachtel, 2008). This facilitates development of structural and neurochemical changes to support the client's ability to successfully negotiate a lasting relapse prevention plan. Relapse prevention plans often involve using executive cognitive functions that, as previously discussed, addicted clients may not be capable of accessing when they first enter treatment. However, it should be noted that an addicted client may have executive functioning abilities in some life situations (e.g., a doctor who is able to apply problem solving and impulse control when operating on someone), but the same client may be unable to use executive functioning or higher-level cognitive processes in relationship to environmental triggers that lead to addictive behaviors (e.g., conflict in interpersonal relationships). Many clients possess effective coping skills in contexts that do not evoke unconscious triggers. But in the presence of unconscious triggers the client is not able to effectively marshal the same coping skills. Effective coping skills are the observable expression of the development of neural pathways connecting limbic system and executive functioning areas of the brain thereby involving a conscious awareness and connection between the emotional/sensory trigger and the healthier defense/intervention. Psychoanalytic therapists identify where clients have these skills in other areas of their lives and attempt to use those experiences to inform relapse prevention.

Philosophical Underpinnings and Key Concepts of the Theory

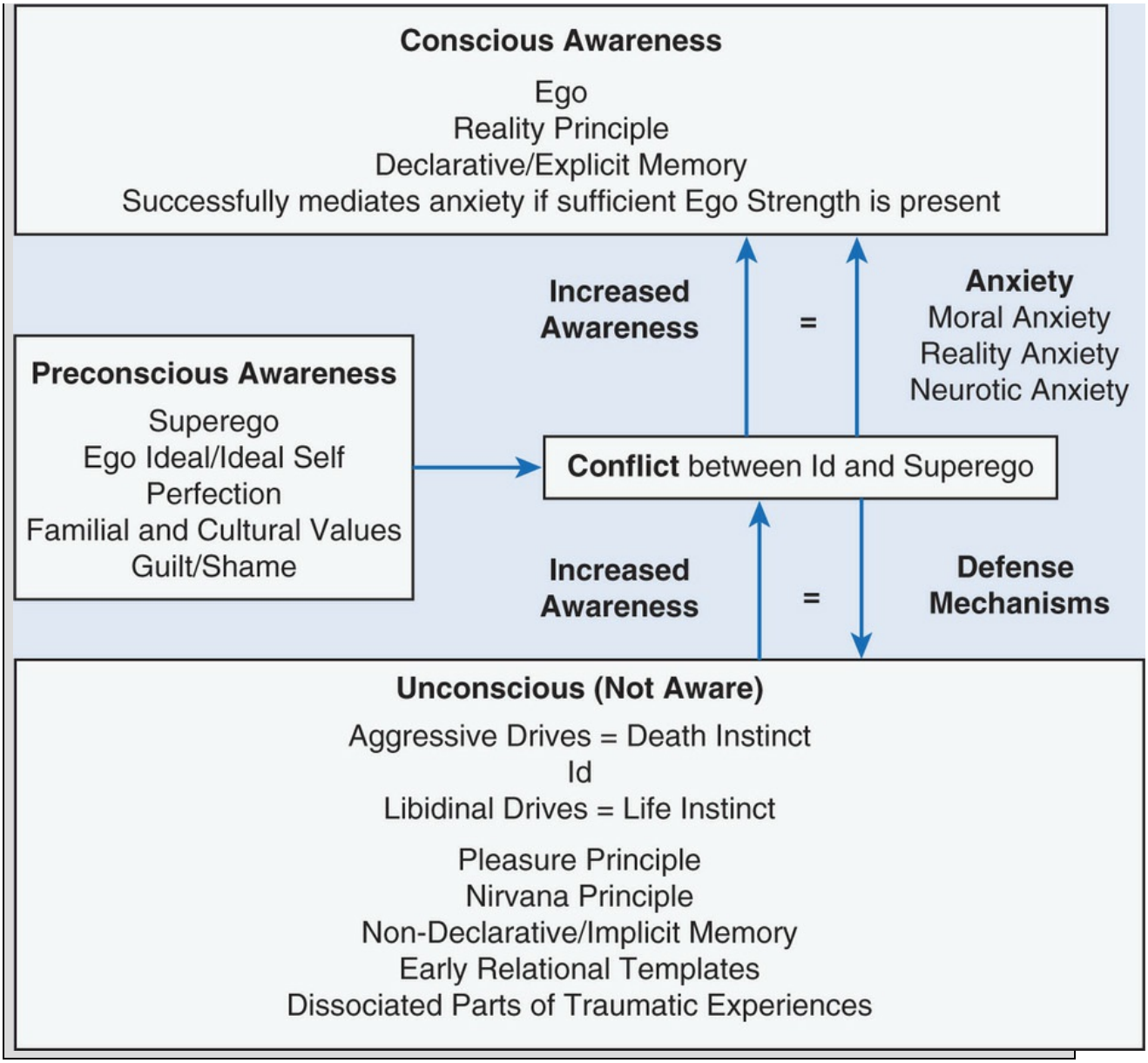
Several key concepts form the foundation of psychoanalytic thought. It is generally believed that the motivation for the addiction can be found by better understanding the unconscious and preconscious experiences our clients have stored outside their everyday conscious awareness. The unconscious consists of nondeclarative memory or wholly dissociated traumatic memories (Grawe, 2007). The preconscious consists of declarative memory that also may have dissociated parts that are nondeclarative.

In the field of addiction counseling, this conceptualization is even more interesting in that addictive substances or behavioral processes (e.g., sex or gambling) are often used by the client to dissociate unwanted emotions, bodily sensations, or thoughts from their conscious awareness. This is a key reason psychoanalytic therapists believe addicted clients with trauma backgrounds must deal with past traumas simultaneously as part of their recovery process. Otherwise, they are continually triggered by resurfacing memories and experiences.

Psychoanalysis offers a structural conceptualization (Wachtel, 2008; Williams, 2002) of

human behavior involving three structures: the ego, the id, and the superego. The ego exists in conscious awareness and generally involves executive functions of the brain for problem solving, weighing choices, decision making, and impulse control. It is ruled by the “reality principal” that mediates between the id and the superego using compromise and adaptation to manage tension or conflict between instinctual drives and the ego ideal. In its most functional manifestation, the ego represents optimal development of neuronal networks between the more basic evolutionary limbic system and the more developed neocortex. In a less functional manifestation of brain development, the impulses of the id and the ideal self, represented by the superego, are not effectively mediated by the ego, resulting in anxiety. In these situations, defense mechanisms are developed to help people mediate their experience of anxiety. When the client's anxiety intensifies, the client increases reliance on defense mechanisms. Clients may use one defense mechanism more than others or they may use a constellation of defense mechanisms to deal with their anxiety.

Box 4.2 Illustration of Psychoanalytic Theory



Defense mechanisms are considered to be compromises between impulsive unconscious urges and expressive urges in the client's conscious awareness. They may be unconscious and are often a source of material for the psychoanalytic therapist's interventions. For example, a court-mandated client with multiple drug arrests for possession may have few or no other emotional coping resources when entering treatment. If the court mandates that he enter an inpatient treatment facility, he will be forced to give up the substance because it is a controlled treatment environment. This event will likely result in intense, possibly overwhelming anxiety.

He may be angry with the court for mandating his treatment, but because the court is an entity that is not present or could further punish him, he instead may project his anger onto staff and his therapist for "making" him come to treatment. He may have a number of reasons for why he was caught with substances, like he was "holding it for a friend." His reasons are examples of using the defense mechanism of rationalization. Intellectualization is another defense mechanism that may be illustrated by a client who

may be able to clearly articulate the problems with his behavior and the reasons why he needs to stop, but he is completely unable to demonstrate emotion while discussing these issues and cannot answer any questions about his feelings aside from responding that he is feeling fine or is angry. Many addicts initially use denial as a defense mechanism. In this case he may state that although he may like to "party," he is no different than any other 21-year-old guy other than being unlucky because he got caught. These are just some of the potential manifestations of defense mechanisms that a client may use when entering addiction treatment.

The id exists somewhere between the unconscious and preconscious levels of awareness. When applying neurobiology to psychoanalysis, also referred to as *neuroanalysis* (Peled, 2008), we may consider the id to exist within the limbic system involving sensory experiences, memory, and the stress response. The id is where instinctual drives exist. These drives motivate behavior. Freudian psychoanalysis categorized these drives in two categories: sex (also called libido or the life instinct) and aggression (also called the death instinct). The id is ruled by the *pleasure principle*, the goal of which is to maximize pleasure and minimize pain.

People attempt to gratify the pleasure principle urges in order to reduce anxiety resulting from conflict between the life and death instincts by attaining a sense of nirvana or nothingness, also called the *nirvana principal*. This sense of nothingness is an interesting concept in addiction counseling because it is similar to the numbing effect addicts describe experiencing. Unconscious memories, such as early relational trauma, are often associated with *primary-process thinking*. This type of thinking is not filtered by executive functioning aspects of the brain such as problem solving, considering options, or impulse control. In fact, sometimes primary process is experienced as a hallucination, a flashback, or a partially or wholly dissociated memory.

The superego may also be referred to as the *ego ideal* or *ideal self*. This is where parental and cultural standards are stored in unconscious and preconscious memory. The superego reflects perfection in terms of meeting familial or cultural expectations. When an individual is unable to do this, he or she may experience anxiety. In some familial, cultural, or gender contexts, some or all emotional expression is deemed unacceptable. Restriction of emotional expression may also be a real consequence of early relational trauma in which it was not emotionally or physically safe to possess or express certain emotional reactions about the trauma or toward the person(s) perpetrating or facilitating the trauma.

When emotional expression is restricted, people dissociate these emotions and sometimes other aspects of associated memory from conscious awareness. Memories may be dissociated on one of four levels or any combination of the four levels illustrated by the BASK model of dissociation (Braun, 1988). Braun asserted that individuals dissociate on a continuum from full awareness to fully dissociated or unconscious awareness. The level of dissociated awareness may impact one's behavior

(B) associated with the experience, one's affect (A) associated with the experience, the bodily sensations (S) at the time, and/or knowledge (K) of an experience.
Psychoanalytic therapists believe that emotions that are not fully expressed will lead to anxiety. When anxiety becomes significant enough it crosses into conscious awareness. Three types of anxiety are discussed in psychoanalysis.
Reality anxiety occurs when the ego becomes overwhelmed by real threats and the person attempts to avoid the triggering situation (Weegmann, 2002a). For example, the client may have grown up in an abusive home. This is a real threat in which the child has little or no power. The child may attempt to avoid the abusive home environment by available means such as drinking, using drugs, compulsively masturbating, or spending endless hours on Internet gaming. In this manner, the reality anxiety situation is successfully contained by the substance or behavior being used as a method of avoiding the source of the anxiety and therefore adaptive in that environment. But later, the substance or behavior may become an addiction for that individual when he or she uses these behaviors to deal with all emotionally dysregulating experiences. Therefore, a psychoanalytic therapist would work with the client on early childhood trauma as part of the relapse prevention plan. Without working through the emotions and cognitions associated with the trauma, environmental sensory and emotional reminders will continue to trigger the client to engage in addictive behaviors. Through becoming more conscious of the effects of the trauma, the client is able to consciously address these situations in a healthier manner.
Neurotic anxiety (Horney, 1945) occurs when an individual has an unconscious fear of losing control of his or her impulses. For instance, the same individual who grew up in a physically abusive home may impulsively want to beat up his teacher or boss when he becomes angry at being reprimanded. This person may fear losing control of his impulses as he did growing up in an abusive home as a child, but he is also fearful of impending punishment (e.g., being kicked out of school or loss of a job). The individual sublimates aggressive urges by becoming a high-level athlete. In this way, the behavior is adaptive. However, if the person's athletic involvement expands to include excessive exercise and significantly limiting food as a way to control body weight, rationalizing that this is a necessary part of being competitive, then the client may actually develop an eating disorder. If controlling energy intake (food) and output (exercise) becomes an exclusive method for avoiding any emotionally dysregulating experience, such as interpersonal conflict, then the behavior becomes maladaptive within this context.
In order for a psychoanalytic therapist to work with this client, the underlying fear of losing control needs to be addressed. In fact, a psychoanalyst may create as much ambiguity in the therapeutic situation as the client can psychically handle and use the resulting anxiety as a basis to process the client's thoughts and feelings around the ambiguity. The therapist then facilitates the client's emotional and cognitive processing about the increased anxiety and fear of loss of control experienced in these situations.

Moreover, the therapist will provide an *emotional holding environment* in the therapeutic setting to contain the client's anxiety, thus facilitating the client's increased tolerance for uncontrollable situations (Weegmann, 2002a).

Moral anxiety is the fear one will violate his own values or moral code. This is the classic conflict between the id's sexual and aggressive urges and the superego's ego ideal that develops from one's cultural and familial values. When moral anxiety is present, it often results in guilt over thoughts the client believes he should not have or shame over acting out behaviors that are inconsistent with the individual's moral code. For instance, a preacher's child may be raised in a family and culture to believe that sex between a man and another man is a sin. However, he may be homosexual and have fantasies and urges to be sexual with other men. He may therefore suffer moral anxiety resulting in feeling shameful of his sexual orientation. His feelings of shame may be a trigger for him to use substances to avoid the feelings, or he may use another behavior like hypersexuality in which he places himself in situations where he attempts to "master" or change his sexual orientation. Therefore, when working with this client, the psychoanalytical therapist will attempt to help the client become consciously aware of his anxiety and the conflict driving his addictive behavior. *Reality testing* will help the client address the reality distortions that are part of his shame and self-rejection. Otherwise, the essence of who he is as a sexual being will always be a potential trigger. Generally, psychoanalytic therapists view relapse as evidence that the client's anxiety is overwhelming, triggering the addictive behavior as a coping mechanism (Wanigaratne & Keaney, 2002). It also indicates that the client had not fully worked through the unconscious feelings or memories that underlie the trigger. Although relapse is not ideal, psychoanalytic therapists understand that it is a part of the healing process because building and strengthening new neural pathways takes consistent experience over time. So relapse situations are harnessed as teachable moments to help the client improve conscious awareness of sensory environmental or emotional triggers and facilitate the client's working through any identified unresolved emotional issues.

Relapse may result in guilt for addicts because it is a manifestation of the conflict between the client's ideal self and relapse behaviors that represent the id's pleasure principle. The meaning the client attributes to the relapse is important to clarify. The client may believe, for instance, that she has "failed" to meet the standards or expectations of her family, the court, or the therapist. The client's *meaning attribution* in this example may be "it's inevitable that I remain at the mercy of my addiction," or "I am a failure." Meaning attribution is often unconscious or preconscious. Therefore, through verbal processing the therapist is able to help the client become conscious of the meaning attributed to the relapse. This verbal processing also helps the client become conscious of her view of "self" as an addict. This is an important aspect of counseling because guilt and shame are often motivating the addict's self-punishment for being a "failure" through repetitive maladaptive use of the addictive substance or

behavior to reduce the tension between the unconscious/preconscious ego ideal and the conscious ego (reality).

How the Theoretical Approach Is Used by Practitioners

A psychoanalytic therapist approaches all counseling situations as a participant-observer (Horney & Bernard, 1999; Kuriloff, 2001). The therapist understands that she is a participant in the therapeutic relationship being affected by the client and affecting the client through her interpersonal interactions with the client. The therapist is also an observer, continually analyzing the interpersonal interactions between therapist and client in relationship to previously gathered data and in relationship to the verbal and nonverbal information the client is currently sharing in therapy. The client's verbal and nonverbal interactions are considered feedback for the therapist about whether the interventions are effective. Through continuous analysis, the therapist is able to adjust therapeutic interventions during a session when necessary to engage the client in the therapy process and to develop better client outcomes.

Psychoanalytic therapists believe that early relational templates are developed based on early caregiver relationships, and later relationships are informed by those relational templates (Teyber & McClure, 2011). This is an important concept related to how therapy is practiced because contemporary psychoanalysts believe that these relational templates will be reenacted with the therapist and in the therapeutic treatment milieu and therefore will create opportunities for therapeutic intervention. Stuart writes that "understanding the complex interpersonal patterns that occur in the life of an addict is the most important factor in the treatment of addiction, because addictive behavior entrap[s] others in the addict's deleterious dynamics" (Petrucelli & Stuart, 2001, p. 31). The foundation of psychoanalytic technique is *free association* as it relates to the client's acting out of relational templates in therapeutic contexts. Initially, therapists attempt to be neutral or a "blank slate," thus encouraging the client to project his relational templates onto the therapeutic relationship (Meissener, 1998).

In an attempt to become a blank slate, the therapist must be consciously aware of personal and cultural biases and actively attempt to remove them from the therapeutic situation (Horney & Bernard, 1999; Wachtel, 2008). Gender and ethnicity are examples of inherent bias that cannot be removed from the clinical situation. It therefore must be understood that these attributes will impact the client's projections or transference reactions (Read, 2002). This is one reason that psychoanalytic therapists believe it is often helpful for clients to interact with multiple people in the therapeutic situation (therapist, treatment staff, group members, sponsor, and family), thus maximizing the client projections. Inevitably, the therapist's biases and values will impact the client's experience of therapy. It is therefore important that the experience around these conflicts be consciously processed between therapist and client. If unacknowledged, these may result in a *relationship rupture* (Horney & Bernard, 1999; Wachtel, 2008). However, if managed in a clinically responsible manner, the situation may become a source of

therapeutic growth.

As previously illustrated, the role of anxiety is central to psychoanalytic therapy. Addiction is conceptualized by the way clients manage anxiety about conflicts between sexual and aggressive urges of the pleasure principal and the ego ideal or the superego (Petrucelli & Stuart, 2001). If the client has not had healthy experiences consciously mediating these conflicts, he or she will use unhealthy defense mechanisms in an attempt to manage or contain the anxiety. The therapist understands that the therapeutic setting and the therapeutic relationship must act as the holding environment or a container (Teyber & McClure, 2011; Williams, 2002) for the client's anxiety, particularly when anxiety becomes overwhelming. This is expected to happen very intensely and early in the relationship when the client first attempts to abstain or minimize the use of the addictive behavior during times of emotional dysregulation.

If a client experiences increased anxiety, an accurately attuned therapist will also experience the client's increased anxiety (Horney, 1950; Horney & Bernard, 1999). Generally, structure and encouragement help alleviate anxiety. The therapist must be aware of his or her experience of the client's anxiety and actively work to provide structure and encouragement to him or her through this period. This will provide a safe holding environment for the client's anxiety in therapy and therefore help the client experience therapy as a safe place to explore unconscious motivations for addictive behaviors (Williams, 2002). However, at times the therapist or therapeutic setting leads clients to reexperience unhealthy interpersonal dynamics that confirm early relational templates. When this happens it is crucial that the therapist process the situation with the client (Petrucelli & Stuart, 2011). Processing helps to repair ruptures in the therapeutic relationship. In fact, processing therapeutic ruptures may be the most therapeutic interventions the client experiences in the therapeutic process.

It is equally important that the therapist help the client become consciously aware of the anxiety (Horney & Bernard, 1999). This includes identifying what events, relationships, or feelings trigger his anxiety. Triggers for anxiety become triggers for acting out addictive behaviors. This is part of the relapse prevention process. The client's corrective emotional experiences in therapy and the verbal processing of these experiences help the client become consciously aware of healthier ways to respond, rather than using addictive behaviors to contain the anxiety.

As an observer, the therapist attempts to identify themes or patterns of interaction that are significant to the client's addictive process (Mitchell & Aron, 1999). The therapist observes his own reaction to the client. This is particularly true when the client acts out interpersonal maneuvers within the therapeutic relationship that are based on previously identified early relational templates (Petrucelli & Stuart, 2001). Often these interpersonal maneuvers are designed to elicit a certain response from the therapist that will substantiate the client's model of the relationship. The acting out of those relational templates is considered a client's transference because the client is projecting onto the

therapist characteristics based on his early relationships (Read, 2002).

For instance, Jamal, an incarcerated black male whose experience of racism and oppression are triggers for his addictive behavior, may experience anxiety when working with a predominately white treatment team. He may perceive the experience as similarly oppressive. There may be legitimate issues regarding the lack of diversity among the staff on the treatment team that need to be addressed; however, he may experience his primary therapist, Sue, a white female, as trustworthy. If Jamal is denied a level increase in privileges for behavioral reasons by the treatment team, he may act out in anger toward Sue because he thought he could trust her to be on his side in the treatment team meeting. Jamal may project all of the anger and resentment he's experienced in his life from oppressive systems and individuals onto his white therapist because she is a safe target for his anger. The therapist could respond in a manner that supports his previous relational templates by refusing to further discuss the treatment team's decision or by focusing solely on the level system that increases privileges. However, this would result in a *relationship rupture* that may have negative outcomes for the client.

The clinically prudent approach for a psychoanalytic therapist would be to help Jamal identify underlying thoughts and feelings associated with his response and how they relate to his addictive behaviors. This may also include processing the experiences he has had with oppression and racism. It may be further processed that his projection of anger is a substitute for acting out through using drugs, which is his presenting issue. This approach will do three things: (a) heal the relationship rupture, (b) facilitate the client's corrective emotional experience, and (c) facilitate an increase in Jamal's conscious awareness of his triggers and how the triggers drive his acting out. This type of processing requires the therapist to be consciously aware of her own experience of white privilege. Additionally, the therapist must systematically seek out and be open to feedback from Jamal and from colleagues and supervisors regarding how the therapist's white privilege may be biasing her interactions with the client. This level of self-awareness and constant self-appraisal requires discipline and humility.

The therapist's emotional response to Jamal may take three forms: countertransference, projective identification, and use of interpersonal process. *Countertransference* is based on the therapist's own relational templates (Petrucelli & Stuart, 2001; Rodriguez de la Sierra, 2002). The therapist in this situation may have a reaction to Jamal that is minimally attributable to the client, but it may be based on the therapist's own life history. Working with clients in addictions can be so challenging that psychoanalytic therapists are expected to continue in supervision, engage in case consultation, and attend their own therapy (Rodriguez de la Sierra, 2002). The best response when countertransference is acted out in counseling is for the therapist to verbalize the error and take responsibility for her error; otherwise, the client may reexperience a situation where his reality is not honored. This repair of the relationship rupture can be very

therapeutic for clients because they generally have not had the experience of someone who has more power (the therapist) accepting responsibility for her mistakes.

Projective identification is a complicated defense mechanism. It begins when a client exhibits a transference reaction by projecting a characteristic onto the therapist that does not actually describe the therapist's behavior. This is called projection. Usually the characteristic is one from the client's early relational templates (e.g., an abusive parent) or someone who is in a position of power (e.g., the judge) whom the client fears addressing directly. In this situation, the therapist becomes a safe container for the client's difficult or unwanted negative feelings (Williams, 2002). However, rather than simple transference, the therapist in this situation takes on the characteristic (e.g., abusing her power) as though it were real, even if there is clear evidence that the therapist doesn't have the characteristic (e.g., is aware of power differentials and actively attempts to minimize them while respecting the client's experience). This is when projection turns into projective identification because the therapist is identifying with the client's projection as if it were substantiated by evidence when it is not.

> Box 4.3 Countertransference
> Small groups: Discuss how countertransference might manifest with Jamal. Identify your own cultural and familial biases that may impact countertransference reactions for each group member. How would you address this potential issue if you were Jamal's therapist?

To illustrate projective identification, suppose the client is angry at the court and the "bad cop" who "put him away when he let off two white middle-class kids for the same offense" and angry at his dad for "making" him this way because of abuse he suffered as a kid. But the court, the police, and his abusive father are not safe to lash out at. So he directs his anger toward the therapist (a safe target) by projecting the characteristics of abusive power onto the therapist. She is actually just enforcing the rules of the therapeutic milieu by reminding him of the consequences for missing group in order to go smoke outside of posted smoking times. The client may respond, "You're just like everyone else in the system. You decide who you like and let them slide and punish the rest of us." The therapist in this situation may then identify with the projection, feeling as if she might be abusing her power. This may in turn impact the therapist's interpersonal interaction with the client resulting in her allowing the client to miss group "this one time" to smoke, although it is contrary to the treatment center rules.

In this example, the client projects relational dynamics from early relational templates onto the therapist, and the therapist identifies with it as if it was true and acts out of this identification rather than acting in a manner consistent with her normal behavior. As a result, the therapist enables the client's acting-out behavior. If this situation occurs and the therapist identifies it later, it is important for the therapist to process the interpersonal dynamics that occurred with the client. The therapist should attempt to

draw correlations between this situation and the interpersonal maneuvers the client uses to get other people to enable his addictive behavior.

Finally, the therapist may observe the client's transference behaviors and reflect on her own reaction to the transference, ultimately formulating a process comment to further examine the relational pattern. Interpersonal process interventions such as this involve drawing the client's attention to the interpersonal dynamics and what the behavioral patterns mean within the context of the client's treatment (Horney & Bernard, 1999; Mitchell & Aron, 1999; Read, 2002; Teyber & McClure, 2011). So in the same situation previously discussed, instead of identifying with the transference and projection, the therapist may respond with a *process comment* by stating something like, "It sounds like you feel I'm abusing my power in the same way you have experienced the court system being racist toward you." This is just one potential way to comment on the interpersonal dynamics and refocus on the underlying unconscious motivator for the client's acting-out behavior. Process comments like this can facilitate the client's identifying and processing his thoughts and emotions associated with the underlying feelings of devaluation the client has truly experienced in his life. This creates a situation that acknowledges and honors his experience without allowing those experiences to result in enabling behavior by the therapist.

Psychoanalytic therapists observe how the client's *defense mechanisms* are used in the therapeutic relationship or therapeutic treatment milieu (Petrucelli & Stuart, 2001; Weegmann, 2002a). "From an interpersonal perspective, an individual's addictive pattern in not only a search for pleasure and relief from psychic pain but also an attempt to find a way around the thorny problems of being in relationships" (Petrucelli & Stuart, 2001, p. 31). The therapeutic milieu is an important source of intervention in psychoanalytic therapy. Treatment centers or programs create an environment with complex and changing relationships involving cultural differences, power differentials, and rules and consequences. This environment serves as a microcosm of the larger world in which addicted individuals attempt to function. So the psychoanalytic therapist uses the therapeutic milieu and an interdisciplinary treatment team as a source of therapeutic material and opportunities for intervention. It is believed that clients will act in the therapeutic treatment program in a manner similar to the one in which they act outside of treatment and therefore will provide evidence of how they structure their lives and relationships to support their addictive behaviors and avoid anxiety or dysregulated emotions.

Therapeutic staff must be aware of client defense mechanisms when their typical addictive behaviors are not available to them to manage dysregulated emotions (Safran & Muran, 2000). The constellation of defense mechanisms and the process the client goes through to act out these defenses are unique to each client. It is imperative that therapeutic staff be aware of the interpersonal dynamics present in the therapeutic relationship and the client's interpersonal interactions with others in the therapeutic

setting. This information informs relapse prevention planning.

One common issue in controlled treatment situations is a client's use of the defense mechanism of sublimation, also called *symptom substitution*, to contain his anxiety. For example, a client may use sexual acting-out behavior by having multiple unsanctioned sexual encounters with other clients in treatment in order to contain anxiety because the alcohol and drugs he previously used are not available in a controlled treatment setting (e.g., hospital, residential treatment, jail). This may also be evident in outpatient settings when clients are able to sustain sobriety from alcohol and drugs for years but present in counseling with sexually compulsive behavior or pathological gambling behaviors.

The therapist and/or treatment team must use the information gathered through these observations to formulate working hypotheses about the client's intrapsychic and interpersonal experiences (Teyber & McClure, 2011; Wachtel, 2008). The therapist uses her interpersonal therapeutic relationship with the client to test out these hypotheses experientially. For instance, the therapist may act in a manner that is different than what the client expects based on the client's relational templates (Horney, 1945; Horney & Bernard, 1999; Wachtel, 2008). An example would be a therapist reflecting the feeling observed rather than reacting to a client's angry threats directed at the therapist. The therapist may say in an empathic tone, “Wow, it must really be scary to not have control so you feel the need to verbally threaten hoping I'll kick you out of treatment,” rather than actually kicking the client out of the therapeutic program for verbally threatening the therapist. Obviously, the acting-out behavior may also have other consequences imposed by a probation officer, a parent, or a treatment team as part of the milieu level system, but the therapist's role is to interact in a manner that is a uniquely relational psychoanalytic intervention.

This type of verbalized reflection or observation often results in the client feeling off balance because he expected to elicit a different reaction from the therapist. It requires the client to stop the automatic cycle of acting out at least for a moment to consider a different experience. The therapist must capitalize on these events quickly by encouraging the client to verbally process and thus increase his conscious awareness of the new experience. The therapist might say something like, “It seems you weren't expecting that reaction from me. I'm curious what reaction you usually get in a situation like that.” This type of reflection will help the client begin to connect his present and past experiences, to identify and take responsibility for the interpersonal maneuvering he uses to get his needs met, to identify feelings associated with his addiction, and to increase conscious awareness that these feelings or triggers do not have to end with engaging in addictive behaviors. He has a corrective emotional experience by realizing that his feelings can be dealt with directly through verbal processing.

This is an experiential type of intervention that provides the client with a *corrective emotional experience* that can act as a foundation for a new healthier relational template (Teyber & McClure, 2011). Over time, repeated experiences different from the

client's early relational templates will build new neural pathways and strengthen those neural pathways (Siegel, 2012). It is through this type of ongoing relationship that the therapist is able to help the client become resilient to triggers in a manner that will last longer. This type of restructuring is enhanced by healthy relationships with sponsors; family members who are becoming healthier; and other treatment staff, probation/parole officers, child protection workers, and group members.

When corrective emotional experiences occur, the therapist processes the client's perceptions, thus encouraging the client to be reflective about his current relational experience and how this new experience is different from earlier relational templates (Mitchell & Aron, 1999). This verbal processing of the emotional experience is meant to build neural pathways from the executive functioning areas of the brain to the limbic system where sensory memory and emotion are located (Siegel, 2012). Doing this helps improve the client's ability to cognitively process emotions experienced. The client needs to have the ability to inform emotion with thought if he is going to successfully combat environmental, emotional, and sensory triggers as part of a relapse prevention plan.

Therapists also make *process comments* about the themes or patterns they observe in a client's verbalized retelling of stories or in the client's interactions with the therapist or other people in the therapeutic setting (e.g., sponsors, group members, nurses). Process comments are the way a therapist verbally reflects on the observation(s) he makes about these interactions (Horney & Bernard, 1999; Teyber & McClure, 2011; Wachtel, 2008). For instance, the therapist may say something like, “I notice that whenever staff doesn't allow you to go to the smoking porch outside of posted hours, you seem to become angry and verbally degrade them,” or “I'm wondering if you've noticed a pattern in how you interact with staff when you aren't able to go to the smoking porch outside of posted hours.” These comments are intended primarily to increase the client's conscious awareness of underlying preconscious or unconscious motivations.

The therapist would continue by encouraging the client to identify the underlying feelings experienced in these situations and to make associations with early life experiences. If the client does not associate the current behaviors and feelings with past experiences, but the therapist is aware of the client's history and can make these associations, she may express this as a tentative hypothesis such as, “I'm curious if the feelings you have when you are told ‘no' by staff remind you of any experiences you had with your parents growing up,” or “It's interesting when you describe how you feel when you are told ‘no' by people in authority. I am reminded of your stories about your dad punishing you for using meth when he was an alcoholic himself.” These comments are designed to clarify the therapist's understanding, to express curiosity about patterns or themes observed, and to increase the client's conscious awareness of his internal experience of the world (Teyber & McClure, 2011).

Box 4.4 Biases, Countertransference, and Clinical Supervision

Small groups: Identify potential biases you have working with addiction clients based on the previous small-group discussion (Box 4.3). Analyze how countertransference might impact clinical training and supervision. How might this result in a similar parallel process as the one described between client and counselor? Discuss how a clinical supervisor can assist you in working through these potential unconscious biases to help you work more effectively with your clients.

In addition to understanding the client's relationship with the therapist, with others in the therapeutic setting, and with people in his life, the psychoanalytic therapist understands that the client has an intrapsychic relationship with the substance or behavior that he is addicted to (Read, 2002). It is crucial to understand how this relationship developed, what it means to the client, and how losing the relationship will impact his functioning. In fact, the therapist may need to facilitate a grieving process for the loss of the addictive substance or behavior. It is also important for the therapist to understand that she may become a substitute for the addictive behavior. If this happens, then absences from therapy such as a vacation or a weekend may become triggers for the client. If this occurs, it needs to be processed in therapy and may indicate that a sufficient grieving process has not yet occurred for the client related to the addictive substance. Similarly, the client may identify as an addict and nothing else (Read, 2002; Yalisove, 1997). It is important for the therapist to explore the client's intrapsychic or intersubjective experience of self. If the client is unable to identify other aspects of his personality or likes and dislikes separate from the addiction, then it is crucial that the therapist work with the client to explore self-concept and develop a healthier, more comprehensive understanding of self. Alternatively, the client may completely disavow self as addict by denying any issues with addictive behavior. This may be problematic because the dissociated part of the client's being is the focus of treatment (Petrucelli & Stuart, 2001; Weegmann, 2002a). In this situation, exploration of self as addict may include the therapist facilitating a fantasy projection of an addict onto someone else and then helping the client process his experience of who that person is, the characteristics of an addict, and the meaning or worth the client attributes to someone who is an addict. Then the therapist can help the client integrate a conscious view of self that includes, although is not solely defined by, challenges with addictive behaviors.

Assessment and Prevention Implications

Rapport building is a crucial foundational piece for psychoanalytic therapy, so assessment should be conducted in a manner that supports therapeutic rapport building (Weegmann, 2002b). Although there is a clinical focus on gathering information, that role should never take precedence over the relationship. Projection is a key part of the therapeutic process in psychoanalysis, so initially the therapist should remain as neutral as possible in order to encourage transference reactions, while being warm and

engaging with the client. Assessment data are gathered through one or more clinical interviews with the client, the family, and other collateral sources such as a referral source. Behavioral observations of the client are also documented, and a client may be assessed with standardized assessments as well. Although a lot of data are gathered at the beginning of treatment, assessment is an ongoing process.

When the therapist is neutral it allows the client to direct what is discussed in session, creating an environment for *free association* to occur. This naturally allows the therapist to gather information about how the client associates significant pieces of information. The lack of therapist directedness also may create an atmosphere that encourages anxiety. The manner in which clients manage the anxiety demonstrates their unique constellation of defense mechanisms and processes. It is important to understand the client's unique emotional logic motivating the addictive behavior and the constellation of defense mechanisms he employs to deal with the anxiety. So gathering information through discussion and behavioral observation of the client's defense process is crucial to psychoanalytic assessment (Weegmann, 2002b). In fact, the most commonly used method of assessment is for the therapist to observe and analyze the interpersonal dynamics that occur between the therapist and client.

For the same reason, some therapists use projective techniques such as inkblot tests, the Thematic Apperception Test, or the House-Tree-Person Test to gather information. Formal assessment measures such as these require specialized training, and some states significantly regulate which professionals may use these assessments. However, there are other ways to gather projective data from clients. With proper continuing education, therapists may use art, psychodrama, music, ropes courses, sandtray, or sandplay to facilitate the projective process. These creative methods are particularly helpful with clients who intellectualize their presenting issues or minimize the impact of relational trauma. They are also helpful in engaging clients with complex trauma backgrounds such as those who exhibit alexithymia, an inability to identify emotional states and label them with feelings (Krystal, 1977, 1982).

As a foundation for treatment, a psychoanalytic therapist is expected to complete a thorough psychosocial history early in the process as part of a comprehensive assessment. Specifically, the therapist needs to understand the client's experience of early relationships, particularly those in his family of origin. Information about the client's familial and cultural experiences, gender, socioeconomic status, and sexual orientation (when applicable) is also necessary for the therapist to understand (Wachtel, 2008). The client's experiences of current significant relationships also need to be explored. The therapist may conduct clinical interviews with other important people in the client's life in order to better understand the client's experiences. These interviews are particularly helpful in formulating working hypotheses about the interpersonal dynamics that support the client's addictive behaviors and those that may support the client's recovery process. Additionally, the therapist must understand the client's

relationship to the addiction and his identity as it relates to the addiction (Read, 2002). The goal of assessment is to understand the client's developmental trajectory of addictive behaviors and how early relational templates inform the client's current experience of his relationships with others and the world (Horney & Bernard, 1999; Teyber & McClure, 2011; Wachtel, 2008). Once these are understood, the therapist is able to identify potential sources of shame and guilt that may be driving the addictive behavior and the manner in which defense mechanisms are used to support the addiction (Weegmann, 2002a, 2002b). This information allows the therapist to formulate working hypotheses based on client experiences and her observations of the therapist-client dynamics. An assessment of motivational triggers helps the therapist avoid re-creating harmful relational themes within the therapeutic relationship. When a relationship rupture occurs, the client responds to the therapist negatively. Assessment data gathered early in treatment are crucial to informing the therapist's interventions as she processes the rupture with the client and attempts to create a corrective emotional experience as a result.

Box 4.5 Psychoanalytic Assessment
Identify 10 questions or prompts you would explore with an addiction client during your initial two or three sessions to help you gather the information you need to understand his or her addictive process. (The list won't be exhaustive.) Get into triads with two other students. Take turns trying to gather the necessary information while also building rapport with the client. Each participant will be a client, a counselor, and an observer. After each role-play, discuss what you found most challenging. Identify what you did well. Try to identify patterns and observations of the interpersonal interaction that may be relevant to understanding the client.

Strengths and Weaknesses of the Theory

Some of the challenges in using a psychoanalytic approach to addiction treatment are based on the complex nature of the treatment itself. Due to the individual variability of the client and therapist and the complexity of interpersonal dynamics, this method of assessment and intervention generally takes more time and individualized supervision to train therapists who engage in this form of therapy. Additionally, it is a foundational belief of the theory that because the therapeutic relationship is the most important vehicle to motivate client change, the best client outcomes occur when clients have access to the same therapist and treatment team over time. This necessitates a longer-term therapy than may be approved for payment. Similarly, given that there is a high rate of job stress and burnout among addiction professionals, it is more challenging to support therapists in positions that require them to engage clients interpersonally at this level. Finally, research to establish evidence-based practice is more complicated because of the length of treatment required and because there are so many individual

variables that must be accounted for in order to adequately support quality research methods.

The strengths of the psychoanalytic approach are based on the same foundational beliefs around the therapeutic relationship. Because so much time and energy is spent on the therapeutic relationship and the therapeutic milieu in treatment programs, interventions tend to be very individualized. Psychoanalytic therapists focus on deeper personal motivations behind addictive behaviors, rather than just the presenting substance or behavioral addiction. This results in interventions that are more meaningful and emotionally impactful. Clients are able to work through underlying trauma and other issues that drive their addictive behaviors so that the client tends to take responsibility for his relapse prevention and understand the addiction as part of his life journey. Because there are not manualized treatment protocols, this approach allows for use of a variety of techniques that are creative and culturally consistent and allow for technical eclecticism. Psychoanalysis reflects a way of being with the client and a way of thinking about the client (conceptualization) more than a set of techniques used for intervention. The *why* associated with the client's behavior drives the *when* and *how* of intervention, but the actual intervention is informed by the unique client dynamics, not by the theory itself.

The one technical exception is a consistent use of the interpersonal process in the therapeutic relationship as a method of assessment and intervention throughout the relationship. The strength of this technique is that it often allows clients to develop genuine relationships with a therapist that can be used as a foundation for dealing in a more genuine manner with relationships outside of therapy. The client's ability to deal effectively with challenging interpersonal situations is often the difference between being in relationships that enable addictive behaviors versus those that support the recovery process.

Case Study Responses

A contemporary psychoanalytic therapist would conceptualize Gabriel's challenges with addiction using his early relational templates and multigenerational traumas to inform his case conceptualization. To begin with, Gabriel has experienced his father only as an active drug user and as the person who initiated Gabriel into the world of using. His only positive relationship with his father is one where they used drugs together. He loves his father but experiences him as unaccepting. Gabriel's drug use is likely an unconscious attempt to gain his father's acceptance and unconditional love. This represents a challenge in therapy because he may have an unconscious belief driving his behavior that in order to gain his father's acceptance, he must use addictive substances. Similar to his father, Gabriel's sponsor was older and had lived the life of an addict. He describes experiencing his sponsor as a “hard but caring man.” He likely projected onto the sponsor this father-son relationship and attempted unconsciously to work through some of the emotional disconnect he has with his father. This represents the longest time

he was able to maintain sobriety. The description provided indicates that when he relapsed he broke the relationship with his sponsor. It is crucial to understand how he made sense of the relapse in relationship to this pseudo father-son relationship. It is possible that he projected onto his sponsor the lack of acceptance that he experienced from his own father and that shame unconsciously motivated his continued use rather than seeking reconnection with the sponsor whom he assumed would reject him, based on his existing relational template.

It is possible that an older male therapist or sponsor may be helpful in encouraging Gabriel to project these unconscious thoughts and feelings onto the therapist, thus allowing corrective emotional experiences that provide a working-through process. If he is able to become consciously aware of his thoughts and feelings about his relationship with his father he is more likely to resolve some of these issues and be open to processing how the remaining ones impact his recovery process.

Gabriel experienced his mother as caring toward him and his sister but enabling his father's behavior to the point of subjecting her children to their father's physical abuse. His unconscious expectation is that the women in his life, including his mother, should enable his addiction if they care about him. Gabriel views his mother and sister as victims of men. His self-concept as a man needs to be explored to identify how he deals with his own anger and whether his identity as a man is defined by physically aggressive behavior or if he avoids using violence, and thus “isn't a man.” This informs the type of anxiety he may experience and the way he contains the anxiety.

Gabriel also may be attracted to women who have been victims and who demonstrate enabling behaviors, thus allowing him to be the protector. However, he demonstrates ambivalence toward committed romantic relationships that reflect the ambivalence he unconsciously carries about his mom's enabling behavior toward his father. When his mother or other women he is in a relationship with set boundaries with Gabriel, he experiences this as an unbalancing because it does not support his early relational templates with women. This results in anxiety for Gabriel triggering acting out by relapsing in order to mediate the anxiety. When alcohol or drugs are not available, as was the case when he was in a controlled inpatient treatment setting, he substitutes substance addiction with hypersexual behavior that may indicate a comorbid sexual addiction.

Gabriel likely projects onto his niece his experience as a vulnerable child who has endured abusive and addicted men. Similar to his role as protector for his mother and sister, he is placing himself in a protector role for his niece. He may be projecting a father-daughter relationship onto his niece. He likely experiences shame about his addiction and relapsing in this context because he is unable to meet his ego ideal vison of what a father figure should be, based on his cultural values. He is motivated to change his addictive behaviors because of his unconscious desire to be the ideal father figure for his niece. It is likely that his relationship with her is an unconscious attempt to

master the abusive situation he grew up with and work through the emotional impact of the experiences with his own father. Through providing a good parent for his niece he may be able to reparent himself as a young boy in a healthier way.

Gabriel does not reference his ethnic or cultural heritage other than identifying his parents' ethnicities. He has lived as a multiple-heritage individual due to his mother's African American ethnicity and his father's Cherokee ethnicity. Both groups have historically experienced disempowerment by the white male majority. Along with these, there is the unique culture of growing up in Appalachia where significant poverty is the norm. The use of alcohol and other drugs, much like the Cherokee culture following the "white man's invasion," has been readily available as a method for numbing and escaping conscious awareness of their circumstances. It may be that Gabriel is unaware of how his multigenerational heritage of disempowerment may have culturally predisposed him to a belief that he is powerless to change his circumstances.

It is notable that Gabriel discusses himself only in relationship to others or in relationship to his addiction. This indicates that he does not have a sense of himself separate from others or separate from his addiction. This may pose a significant hurdle in therapy. He is likely to experience significant, possibly overwhelming anxiety when he is challenged to explore his inner self without using his addiction as a container for that anxiety (Williams, 2002). Exploration of Gabriel's self-identity, including self as addict, self in recovery, self as protector, self as sexual being (including wrestling with sexual orientation issues), self as multiple-heritage individual, self as parent/uncle, and self as athlete/coach, are all areas to focus on in therapy because these either potentially result in anxiety that he contains with his addictive behaviors or may be sources of strength that will support a positive self-concept that will help sustain his recovery.

The therapist's gender, sexual orientation, ethnicity, perceived socioeconomic status, and education level will impact the type and quality of transference reactions Gabriel has in therapy (Wachtel, 2008). The best scenario would be that he is exposed to a diverse group of people in treatment in order to increase the likelihood that transference reactions develop in such a way as to maximize therapeutic potential of interpersonal process interventions. The reader may note that much of the conceptualization is presented as tentative hypotheses. A case conceptualization, like the individual, is dynamic. Therefore, it is expected that as transference reactions occur, as new unconscious material becomes evident, and as tentative hypotheses are tested out, the conceptualization will necessarily change.

Summary

Contemporary psychoanalytic treatment of addictions is based on a belief that early relational templates and unresolved trauma impact a client's unconscious motivational drives. Unconscious environmental, emotional, and sensory triggers result in the client's desire to act out addictive behaviors as a method of mediating anxiety experienced in these situations. Through interventions maximizing client projections, psychoanalytic

therapists use the therapeutic interpersonal relationship to help the client experience new corrective emotional experiences and become more consciously aware of previously unconscious or preconscious triggers in the environment. This forms the foundation of the client's relapse prevention plan. However, it is also understood that relapse may occur as part of the change process because neural networks supporting addictive behavior and those reinforcing early relational templates and unconscious cognitions and emotions from unresolved trauma will need to be restructured and reinforced through consistent therapeutic interpersonal interactions over time.

Resources for Continued Learning

Websites

International Association for Relational Psychoanalysis and Psychotherapy: http://iarpp.net.

New York University Postdoctoral Program in Psychotherapy and Psychoanalysis: http://postdocpsychoanalytic.as.nyu.edu/object/faculty.paul.wachtel.

Psychoanalysis—Techniques and Practice: www.freudfile.org/psychoanalysis/index.html.

Psychoanalysis Today: www.ncbi.nlm.nih.gov/pmc/articles/PMC1525087.

Relational Psychoanalysis: https://en.wikipedia.org/wiki/Relational_psychoanalysis.

Washington Center for Psychoanalysis: www.wcpweb.org.

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5 Self-Psychology Theory: *Addiction and the Wounded Self*

Joseph B. Cooper

In 1977, the National Institute on Drug Abuse published a little-known research monograph regarding the psychodynamics of drug dependence. The preface, written by Heinz Kohut, the founder of self-psychology, outlines his understanding of addiction through the lens of self-psychology. He writes:

> The addict, finally, *craves the drug because the drug seems to him to be capable of curing the central defect in his self*. It becomes for him the substitute for a self-object which failed him traumatically at a time when he should still have had the feeling of omnipotently controlling its responses in accordance with his needs as if it were a part of himself. By ingesting the drug he symbolically compels the mirroring self-object to soothe him, to accept him. Or he symbolically compels the idealized self-object to submit to his merging into it and thus to his partaking in its magical power. In either case the ingestion of the drug provides him with the self-esteem which he does not possess. (Blaine & Julius, 1977, p. vii; italics added)

Here, Kohut outlines the central tenets regarding substance dependence and self-psychology that will be explored in greater detail in this chapter. In short, the model of self-psychology views the driving force behind addictive behavior as the result of a defect in the structure of the self and that addictive behavior as an attempt at self-repair in order to fill in what is missing in the defective self. Unfortunately, these addictive attempts at self-repair are temporary and do not succeed, because they cannot provide the missing psychic structure necessary for healing the self. Finally, as we will see, from the framework of self-psychology, the recovery process is more than just stopping or reducing the addictive behavior but involves interventions that aim to help the addicted individual to ameliorate the central defect in his self-structure and to encourage the development of a stable and cohesive internal psychic structure. The goals of this chapter are twofold. First, I provide a conceptual overview of development and maintenance of addiction as understood from the perspective of self-psychology, and second, I offer some preliminary guidelines for the treatment of addiction by way of this model.

Philosophical Underpinnings and Key Concepts of the Theory

Self-psychology was developed by Heinz Kohut and colleagues through a series of publications over a 15-year period (Kohut, 1971, 1977; Kohut, Goldberg, & Stepansky, 1984). Although considered a model under the umbrella of psychodynamic theory, his constructs and understanding of the etiology of psychological disorders are radically different from the traditional understanding of the psyche and emotional disorders as

delineated by Freudian theory (Cratsley, 2016; Fenichel, 1945). Thus, instead of unresolved intrapsychic conflicts, emotional disorders, according to Kohut, are the result of a developmental arrest, the failure to develop a normal and cohesive internal psychic structure, or "self," due to repeated empathic attunement failures in one's early attachment relationships (Levin, 1991). These internal psychic structures are important in one's ability to regulate affective states, have good self-esteem, and self-soothe and calm oneself in times of distress. As we all too often see in those suffering from addictive disorders, they show deficits in these basic capacities related to a cohesive internal psychic structure. In order to understand more fully how this self-deficit is developed, we first explore the central concepts related to the healthy development of psychic structure from the perspective of self-psychology.

Development of Self

What is psychic structure, and how is it developed? At the center of Kohut's model for the development of psychic structure is his understanding of the self, which he understood as the core of one's personality. Kohut (1971) defined the self as "a unit, cohesive in space and enduring in time which is the center of initiation and a recipient of impressions" (p. 99). The self is not something that exists a priori but is created over one's life through relational experiences, primarily with one's caretakers. In this regard, Kohut stressed the central role of parental responsiveness in the development of the self. This responsiveness is expressed in the parent's ability to be empathically attuned to the growing child's emotional needs. Lack of or inconsistent empathic attunement results in deficits in the development of psychic structure, leading to disturbances in affect regulation and self-esteem.

Selfobject Needs

The child's nuclear self is formed in infancy and progresses through a number of stages, starting with a primitive, fragmented self and culminating with a cohesive, mature self. Kohut conceived the inchoate nuclear self essentially as bipolar, developing along two lines of tension, that of the grandiose self and the other pole, the idealized parental image (Kohut, 1977). Along this path of self-development, Kohut hypothesized that for each of these poles of development, there are basic needs, which he termed *selfobject needs*, necessary for the optimal development and internalization of psychic structure (Giugliano, 2011). A selfobject is neither an object nor a person but rather the subjective aspect of a function performed by a relationship. Other people can serve the role of selfobjects, but as we will see later, so also can alcohol and drugs (Flores, 2001). Selfobjects are central to the developing self and are primarily performed by the infant's empathic caretakers (Mann, 2015).

Kohut initially described two selfobject needs: mirroring and idealizing (Kohut et al., 1984). Mirroring needs are met through the caretaker's ability to mirror the child's innate sense of greatness, competence, and uniqueness, whereas the idealizing needs are

met through the child's experience of a strong, soothing, and idealized other whom the child can look up to and model as a figure of calmness and strength. Kohut later added a third selfobject need, *twinship*, to refer to the need to experience a kinship and belonging to others (Banai, Mikulincer, & Shaver, 2005). Imagine the scene of a mother and her small child playing in the yard. When the child laughs, the mother laughs too, and when the child smiles and shows her mother a leaf she found, the mother smiles warmly, looks her child in the eye, and says, "What a beautiful leaf you found for Mommy!" Here, the mother is meeting her child's mirroring selfobject needs. When mirroring needs are met, the child internalizes a sense of healthy self-esteem, appropriate ambition, assertiveness, and sense of wholeness. Or imagine the same scene again, yet this time as mother and child are playing, the child falls down, scrapes her knee, and begins to cry. Our mother runs to the child and begins to soothe her, telling her daughter that it must have been very scary to fall down, that she knows it hurts, but that she will be okay, and to let Mommy kiss her knee to make it all better. Here, the mother is now meeting her child's idealizing selfobject needs. When idealizing needs are met, the child develops the capacity to self-soothe, identify feeling states, and have awareness of his or her own personal ideals. Finally, twinship needs allow for the sense of community and connection with others, which translates into a sense of belongingness (Alaggia & Mishna, 2014). Overall, it is within the context of an emotionally attuned environment in which the child's mirroring, idealizing, and twinship needs are met that psychic structure is developed and internalized.

Transmuting Internalization

The process of how these selfobject needs are internalized and become a part of the permanent self-structure is called *transmuting internalization* (Kohut, 1971). This term refers to the fact that parents cannot, and do not, always adequately meet their child's mirroring and idealizing needs. This would require a level of perfection that most humans do not possess. However, if these empathic misalignments are minor and nontraumatic, and can be repaired vis-à-vis the child and the person providing the selfobject functions, then psychic structure can be internalized. Thus, it is not perfection but "good enough" parenting and the provision of optimal frustration that allows transmuting internalization to take place. *Optimal frustration* represents the healthy environment by which the child experiences this rupture and repair process. Within a context of optimal frustration, the empathic failures can lead to the relinquishment of external selfobject functions and the internalization of one's *own* burgeoning capacity to self-soothe and calm oneself (Flores, 2004). Because these resources are now an internal part of one's self, a person will be less dependent on external resources for self-esteem, soothing of self, and gratification—often the opposite of what we see in those suffering from chemical dependency: feelings of inadequacy, low self-esteem, and difficulty with self-soothing and frustration tolerance.

Box 5.1 “Good Enough” Parenting
Discuss with each other what you believe is understood as “good enough” parenting. What would that look like? How would you know when parenting was not good enough? Would the understanding of good enough parenting differ among various cultural groups?

Development of Addictive Behavior

The previous provides an overview of the basic tenets of self-psychology and the process for the optimal development of the self and psychic structure. Unfortunately, this process is often not optimal. Gross empathic failures to any of these selfobject needs over time results in severe deficits in the self and the developing self-structure. This results in profound feelings of shame, depression, anxiety, fragmentation, and emptiness, which Kohut (1971) understood to be the underlying source of pathological narcissism (see Exhibit 5.1). These feelings underlying pathological narcissism result in compensatory behaviors to either seek the presence of an idealized other (“My self-esteem and worth are enhanced by your greatness”) or mirroring selfojbect (“My self-esteem and worth are validated by your greatness”).

As opposed to healthy narcissism, pathological narcissism becomes a defense against painful feelings of shame, inadequacy, and low self-worth (Levin, 1994). In other words, Kohut found that these psychological issues were related to deficits in the psychic self-structure due to the failure of early attachment figures to meet the child's selfobject needs. From an attachment perspective, these failures were related to the inability of the caretaker to be empathically attuned to the child's emotional states (Flores, 2004). Exhibit 5.2 lists the emotional and psychological consequences of these failures to internalize mirroring and idealizing selfobject needs (Georgi, 1998).

- Cohesive yet insecure self
- Threats of fragmentation
- Grandiosity
- Unrealistic goals
- Interpersonal isolation
- Feelings of entitlement
- Poor affect tolerance

Unmet Mirroring Needs (Grandiose Pole)	Unmet Idealized Needs (Idealized Pole)
• Feelings of inadequacy	• Profound insecurity
• Emptiness	• Ill-defined sense of self
• Low self-esteem	• Unclear personal boundaries
• Feelings of worthlessness	• Need for black-and-white thinking
• Overly critical of self and others	• Feeling states unclear
• Need for control	• Difficulty self-soothing

How does this set the stage for addictive behavior? Failures to meet the child's selfobject needs, in other words, lack of appropriate mirroring and idealizing due to repeated failures in empathic attunement of the child's caretakers, results in deficits in the self and a lack of cohesive self-structure. This lack of structure produces a compensatory drive to fill in what is missing. In a nutshell, addiction is the unsuccessful attempt to compensate for this failure in internalization, regulate affect, and provide or fill in this missing self-structure.

Deficits in one's ability to regulate affective states are also a consequence of inadequate psychic structure (Khantzian, Halliday, & McAuliffe, 1990). Without clear internalized psychic structure, the ability for self-regulation is limited. In this regard, Khantzian (2001) considers addiction to be a disorder of self-regulation, and through his clinical observations, he found deficits in addicts' ability to regulate not only their affect but also their self-esteem, relationships, and behaviors. Thus, his clinical experiences built on and corroborated Kohut's theoretical understanding and formulation of addiction. Khantzian observed that addiction is not just an attempt to achieve pleasurable states but also serves the function of helping clients regulate their emotional states by soothing their internal feelings of shame, emptiness, and deprivation. The addiction (e.g., drugs, alcohol, sex) becomes the new selfobject.

Because mirroring and idealizing selfobject needs were not adequately internalized, the addictive behavior becomes a surrogate selfobject, attempting to provide the individual with those selfobject functions that can reduce tension and regulate self-esteem. Kohut writes:

> It is the tragedy of all these attempts at self-cure that the solutions which they provide are impermanent, that in essence they cannot succeed. … They are repeated again and again without producing the cure of the basic psychological malady. … It is as if a person with a wide open gastric fistula were trying to still his hunger through eating. He may obtain pleasurable taste sensations by his frantic ingestion of food but, since the food does not enter that part of the digestive system where it is absorbed into the organism, he continues to starve. (Blaine & Julius, 1977, p. viii)

As such, addicted clients are always vulnerable to compulsive and obsessive behaviors

and will substitute one addictive behavior for another, until they can achieve a restoration of the vulnerability in their self-structure (Flores, 2004). This explains why addiction is often so entrenched as part of one's psychological and behavioral system of functioning and also hints at an important treatment consideration. If we conceptualize addictive behavior to be the result of missing psychic structure and understand that one's addictive behavior is actually an attempt to heal oneself and fill in what is missing, then our interventions need to be tailored to provide a set of experiences that can help to fill in, in a healthy and adaptive way, those unmet selfobject needs our client is so desperately seeking. If the stage for addiction was set in relationships, then the healing process also needs to take place *through* relationships.

How the Theoretical Approach Is Used by Practitioners

At the heart of Kohut's understanding of addiction is a disruption of the healthy development of the self. This wounded self seeks healing experiences, and addictive behavior is a failed attempt to provide that. As we saw earlier, the key to the healthy development of the self is the extent to which one's caretakers could empathically respond to the child's grandiose (mirroring) and idealizing selfobject needs. As such, *relational empathy and mirroring* of both your client's self-experience and his or her affective states play a central role in this treatment approach.

We must keep in mind, however, for the purposes of this chapter, that the focus on treatment interventions as they pertain to self-psychology will be based mainly on relational and psychological interventions. Addiction is a complex interplay of biological, interpersonal, psychological, and spiritual components, and the treatment of such should be comprehensive in addressing the deficiencies of each of these domains (G. Miller, 2010). For example, it is difficult to heal psychic structure if one is currently in need of detoxification first! Obviously, issues such as crisis intervention and management, physiological stabilization, detoxification, and managing suicidality will need to be addressed *first* before the interventions based on the model of self-psychology can begin.

The deficits in self-structure leave these clients narcissistically vulnerable with an intense need for mirroring and approving responses, as well as a tendency to strongly idealize (or devalue!) the therapist. In general, the treatment should focus on damages to the client's already low self-esteem, exploration of the failures in his or her childhood environment to adequately receive the phase-appropriate mirroring and idealizing experiences from his or her caretakers, and the management of the client's rage and anxiety (Levin, 1994).

Early Stage Treatment Issues

A self-psychological approach to treating substance dependency can take place in either individual or group therapy, although the optimal approach would be a combination of the two. In early treatment, the therapist's stance should be one that is active and

supportive, by providing structure, education, and interventions that are simple and clear. Because the primary function of the addiction was to fill in what is missing and to meet the client's mirroring and idealizing needs, helping the client to detach from his or her object of addiction, achieving abstinence, and dealing with any physiological or medical issues is the first order of business. Otherwise, more in-depth psychological interventions will fall flat or exacerbate symptoms.

Because the client has an impaired capacity for healthy attachments and relationships, one of the counselor's first tasks in early stage treatment is the building of the therapeutic relationship. In fact, deepening and expanding the client's ability to relate to both the therapist and other group members is one of the primary goals of this approach (Levin, 1994). The relationship is built by providing active listening, supportive statements, and nonjudgmental positive regard for the client. Also, providing an atmosphere of gratification, support, and containment is necessary for the building of the alliance and enhancing healthy attachments (Flores, 2004). Finally, empathy and mirroring of the client's needs and vulnerabilities is central to the relationship-building process and sets the stage for the healthy transmuting internalization of the client's selfobject needs and the rebuilding of psychic structure.

Individual Counseling

As noted earlier, individual counseling can be used as an adjunct to group counseling. Once abstinence and detachment to the object have been obtained, then the aim of individual counseling is increased self-awareness and the repair of structural deficits of the self. This is accomplished through developing the alliance, building trust, and allowing the space for the analysis of transference reactions and the interpretation of defenses as wounds to the client's narcissistic vulnerability (Davis, 2015). From the vantage point of self-psychology, addicted clients have tremendous wounds to their self-image and self-esteem. Thus, in individual therapy, they often develop an intense need for mirroring (approval) responses from the counselor or the need to idealize the counselor. These mirroring or idealizing transferences are to be considered a normal part of the treatment process and are welcomed, for the counseling relationship offers an opportunity for the expression of the client's grandiose self and the development of an idealizing transference. In turn, these reactions are analyzed and interpreted, whereby the counselor and client can explore and understand the genesis of these needs as being related to failures in the childhood environment to provide the phase-appropriate mirroring and idealizing experiences to the client (Levin, 1991).

Development of New Psychic Structure

As discussed, the development of healthy psychic structure takes place in an environment of optimal frustration, where the caretaker's nontraumatic failures in meeting the child's selfobject needs can be repaired. As in the family environment, the therapy relationship is no exception, for it is impossible for the therapist to accurately

meet the client's moment-to-moment mirroring and idealizing needs. Thus, each nontraumatic failure on the part of the counselor to provide empathy or to protect/soothe the client can be explored, worked through, and repaired. It is important that this be not just an intellectual process but that the counselor directly encourage the client to feel, express, and work through the feelings (e.g., anger, rage, pain, grief) related to these empathic misattunements. It is the small repetitions of this process, over and over, wherein the capacities done by the therapist (e.g., affect regulation, self-awareness, repair, support, identifying feelings) can slowly be taken in by the client and become part of his or her self-structure and internal capacities. Over time and by transmuting internalization, psychic structure is built.

The therapist can serve as a temporary selfobject that provides those needed functions. In this way, the therapy relationship becomes a corrective emotional experience for the client (Alexander, 1946). With the internalization of their mirroring and idealizing selfobject needs, clients can develop their own capacities for healthy self-esteem, affect regulation, and self-soothing abilities. These capacities replace the need for the client to rely on drugs and/or alcohol to meet his or her selfobject needs.

Group Counseling

Because shaming, painful, and often rejecting relationships resulted in deficits in self, clients found it hard to turn to others to get their emotional needs met. However, it is precisely in the context of relationships that the wounds of the self can be healed and psychic structure restored. Therefore, group therapy offers the optimal platform by which the concepts of self-psychology can unfold in the treatment of those suffering from addiction. Group therapy offers the unique opportunity to provide the client with a consistent nurturing, mirroring, and holding environment that can help contain strong affects while providing the client with the opportunity to incorporate a healthy internal object and self-structure (Flores, 2001). Over and above individual counseling, group therapy provides the perfect opportunity to transmute mirroring and idealizing selfobject needs into one's own sense of self.

Guidelines for Group

The self-psychology group should be a supportive, *process-experiential* group experience, allowing members to examine, challenge, and change their vulnerabilities in four main areas (Georgi, 1998):

1. Problems in relationships
2. Accessing, tolerating, and regulating affects
3. Self-care failures
4. Self-esteem deficits

Because the group is process-experiential, versus psychoeducational, it is vital the leader work to promote and maintain an atmosphere of safety. This is based on the understanding that clients are more likely to change if they feel safe enough to do so. As

the focus of the group is on the here and now, client issues and the present relational dynamics taking place member to member, member to leader, and member to group as a whole are examined and explored. There is less of a focus on content issues and "there and then" items, except as it relates to what is taking place now.

In addition to creating a space of safety, there are also a number of tasks the group leader can do to facilitate the incorporation of psychic structure. These include the following (Georgi, 1998):

1. Keep the group focused on the here-and-now experience of the members. This can promote the development of group cohesion and allow for the member-to-member unfolding of selfobject needs and experiences.
2. The most fundamental concept that orients a self-psychology group is the selfobject experience. The intervention of choice is whatever facilitates members' ability to clarify what they need from others, how to ask for it, and what they experience when they do and don't get some level of optimal responsiveness from either the leader or other members in the group.
3. Directly encourage the group members to explore how they are in the group and how they experience themselves with others.
4. Encourage members' interpretation of their interpersonal behavior and the expression of their inner experiences and vulnerabilities.
5. Protect group members and provide emotional regulation to the group when needed. Do not let emotions get too overwhelming or out of hand. For example, too much anxiety can interfere with the trust and safety necessary for the exploration and openness that members need to reveal themselves.
6. Provide affect regulation by naming and mirroring feelings when they occur in the group.
7. Create an environment that meets the members' need to be mirrored, to be seen, and to be seen as wonderful. Do this by going slowly, making eye contact with each member, and believing that the members have the capacity to do the hard work necessary for recovery.
8. Be aware of shame as the driving force behind narcissistic wounds. Be sensitive to potential comments from members (or yourself!) that could be shaming and encourage other ways of communicating and relating.

From a self-psychology perspective, what is ultimately healing is not content but connection, mirroring, here-and-now experience, and the safe expression and mirroring of feelings. The here-and-now experience is healing because addicts, due to their narcissistic wounding and lack of internal structure, avoid being in the here and now. The group allows them to experience that in a safe place.

Assessment and Prevention Implications

The implications for assessment are related to identifying if your client is expressing a vulnerability of the self and if treatment informed by self-psychology would be

warranted. In addition to a thorough biopsychosocial assessment (G. Miller, 2010), assessment should also be focused on specific manifestations of your client's narcissistic injury. These include issues of deep pain; intense levels of shame and impoverished self-concept; and compensatory behaviors such as grandiosity, feelings of entitlement, and isolation from others. Because there is a paucity of cohesive self-structure, the clinician should assess for examples of deficits in the four key areas discussed earlier: (a) pattern of difficulties in relationships, (b) accessing and tolerating affective states, (c) self-care failures, and (d) deficits in self-esteem. Finally, difficulty regulating affective states, impulsivity, the inability to delay gratification, lack of clear boundaries, and heightened levels of anxiety are also common expressions of deficits in self-structure due to failure to internalize healthy mirroring and idealizing selfobject functions.

Strengths and Weaknesses of the Theory

The strength of this model is that it provides a conceptual tool not only for understanding the formation and cause of addictive behavior but also for the development and use of specific treatment interventions aimed to repair the self and promote healthy internalizing of selfobject needs. Understanding addiction from the perspective of self-psychology provides both the counselor and the client a way of making sense out of the substance abuser's often puzzling self-destructive behaviors and relapses. Reframing addictive behaviors as one's attempt at self-cure lessens the shame and stigma associated with addiction and provides a theory that explains drug use as an attempt to fill inner emptiness and regulate affect and self-esteem.

Although providing a cohesive conceptual tool for understanding the psychological and emotional antecedents to addictive behaviors, the model lacks sound empirical support for both the specific constructs (i.e., transmuting internalization) and the efficacy of treatment interventions based on this model. Also, because this model is a *deficit* model, one that understands addiction as an attempt to provide something that is missing, it remains uncertain if this “missing structure” is the cause of addiction or the consequence of addiction. The model speaks very little to the societal and cultural influences of addiction. It does not take into account the severe impact of poverty, discrimination, and oppression. The model also does not speak to ways this approach would be modified or adapted to different cultural groups. In addition, there is the risk of this approach becoming one-sided, because the primary focus on internal psychic structure deficits could cause counselors to downplay the important influences of culture, peer group, poverty, discrimination, and biological and hereditary factors related to addiction.

Case Study Responses

The case of Gabriel exemplifies many of the facets of an individual suffering from deficits in the self and the compensatory use of alcohol and other drugs as an attempt at

self-cure to fill in what is missing and to repair his narcissistic injuries. Gabriel is a 26-year-old biracial male, questioning his sexual orientation, who has a history of stormy interpersonal relationships, sexual acting out, intense shame, and lack of clear boundaries between self and others. Thus, from the purview of self-psychology, Gabriel is suffering from an unclear and fragmented sense of self due to a lack of healthy internalization of selfobject functions. As the case shows, this deficit of internalization is related to his caretakers' inability to meet his age-appropriate selfobject needs. The result for Gabriel is a state of pathological narcissism.

Pathological narcissism is a regression to a stage of the archaic self. Gabriel's archaic self is crippled with shame, has difficulty differentiating between self and others, and has extreme self-regulation deficits. Gabriel's self is continually threatened by regressive fragmentation and massively low self-esteem, which is expressed as anxiety and shame. These symptoms, in turn, are compensated through feelings of entitlement and the need for omnipotent control via obsessive-compulsive disorder and his sexual conquests. Because the self of Gabriel is tenuous, it is continually subject to high levels of anxiety, which is the consequence of his fear of annihilation and fragmentation of self. For instance, this fragmentation is displayed in his uncertainty regarding his sexual orientation and his inability to commit to or be faithful to one woman, constantly jumping from one romantic relationship to the next. He attempts to boost his damaged self-esteem through a series of sexual escapades, seeking mirroring and idealizing selfobject experiences through others.

It is clear from the case study that Gabriel's caretakers did not adequately meet his mirroring and idealizing selfobject needs. For example, his mirroring selfobject needs would have been met through his caretaker's ability to mirror Gabriel's innate sense of greatness, competence, and uniqueness, whereas his idealizing needs would have been met through his experience of a strong, soothing, and idealized other—one whom he could look up to and model as a figure of calmness, strength, and self-soothing capacities. Unfortunately, there is very little evidence in the case study that this took place on a consistent and “good enough” basis. For instance, he was raised in an environment with very poor interpersonal boundaries and a history of unstable relationships; his own father not only used drugs with him but also was the one who first introduced him to cocaine. And his father not only abused alcohol and drugs for as long as Gabriel could remember but also was emotionally and physically abusive to his family, leaving Gabriel to defend his mother and sister from his father's violent behaviors when his father was on a binge. It would be a Herculean feat for an addicted father and terrified mother to, in any way, consistently meet Gabriel's selfobject needs and to be empathically attuned to his emotional states. Because of this, Gabriel was never able, via transmuting internalization, to incorporate his selfobject needs into his own, internalized, psychic structure and sense of self.

The case provides clear examples of the emotional and psychological consequences of

this failure. For one, Gabriel displays difficulty regulating affects in a healthy way, turning to alcohol, drugs, and sexual acting out to regulate his emotions and self-esteem. Related to this is also the extreme difficulty he has in self-soothing his affective states. Without these internalized selfobject functions in place, he has to turn to outside sources for help. The missing parts of his self he experiences as a void, which he tries to fill with alcohol, drugs, and compulsive sexual relationships. As was noted earlier in the chapter, these attempts at self-cure are impermanent. Kohut asserted that the solutions these self-cure behaviors provide are temporary and bound to fail and are thus repeated again and again without producing the desired cure. This would explain Gabriel's history of relapse and continued use despite consequences. For example, Gabriel has a history of failed attempts to stop using alcohol and drugs and has even been through two inpatient hospitalizations, all without success. In spite of the consequences to his relationships, family, and personal health, he continues to use again and again. He is desperately seeking but failing to find psychic structure to fill in his internal void.

Internalization of Recovery

The treatment and healing of the self cannot begin as long as Gabriel continues to use. It would be impossible to see who is “really there” while he is still under the physiological effects of his drug and alcohol use. The first order of treatment then would be referral to a level of care in order to provide structure and safety to promote sobriety. Although more information is needed from the case, I would feel comfortable referring Gabriel to at least the level of intensive outpatient, or possibly brief inpatient, treatment to begin with and to monitor his progress and adjust level of care accordingly (Cavacuiti, 2011).

The approach to treating addictions from a self-psychology perspective is not unilateral. It can integrate other models and approaches, while still maintaining the stance of the treatment components to be discussed. Therefore, I would also incorporate the principles and techniques of motivational interviewing, because I would want to shore up Gabriel's motivation for change (W. R. Miller, 2012). The goal is to strengthen and *internalize* his motivation to change, in that the case states he is coming to treatment at the request of his mother and sister, indicating an external locus of motivation. I would want to explore more fully his concerns about his use, the effects on his life and relationships, how important it is for him to change, and how confident he is that he can do it.

Gabriel has a number of strengths that I would also want to highlight to him and promote. For instance, he is willing to attempt treatment and has also shown a past willingness to attend treatment and AA meetings. He has been able to achieve sobriety before and was able to complete the requirements of his court-mandated treatment. Members of his family are important to him (mother and niece), and I would draw on these sources of support.

Due to space limitations, I will speak only to the focus of the recovery work in

individual therapy, keeping in mind that the individual work would be an adjunct to group therapy, family counseling, and self-help meetings.

Because the wounds of the self were created in relationships, the healing can take place only in relationships—healthy relationships that can promote a corrective emotional experience and the internalization of psychic structure. Thus, the first task in our individual work together is the *development of the relationship* and the creation of safety and trust. This would be done through a *nonconfrontational* approach and the use of mirroring interventions to reflect back to Gabriel that the therapist is able to empathically attune to his inner states. This requires an attitude of active listening, empathic reflections, eliciting feelings, and a stance of unconditional acceptance. This does not mean that resistances (which will come up) would be ignored but would instead be interpreted as expressions of his vulnerable self and need to self-soothe. For example, "Right now a part of you thinks it is still OK to have a drink again, because you want so badly to feel that you are in control of your life and to calm the inner turmoil you often experience."

Early in the stage of treatment with Gabriel, I would provide structure, keep interventions clear and simple, provide education and support, and avoid trying to break down any manifestations of denial. Instead I would put forth efforts to help teach Gabriel how to best use his internal capacities. Treatment goals with Gabriel should be both realistic and codetermined. They should take into account his strengths, resources, and life situation, and they should be provisional; they are subject to change over the course of treatment. From a self-psychology perspective, the overarching goal is the expansion of self-awareness and to repair the structural deficits in Gabriel's self. Specifically, we would (a) explore specific examples of his narcissistic injuries and how he attempts to ameliorate the pain of these through drug and alcohol use, (b) explore the failures he experienced in his life from his caretakers to appropriately meet his mirroring and idealizing needs, (c) help him to see how his narcissistic rage is either acted out in the form of relapses or turned against the self in the form of depression, (d) show him that his profoundly low self-esteem resulted in drug use and sexual acting out as a way to soothe his pain, and (e) illustrate the centrality of his shame experiences (Flores, 2013).

Shame

One of the reasons for Gabriel's use of alcohol and drugs, as well as his sexual acting out, is that it confirms his grandiosity and compensates for intense feelings of shame, self-hatred, and low self-regard. Gabriel feels empty inside and has one long experience of narcissistic injuries to confirm this: loss of loved ones, humiliation, job setbacks, failures at recovery, and legal issues. Each outside negative experience is another narcissistic wound for Gabriel. To intervene effectively, it is important to empathize with his suffering to facilitate his experiencing of this pain in a healthy way, instead of him having to act it out. For example, I might say, "You have lost so much in

life and have lost so many relationships, yet being unloved is what you have always feared," or "You have had numerous affairs, and this has only further confirmed to you that you have lost respect for both yourself and others." Also, it is important to interpret how he has formed mirroring and idealizing transferences to alcohol and drugs, so he can begin to understand the motivation behind his addictive behaviors and to feel the pain and shame they were defending against. "Drinking gave you the sense of love and power that you so desperately wanted," or "Pot felt like the good and soothing parent that could help calm you down and make everything seem okay again. Now that you are getting sober, let's talk about those feelings of shame, anger, and disillusionment."

Affect Regulation

Because anxiety plays a large role in his life, I would help Gabriel to understand that his anxiety stems from the fear and panic of psychic fragmentation and his inner void, which is bound up with strong unconscious feelings of rage, guilt, and shame. To help him work through this, I would begin to explore the feelings *under* the anxiety in the sessions with me and to begin to help him tolerate larger and larger approximations of these painful feelings. For example, "Right now as we speak about your father I notice you becoming anxious. I wonder what is beneath that anxiety? Would you be interested to see? What feelings are getting stirred up as we talk about him?" It is important for Gabriel to experience his powerful affects in a safe and constructive way, because this was not allowed in his family environment. I would want to help him tolerate strong feelings in the session without having to act them out and to encourage what it is like for him to feel these in the presence of me. For example, "I wonder how you experience your anger inside, right now? What do you feel inside that tells you that you are angry? Where is this rage and pain coming from? How was it to feel these feelings with me?" This encourages both the experience of warded-off feelings and the cognitive reflection and understanding of them. The more Gabriel is able to experience and tolerate these powerful emotions with me, the less likely it is that they will be acted out in unhealthy ways, and this dual process of experience and reflection builds his internal capacities and promotes psychic structure (Goldin, 2014).

Empathic Attunement and Transmuting Internalization

It is vitally important that I strive to empathically attune and mirror Gabriel's internal states in the session as they are explored and experienced. For example, "Your disease has cost you so much, and it is painful to face how this has impacted your life," "Your self-image is gone, yet you want so much to be seen, and to be seen as wonderful," "Your father was often not there for you, and you wanted so much to be a part of his life," and "You felt so empty inside, and you sought other women to help fill the void." These interventions provide the missing mirroring selfobject needs that Gabriel was denied in life. However, can the therapist always accurately empathically attune to Gabriel? Obviously not. There will be hundreds of times I would fail to accurately

attune with his internal emotional states. Yet, as we recall from earlier in the chapter, it is precisely the failures to empathically attune to Gabriel, and the exploration and working through of these failures, that psychic structure can be built from within (Ulman & Paul, 2013). My relationship with Gabriel needs to be "good enough" and not perfect. Therefore, each nontraumatic failure of empathy (mirroring needs) or failure to protect (idealizing needs) and subsequent working through of these leads to the piece-by-piece internalization of new psychic structure. The working through of hundreds of these injuries in the session and his emotional reactions to them allow for the gradual accretion of the internalization of those functions that I had failed to adequately provide. Thus, Gabriel's psychic structure, the ability to do for himself what was previously done by drugs or other people, can now become a part of his developing self-capacities and self-worth. What does this process look like? It begins by openly acknowledging the failure: "I see that I was off base just now when I said your father did the best he could." Next includes exploring and mirroring the emotional impact of this: "I can see this was really hurtful to you just now and stirred up the old pain of being misunderstood." And finally is exploring his reactions to my attempts at repair: "What is it like for you to hear my words right now?"

Outcome

What would be the outcome of a successful treatment with Gabriel? Ideally, he would report feeling "full" or more complete inside. The inner urgency to use drugs, or act out sexually, would be greatly diminished. He would feel more comfortable in his own skin. The emptiness and free-floating anxiety would dissipate, his sense of reality testing would be improved, he would be better able to consistently hold a stable level of self-esteem, and he would demonstrate the ability to both feel and manage his affects in an adaptive way. I would inquire about specific examples of his ability to modulate his anxiety, to regulate tension, and to self-soothe in times of need, and celebrate with him in these successes.

Summary

Conceptualizing drug use and other addictive behaviors from the perspective of self-psychology provides both an explanatory tool for understanding the genesis of addictive behaviors and a way of intervening to facilitate the process of recovery. Addictions are seen as the result of deficits in the self-structure due to failures on the part of the caretakers to meet their child's mirroring and idealizing selfobject needs. This results in an individual who lacks a clear sense of self and the functions that come with a cohesive sense of self: the ability to self-soothe, experience healthy self-esteem, regulate affects, and use healthy self-care behaviors. Addictive behaviors are failed attempts to fill in what is missing and heal the wounds of the self. Treatment is aimed to begin the process of allowing the client to internalize these components into a new and secure sense of self.

Resources for Continued Learning

Books

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Websites

Dr. Allen N. Schore: www.allanschore.com.

Self-Psychology Page: www.selfpsychology.com.

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6 A Developmental Approach to Addiction Theory and Treatment

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Developmental theories of addiction assume that as people mature or develop, they also mature in their ability to cope with the addictive process and find ways to cope with tendencies toward relapse. The chapter describes the etiology and maintenance of addiction through a developmental lens. It also explores how developmental shifts toward higher levels of consciousness impact addiction across the life span and discusses how these shifts may relate to recovery from addiction.

Common Elements of Developmental Theories

A range of developmental theories explore the progression of a wide variety of developmental processes and tasks. These theories include models for conceptualizing psychosocial development, moral development, ego development, and faith development, all of which hold particular relevance for addiction counselors. Although these theories each focus on a unique aspect of overall development, they share many common factors. These factors, including the basic tenets, philosophical underpinnings, and uses by practitioners, share commonalities that transcend the specific area of development upon which each theory is focused.

Basic Tenets

Developmental theories include a range of models for conceptualizing human biological, psychological, social, and spiritual functioning across a spectrum from less to more complex. Many developmental processes involve an overlapping progression of each of these elements. For example, as a child begins to develop the cognitive capacity for understanding and using language, he or she also begins to develop increasing awareness of the environment and others with whom the child interacts. Generally speaking, the developmental progression by an individual through the stages of developmental theories is dependent on interactional factors of the individual and the environment in which the individual is developing (Blocher, 2000). This progression is not guaranteed, although developmental theories assume that, under conditions germane to developmental processes, an individual will develop increasingly complex ways of thinking, understanding, and functioning as development progresses (Blocher, 2000).

Philosophical Underpinnings and Key Concepts

As described in the previous section, developmental processes are assumed to progress naturally from simplistic to more complex over time. This progression assumes that the individual is developing in an environment suitable for this progression to occur. Specific environmental factors that promote developmental processes include an

adequate balance of support, challenge, and opportunity for reflection (Brendel, Kolbert, & Foster, 2002). The developmental model of recovery as outlined by Stephanie Brown (S. Brown, 1996) provides a framework for applying these developmental principles to the recovery process. For example, an individual who has successfully completed a 90-day treatment stay for alcohol dependence is likely negotiating the developmental processes of early recovery, which include establishing and maintaining supportive relationships and maintaining sobriety by identifying and adhering to personal values, beliefs, and goals. An environment that provides clear organization and structure to support development in these areas is preferable to an environment that is poorly organized or inconsistent. As the individual begins to develop new beliefs, thoughts, and skills in these areas, an environment that continues to challenge the individual's development through increasingly complex tasks, interactions, or dilemmas will continue to reinforce the developmental processes that have already begun. An environment that provides feedback and allows the individual to reflect on his or her thoughts, feelings, and beliefs about these experiences will also help the individual to reach developmental milestones and continue to negotiate increasingly complex developmental tasks.

A balance of support, challenge, and opportunities for reflection promote development; an environment that does not provide these elements may, at best, fail to expedite developmental processes or, at worst, hinder these processes altogether (Blocher, 2000). As an example, consider the individual described previously. If this individual encounters a home environment with inconsistent or absent structure; few opportunities for experimenting with new behaviors, skills, or beliefs; a lack of support for developing in these areas; and a lack of attention to helping the individual to develop these skills through feedback and reflection, it is likely that this same person will struggle to achieve the recovery-connected developmental milestones at the same rate that he or she would in an optimal environment. Although this development may be hindered, it is still possible that these developmental processes may be supplemented through other environments, such as 12-step participation or outpatient group counseling, that provide support for these developmental processes. These supports may, depending on the consistency with which the individual interacts with these settings, compensate for a primary environment that is less than ideal for supporting development in early recovery.

In addition to the potential for stalled development, there is also a potential for regression of development in situations where stressors exceed an individual's coping skills for managing these stressors (Aldwin, 2007). A frequent instance of this phenomenon occurs when an individual in early recovery reverts to previous ways of managing stress. Often, this regression involves returning to the use of mood-altering substances. The developmental processes impacted by stress may include one or more areas, including psychosocial, ego, moral, or faith development. To an observer, this

regression may mimic behaviors observed during active use, including focus on the self, decision making based on immediate consequences or avoidance of getting caught, or spiritual disconnectedness. In actuality, these observed behaviors may be a result of the inability to compensate for stressors that trigger a developmental regression. This process often puts individuals at risk of relapse and may necessitate additional support and opportunities for reflection and feedback to offset the increased challenges presented by stress.

Box 6.1 Overview of Philosophical Underpinnings of Developmental Theories

- Development naturally progresses from less to more complex
- Development may be hindered by environments that do not provide adequate developmental support
- Support, challenge, and reflection help promote development
- Developmental progression is not guaranteed by age progression alone
- Stressors that outweigh coping mechanisms may promote regression to previous stages of development
- Developmental progression relies on adequately achieved previous stages to progress to the next stage
- Some developmental stages are rarely achieved by most adults and are rarely observed in the general population
- Poorly negotiated developmental transitions may impact subsequent development within and across developmental spheres

The developmental progression is predicated on successful negotiation of previous developmental milestones. In other words, if an individual does not achieve an early developmental transition to a more complex stage, future developmental progressions are impossible until the previous stages are successfully negotiated. In substance use disorder treatment, these failed developmental progressions are often seen as individuals' transition from active use to early abstinence. Residual elements of poorly negotiated developmental milestones such as all-or-nothing thinking, efforts to break treatment rules without getting caught, a focus on the self and immediate needs, and aversion to the spiritual elements of treatment may all serve as evidence of unsuccessfully navigated prior developmental milestones. As a result, treatment environments typically respond with a balance of high structure, high support, and ample opportunities for self-reflection and feedback from others to offset the challenge of early abstinence coupled with an increased expression of developmentally hindered ways of interacting with the environment.

Due to the wide range of developmental processes, challenges, and needs, developmental progressions are not guaranteed by age progression alone. These discrepancies between chronological age and developmental attainments may be

particularly observable in individuals who have been using alcohol or other drugs since adolescence or young adulthood (S. A. Brown et al., 2008). Many of the seemingly immature behaviors observed when individuals begin to make changes to their substance use patterns stem from this discrepancy between developmental maturity and chronological age. As discussed earlier, these discrepancies may be particularly observable and troublesome when an individual initiates treatment for a substance use disorder.

In addition to substance use, other environmental influences, including a history of trauma, abuse, or neglect; a chaotic or unstable environment; or chronic physical or mental illness of primary caregivers, may impact the developmental attainments of children, adolescents, and young adults (Jonsson, 2009). Addiction, which may touch on each of these areas within a family system, therefore stands to profoundly impact the development of children, teens, and young adults whose family of origin was also impacted by substance use disorders. This family history of substance use may also have implications for the individual seeking treatment throughout the treatment and recovery phases. More specific information on these issues is presented later in this chapter.

Overview of Selected Developmental Theories

So far, this chapter has provided information that applies broadly to developmental theories as a whole. Although these developmental theories share many commonalities, each also provides a unique view on the process of development. It is important to remember that developmental progression involves interactive and recursive processes that engage biological, psychological, social, and spiritual domains. Information on five selected developmental theories is provided in this section to provide greater context for understanding specific elements of development and their relevance to working with clients with substance use disorders.

Erikson's Psychosocial Development

Erik Erikson's (1980) theory of psychosocial development focuses on internal and interpersonal processes. Specifically, this theory identifies primary tasks for successful negotiation of developmental milestones from birth through late adulthood, with a focus on developing a sense of personal efficacy, agency, and autonomy. These milestones require interaction between the individual and his or her environment, which includes individuals with whom he or she interacts. Erikson stated that psychosocial developmental milestones that are not successfully negotiated negatively impact the potential for attaining future developmental milestones and also negatively impact the individual's current methods of making meaning, deriving a sense of self-efficacy, and exerting personal agency in new situations. Because the poor negotiation of one or more of these milestones in childhood or adolescence negatively impacts one's future developmental trajectory, and because many of these early developmental milestones

may be negatively impacted by substance use or other environmental stressors, Erikson's theory is particularly useful for understanding the behaviors often encountered as individuals transition from active use to abstinence from mood-altering substances. The specific stages of Erikson's theory and explanations of the consequences of successfully and unsuccessfully negotiated stages are detailed in Exhibit 6.1.

Loevinger's Ego Development

Similar to Erikson's psychosocial theory, Jane Loevinger's (1976) theory of ego development attends to interactive processes between internal meaning-making systems and the external environment. In contrast, however, Loevinger's theory of ego development leans toward internal meaning-making processes—rather than externally observable behaviors—as markers of developmental progression. Specifically, increasingly complex developmental stages are, according to Loevinger, demonstrated by increased awareness of self, awareness of others, and awareness of the interactional processes between the self and others. Although more difficult to observe outright, these meaning-making processes influence interpretation of all aspects of the environment, including self-concept, personal identity, sense of right and wrong, senses of affiliation and connection with others, and personal and universal senses of purpose. As an individual's meaning-making processes develop, so too do his or her nuanced understandings of the separate and interconnected nature of all of these elements.

Psychosocial Development	Description of Stage	Successful Negotiation	Unsuccessful Negotiation
Trust-mistrust	Development of trusting relationships with caregivers	Individual experiences trust in caregiver relationship, begins to trust environment as safe	Lack of trust in caregiver relationship and similar lack of trust in environment
Autonomy-shame	Development of control over self and environment	Individual experiences autonomy and begins to feel sense of control over self and environment	Development of shame and doubt around ability to exert control over self and environment
Initiative-guilt	Assertion and initiation of activities that meet needs and are fulfilling	Individual develops a sense of independence and willingness to assert self to pursue meaningful, necessary, and pleasurable activities	Development of feelings of guilt that may lead to failure to assert self, seek independence, and independently meet needs through self-advocacy
Industry-inferiority	Learning of new skills and abilities in multiple contexts	Individual is increasingly able to adapt to multiple environments, to apply new knowledge and skills, and to feel a sense of competence	Development of feelings of inferiority and failure may cause the individual to adapt poorly to change, to avoid situations that are challenging, and to fail to acquire new skills in multiple domains due to avoidance
Identity-confusion	Development of individual identity in multiple contexts	Identity begins to form and is informed by the individual's thoughts, feelings, values, and beliefs coupled with experiences and expectations	Development of feelings of confusion and poor identity development, which may cause deficits in awareness of self, values, beliefs, and goals
Intimacy-isolation	Developing intimate relationships with others	Individual develops intimate relationships and learns skills to nurture and sustain these relationships	Development of a sense of isolation that may cause the individual to avoid intimate relationships and/or fail to maintain these relationships
Generativity-stagnation	Developing ways to contribute to next generation	Individual channels energy into family, social causes, and/or activities that support the next generation, including passing on values, beliefs, and wisdom	Development of a sense of stagnation and feelings of purposelessness and/or failure to reach out to or nurture the next generation's development
Integrity-despair	Develop awareness of life's purpose and sense of fulfillment in the life lived	Individual engages in self-reflection on life, values, and purpose and accepts and appreciates his or her life's work and attainments	Development of despair as life is viewed as meaningless and/or attainments do not align with the individual's values, beliefs, and goals for his or her life

Adapted from Erikson, 1980

Loevinger's theory contains developmental domains that are rarely achieved by the average adult, even when the environmental supports, challenges, and opportunities for reflection are adequate for promoting development. Because some levels of functioning are optimized in environments that are extraordinary in one or more ways, individuals who are supported through optimal environments may not require the need to make meaning or understand the self and the world beyond the scope of their optimal environment and level of functioning. In contrast, some individuals who experience tremendous hardships; who seek personal enlightenment; or who exist in environments abundant in support, challenge, and reflective opportunities achieve these developmental milestones due to the inadequacy of their then-current level of functioning to cope with the tremendous environmental demands placed on them. This tendency is particularly relevant for individuals who are in recovery from substance use disorders; the often-encountered challenges of recovery combined with support and reflection available through varied treatment modalities may be particularly supportive of achieving these more complex developmental milestones for some individuals. The specific stages of Loevinger's theory and explanations of the consequences of successfully and unsuccessfully negotiated stages are detailed in Exhibit 6.2.

Ego Development	Description of Stage	Successful Negotiation	Unsuccessful Negotiation
Prosocial/symbiotic	Focus on immediate gratification of needs, differentiation from environmental elements	Individual's needs are met and differentiation of self from environment is attained	Inconsistent meeting of needs and poor differentiation of self from the environment
Impulsive	Focus on sensate activities and processes, impulsive behaviors, dependent behaviors; good and bad viewed through the lens of impact on self and dichotomies predominate (bad/good, happy/sad)	Individual increases awareness of sensate self, begins to become aware of mechanisms of self-control; increased awareness of appropriate behaviors based on observations and environmental feedback	Poor control over sensate urges, lack of consistent self-control, poor sense of norms for behavior based on observations or feedback from environment
Self-protective	Focus on avoiding trouble, avoiding consequences, development of manipulation to avoid these; increased sense of rules and development of self-control; use of blame to avoid consequences	Individual's awareness of relationships between actions and consequences increases; increased sense of responsibility and control over actions and consequences and ability to take responsibility for actions and consequences	Lack of consistent awareness between actions and consequences, use of manipulation and blame to avoid consequences, failure to take responsibility for actions and/or consequences
Conformist	Focus on morals, rule adherence, feeling accepted by others, and black-and-white thinking about others and environment; surface awareness of emotions	Increased awareness of self, others, and personal values and morals; increased emotional awareness; ability to see multiple perspective and consider multiple outcomes or choices in a given situation	Poor self-awareness, including emotional awareness and awareness of personal values and morals; difficulty taking perspectives and persistence of black-and-white thinking
Self-aware	Focus on awareness of self and others, including emotional awareness; developing ability to consider multiple possibilities and perspectives; beginnings of reflection on life's purpose, spirituality, wellness, etc.	Increased awareness of self and others, including increased emotional awareness; increased flexibility in considering multiple perspectives and outcomes; increased self-reflection and self-identification of values, goals, and aspirations	Poor awareness of self and others, including poor emotional awareness; continued rigidity in problem solving and perspective taking; little self-reflection and identification of values, goals, and aspirations
Conscientious	Focus on identifying personal standards for self; ability to empathize and take responsibility for actions, thoughts, and feelings; awareness of patterns; engagement in mutually beneficial relationships; increased depth of self-reflection; value placed on achievement	Increased ability to set personal standards, identify and achieve goals, and consider others when engaging in actions or decision-making processes; increased responsibility-taking for personal actions and increased empathy for others; ongoing self-reflection on values, morals, ideals, and goals	Difficulty consistently identifying and setting personal standards of behavior; difficulty consistently empathizing with others and perspective-taking when making decisions; ongoing difficulty in taking personal responsibility for self; difficulty consistently engaging in meaningful self-reflection or seeking opportunities for achievement
Individualistic	Focus on increasing sense of individuality and emotional independence; ability to tolerate ambiguity in people and situations; increasing methods of self-expression; increased value placed on relationships versus achievement	Increased sense of individuality and emotional independence while remaining in relationship with others; increased flexibility in thinking and in tolerating paradoxical or ambiguous situations or individuals; increased pursuit of outlets for self-expression; increased appreciation for relationships	Difficulty developing sense of individuality and emotional independence; ongoing difficulties coping with ambiguity; inconsistent mechanisms for self-expression employed
Autonomous	Focus on coping with inner conflicts; ongoing development of tolerance for ambiguity; integrating concept of conflict as an element of existence; autonomy is respected and relationships are viewed as interdependent experiences; focus on self-actualization, individuality, and emotional expression	Increased ability to tolerate ambiguity and cope with internal conflicts; ability to be both independent and connected to others simultaneously; increased sense of and appreciation for interdependence; ongoing pursuit of intrinsically motivated goals, activities, and outlets for self-expression	Inconsistent tolerance for ambiguity and coping with internal conflicts; inconsistent sense of interdependence in relationships; inconsistent pursuit of intrinsically motivated goals, activities, and self-expressive outlets
Integrated	Focus on developing and honing wisdom; identity development is multifaceted and complete; development of ability to cope with internal conflicts and ambiguity; motivated by growth, fulfillment of potential, and integration	Increased wisdom; acceptance of self, others, and life as a whole; perspective of ambiguity and challenge as essential to being; consistent and persistent attention to ongoing growth and integration	Inconsistent acceptance of self, others, and life as a whole; inconsistent acceptance of ambiguity as essential to experience; inconsistent attention to growth and integration

Note: Gray shading denotes stages not typically realized by the average adult.
Adapted from Loevinger, 1976

Kohlberg's Moral Development

Lawrence Kohlberg's (1981) theory of moral development focused specifically on the development of moral decision-making processes of individuals. Although both Erikson's and Loevinger's theories touch on the role of morality, Kohlberg's theory both expands on these understandings and attends solely to the moral developmental progression of individuals. The specific stages of Kohlberg's theory and explanations of the consequences of successfully and unsuccessfully negotiated stages are detailed in Exhibit 6.3.

Attention to moral development related to substance use disorders is particularly relevant for a number of reasons. First, individuals whose moral development has been hindered are less likely to exhibit complex moral decision-making processes and are more likely to focus on immediate gratification or self-preservation in making choices with moral implications. Because addiction so often coincides with decision-making processes that are impaired in many domains, the potential impact of self-focused moral reasoning within this context is particularly important to attend to in both assessment and treatment.

Moral Development	Description of Stage	Successful Negotiation	Unsuccessful Negotiation
Obedience/ punishment	Avoidance of punishment	Shift from avoiding punishment to considering personal benefits of a choice	Ongoing and persistent focus on avoiding punishment when making choices
Self-interest	Focus on personal gains/benefits	Shift from considering personal benefits to adhering to social norms when making a choice	Ongoing and persistent focus on personal gains when making choices
Interpersonal accord/ conformity	Adhering to social norms	Shift from adhering to social norms to following rules for the good of social order when making a choice	Ongoing and persistent focus on adhering to social norms when making choices
Authority and social order	Following rules to maintain social order	Shift from following rules to maintain social order to perspective-taking and considering benefits to others when making a choice	Ongoing and persistent focus on following rules to maintain social order when making choices
Social contract	Considering multiple perspectives and making choices based on the "greatest good for the greatest number of people"	Shift form considering multiple perspectives and considering greater good to applying universal ethical principles	Ongoing and persistent focus on the greater good when making choices
Universal ethical principles	Application of universal ethical principles based on multiple perspectives	Ongoing application of universal ethical principles	Inconsistent application of universal ethical principles

Note: Gray shading denotes stages not typically realized by the average adult.
Adapted from Kohlberg, 1981

In addition, individuals impacted by addiction may report that they engaged in activities or behaviors that compromised their values, morals, or beliefs. They may describe a personal philosophy of morality that is indicative of more complex moral reasoning, despite their actions to the contrary while actively using mood-altering substances. This discrepancy may cause guilt or shame for an individual, which may also represent a

stressor for which the individual possesses poor coping skills to manage.
This regression in moral development may also be an indication of developmental regression during active use that is similarly reflected in other developmental domains. Attention to information on moral developmental stages may inform both the degree to which an individual has been impacted by the substance use disorder and his or her prior developmental attainments within this domain.
As with ego development, moral development's most complex stages are rarely observed in the general population, even when environmental circumstances are optimal for development. Also, the propensity for most individuals is to function where their needs are most adequately met. For most individuals, the circumstances that require increasingly complex moral reasoning processes are not encountered in everyday life; as a result, those most likely to exhibit the most complex moral developmental attainments are likely to have achieved this capacity amid extraordinary experiences.

Fowler's Faith Development

James Fowler (1981), like the other developmental theorists discussed in this chapter, observed a progression from less to more complex ways of thinking and making meaning of experiences as a result of environmental supports that promote complexity. Fowler's theory focuses exclusively on the domain of faith development. Although both Loevinger and Kohlberg allude to the interaction between faith-based belief systems and developmental stages (particularly in higher-level stages), Fowler's theory attends only to this domain. The specific stages of Fowler's theory and explanations of the consequences of successfully and unsuccessfully negotiated stages are detailed in Exhibit 6.4.

Faith Development	Description of Stage	Successful Negotiation	Unsuccessful Negotiation
Intuitive/projective	Fantasy and reality are often undifferentiated; messages from family and society inform beliefs	Increased ability to differentiate between fantasy and reality; increased awareness of faith stories and sources of information about faith	Focus on self and personal interests; lack of principles guiding decision-making processes
Mythic/literal	Increased awareness of differentiation between fantasy and reality; literal understanding of faith stories experienced in family and community	Increased awareness of storied faith; increased reflection on faith-based experiences in decision making and self-reflection; development of guiding principles	Focus on self and personal interests; lack of principles guiding decision-making processes
Synthetic/conventional	Efforts to integrate multiple perspectives through development of overarching belief system; lack of insight into belief system's role in life domains	Development of unified belief system that provides guiding principles; connection with others who share faith	Overreliance on formalized setting (e.g., church) to promote stability; strong attachment to belief system coupled with lack of insight into role of belief system in personal views and beliefs; strong reactions to threats to belief system
Individual-reflexive	Increased questioning of beliefs, sense of disillusionment related to prior belief system, awareness of many systems of belief	Emergence of personal faith that integrates personal beliefs that align with self-reflection and increased awareness	Sense of disillusionment, abandonment of faith, overwhelming internal conflict that prevents resolution of faith dilemma
Conjunctive	Increased awareness and acceptance of ambiguity and paradox; mysteries of life are accepted and faith stories are referred to in order to make meaning of experiences	Increased comfort with personal faith and with ambiguity and paradoxical nature of existence and faith; increased connection to community and universal concerns; ongoing self-reflection related to faith	Inconsistent comfort with personal faith and paradoxical situations; continued attention to existential concerns without clear resolution or acceptance
Universalizing	Acceptance of faith into all aspects of life; dedication to service for others; lack of concerns or doubts surrounding personal faith	Embracing of personal faith to find meaning and peace and to connect with humanity	Inconsistent integration of faith into all aspects of life; inconsistent ability to find meaning and peace

Note: Gray shading denotes stages not typically realized by the average adult.
Adapted from Fowler, 1981

Faith development is particularly important for substance use disorder treatment. The 12-step peer-support group model attends directly to the necessity of faith in recovery. Even for individuals who do not participate in these groups, a sense of faith may provide hope, support, and a sense of purpose that offsets the many challenges of recovery.

Brown's Developmental Model of Recovery

In contrast to the previously described developmental models, which generally fit most individuals throughout the life span, Stephanie Brown's developmental model of recovery applies specifically to individuals who have used mood-altering substances in problematic ways (S. Brown, 1996). This model's progression parallels the developmental processes of childhood, adolescence, and adulthood as an individual transitions from active use of mood-altering substances through ongoing recovery. As these developmental processes unfold, individuals emerge with increasingly complex understandings of themselves, their relationship with mood-altering substances, their environment, and the individuals who surround them. The specific stages of Brown's developmental model of recovery and explanations of the consequences of successfully and unsuccessfully negotiated stages are presented in Exhibit 6.5.

Brown's model is composed of four discrete developmental periods, which are threaded together by the individual's simultaneous attention to the mood-altering substance, interactions with the environment, and meaning-making processes associated with the self and others. The first period, termed *drinking* by Brown, describes the period of active use of mood-altering substances. During this period, primary attention is focused on the substance, with decreasing attention or energy paid to environmental interactions or reflections on the self or others as substance use progresses. The individual engaged in active use may disconnect with others and with the environment in order to preserve his or her relationship with mood-altering substances. According to Brown, the shift from the drinking stage to the transition stage is often precipitated by an individual's surrender; specifically, this surrender involves acknowledging and accepting an inability to control the use of mood-altering substances.

Developmental Model of Recovery	Description of Stage	Successful Negotiation	Unsuccessful Negotiation
Drinking	Belief that an individual can control substance use; ongoing use of mood-altering substances despite negative consequences	Beliefs that support ongoing substance use are eroded; surrender of control over substance use and initiation of abstinence from substance use begin	Denial of inability to control substance use continues, as does ongoing use despite consequences experienced
Transition	Personal acceptance of responsibility begins by acknowledging inability to control substance use and accepting dependence on substance	Initiation of abstinence, coupled with new behaviors and actions that support substance-free living; initiation of engagement with support system (e.g., 12-step program); adherence to structure, routine, and consistency to support ongoing abstinence	Reinitiating substance use; inability or refusal to seek or accept outside support; chaotic or inconsistent routines, structure, and activities of daily living that result in difficulty with daily functioning
Early recovery	Ongoing meaning-making surrounding acceptance of powerlessness over substance use; increasing engagement in social and environmental settings that support recovery; increasing complexity in view of self, substance use, and recovery	Ongoing maintenance of abstinence and behaviors that support substance-free lifestyle; increasing engagement with social and environmental networks that promote recovery; affective experiences; self-exploration and meaning-making related to self, others, and environment	Possible reinitiation of substance use; limited support system and environment incongruent with recovery lifestyle; inability to cope with affective range; may experience suicidal ideation or severe depression; limited self-exploration
Ongoing recovery	Continued meaning-making surrounding recovery identity, self, and life; increasing connections with others and environmental elements that support recovery; shift of focus away from substance use toward issues of spirituality, self-transformation, and personal contribution	Ongoing abstinence from substance use; attention shifts to identity development, spirituality, connection with others, and congruence of fit between self and actions; affect is experienced and regulated, increasing insight emerges; core values and actions in accordance with these values emerge	Possible reinitiation of substance use; superficial engagement in recovery process; limited self-reflection, openness to connection, and exploration of values; affective range may cause distress or discomfort; ongoing focus on substance use or abstinence that overshadows multidimensional identity development

Adapted from S. Brown, 1996

The second stage of Brown's model, the transition stage, is characterized by the initiation of abstinence from the use of mood-altering substances. As abstinence progresses during this stage, a focus on the substance actually increases as the individual accepts his or her powerlessness over its use. The transition to abstinence may also increase an individual's sense of dependence on others, as the physiological and psychological impacts of cessation of substance use influence day-to-day functioning. According to Brown, participation in 12-step support groups assists with this transition, because the program meshes with this need through providing peer support, structured steps on which to focus, and consistency that supports recapitulation through what is viewed by Brown as an infant-like state. As an individual maintains abstinence from mood-altering substances, his or her ability to manage day-to-day functioning becomes more consistent and the individual transitions into the early recovery stage.

During the early recovery stage, Brown describes an increased awareness of the self, of others, and of the individual's environment. Early recovery parallels the developmental progression of adolescence, when a shift from dependence to independence coupled with an increasing awareness of self are realized. Where the transition stage required a focus on day-to-day survival, the early recovery stage invokes reflective engagement in considering short-and long-term goals, aspirations, and plans through the lens of sobriety. It is during this stage that individuals may acknowledge and attend to environmental elements or relationships that are not conducive to ongoing abstinence. In addition, emotional awareness and attention to the self grow; as a result, symptoms of depression and anxiety may be reported. Throughout this phase, reflection on the relationship an individual had with mood-altering substances and on the individual's ongoing relationship with recovery become increasingly complex and nuanced. As these reflections coincide with increasingly complex thoughts surrounding the self, others, and the environment, the individual transitions from early recovery into ongoing recovery. Ongoing recovery is characterized by complexity of thoughts, feelings, and behaviors that are consistently congruent with the individual's recovery identity. Day-to-day attention to mood-altering substances or recovery from their use may no longer be at the forefront of an individual's focus. Instead, the focus may shift to issues of spirituality, fulfillment, personal congruence, and meaningful relationships with others. Ongoing recovery parallels the processes of adulthood, wherein the focus shifts from surviving to thriving. For individuals who transition to the ongoing recovery stage, life takes on meaning and purpose that transcends the individual's day-to-day basic functioning.

Each of these developmental models represents a balance between universal developmental principles and processes and attention to specific and unique developmental elements that may impact functioning across a lifetime. In considering the role of developmental processes in addiction and recovery, these theories represent

developmental models that hold particular relevance for professionals working in substance use treatment settings. The similarities among the first four of these theories based loosely on age and cognitive complexity are presented in Exhibit 6.6. Please note that these are general guidelines and may not apply to all individuals.

	Rough Age	Psychosocial Development	Ego Development	Moral Development	Faith Development
Less Complexity	0–1	Trust-mistrust	Prosocial/symbiotic		Undifferentiated
	1–3	Autonomy-shame	Impulsive	Obedience/ punishment	
	3–6	Initiative-guilt	Self-protective	Self-interest	Intuitive/ projective
	6–12	Industry-inferiority	Conformist	Interpersonal accord/ conformity	Mythic/literal
	12–19	Identity-confusion	Self-aware	Authority and social order	Synthetic/ conventional
	20–25	Intimacy-isolation	Conscientious		Individual-reflexive
	26–64	Generativity-stagnation	Individualistic	Social contract	Conjunctive
	65+	Integrity-despair	Autonomous		Universalizing
More Complexity			Integrated	Universal ethical principles	

Note: Gray shading denotes stages not typically realized by the average adult.

Practitioner Uses and Applications to Addiction Counseling

As has hopefully become apparent, developmental processes are impacted by substance use and also may impact the initiation or return to substance use for some individuals. Due to the interactive and recursive nature of these processes, it is often difficult—if not impossible—to determine the independence of these factors. Because both development and substance use disorders involve complex interactions among biology, psychological functioning, socialized behaviors, and spiritual connectedness, developmental processes within and across these domains warrant attention within substance use assessment and treatment.

Relationship Between Development and Substance Use

Research supports the fact that developmental transitions are risk factors for initiation of substance use. This is particularly relevant during the transitions involved in moving from childhood to adolescence and from adolescence to young adulthood. Several

developmental processes typically experienced during adolescence increase vulnerability to substance use in some individuals. Schulenberg and Maggs (2002) identify these developmental factors, which include the intersection of multiple developmental points of transition simultaneously, increased discrepancies between an individual and his or her environment, the magnification of strengths and weaknesses during developmental transitions, the presence of risk taking as an element of developmental processes of adolescence, and the increased vulnerability of chance events that include engagement in substance use. As an example, consider a teenage male who is transitioning from middle school to high school after relocating to a new town. The already likely discrepancy between the individual and the new school and community environment may be heightened by the unfamiliarity with the town, school, and peers. This individual, who may struggle to make friends but who may excel academically, may notice that each of these factors increases during the developmental processes of adolescence. This teen may also engage in more high-risk behaviors, such as experimenting with alcohol or drug use for the first time. The chance events of relocation, difficulty making friends, lack of social currency gained through academic achievement, and an environment with few afterschool activities for teens may increase the risk of initiating regular substance use. As can be seen, these factors, both singularly and simultaneously, may make developmental transitions particularly risky for some individuals.

Developmental transitions aligned with older adulthood may also present risk factors for substance use disorders among this population. Factors such as retirement, the death of a spouse or partner, divorce, or declining health represent developmental milestones of older adulthood that may increase the risk of problematic substance use among this population (Substance Abuse and Mental Health Services Administration, 1998). Vulnerability to problematic substance use, therefore, warrants consideration in work with clients across the life span, particularly when an individual is negotiating a developmental transition from one stage of life to the next.

In addition to risks inherent in developmental transitions, the poor negotiation of developmental transitions in childhood may also predispose some individuals to increased risk of substance use. This may be particularly salient for families in which addiction exists as a multigenerational reality; if children fail to successfully negotiate developmental milestones in an environment where substance use is acceptable and biology favors substance use as a coping mechanism, an individual may be particularly at risk of developing problematic substance use patterns. This pattern may be observed across generations in families where addiction has been a common intergenerational experience.

Although poorly negotiated developmental milestones may predispose some individuals to increased risk of problematic substance use, successfully negotiated developmental milestones may serve a protective role against problematic substance use patterns in

others (Schulenberg & Maggs, 2002). Even when development is stalled or regresses due to active addiction, previously attained developmental milestones serve as strengths that may be particularly important during the early recovery stage. These developmental attainments may also cause an individual to reflect on problematic substance use in more complex ways and to connect with ambivalence about the substance use that may be particularly important during the transition from active use to abstinence.

Relationship Between Substance Use and Development

As is often observed anecdotally by professionals working in treatment settings, substance use has the potential to stall developmental processes in both individual and systemic domains. The interactive nature of developmental processes and substance use often leads to developmental arrest in individuals who initiate substance use, particularly when substance use is initiated during adolescence (S. A. Brown et al., 2008). In addition, regression to previous levels of development, even if prior developmental processes were successfully negotiated, is often observed in active use. Individuals may compromise their values, lie, steal, or engage in other behaviors that are clearly contradictory to the individual's nonuse behaviors, beliefs, or attitudes. These developmental regressions demonstrate the impact of substance use on every aspect of functioning within biological, psychological, social, and spiritual spheres (S. A. Brown et al., 2008).

Brown's (S. Brown, 1996) model attends specifically to this developmental stalling in the presence of substance use. Specifically, her model of recovery parallels the tasks of infancy through adulthood. During the transition from active use to abstinence, a high degree of dependence on structure, routine, and support from others is exhibited as the individual learns to cope without mood-altering substances. As the individual moves toward early recovery, hallmark signs of adolescence may be observed as increasing independence and autonomy are asserted. As an individual moves toward ongoing recovery, this independence is transformed into interdependence, and a greater emphasis on the environment, others, and self-reflection emerges. The recovery process allows an individual to recapitulate developmental milestones through the lens of recovery. For some individuals whose substance use began before they successfully negotiated these phases, recovery may support attainment of developmental progressions that were not realized previously.

Development and Recovery Processes

Recovery focuses on biological, psychological, social, and spiritual reconnection, which aligns with developmental processes that promote meaning making, accepting personal responsibility, engaging in reflection on morality, connecting to personal values, and developing a relationship with a higher power that is personal to and meaningful for the individual. Recovery processes also involve examining values, experiencing increasingly complex challenges, making meaning from experiences, and

working to enact a values system that is aligned with increasingly complex personal moral principles that emerge alongside the recovery. Because developmental processes and substance use are intertwined as both risk factors and consequences of use, the attention to development throughout the recovery process is both appropriate and necessary to support long-term recovery. Fostering development may improve recovery rates, in that there is a better match between meaning-making systems and environmental stressors that supports an individual in coping with stress without resorting to substance use. Brown's model of recovery specifically attends to the developmental processes inherent in recovery and may serve as a useful tool for conceptualizing the complex developmental tasks of the recovery process.

Increasingly complex developmental attainments may also promote a more complex understanding of the self generally and the self in relation to addiction specifically. These reflections on the self are supported by 12-step models and many therapeutic interventions, which over time may also promote ongoing developmental attainments. For example, connecting with peers and making meaning of use-based experiences within a 12-step support group may help an individual to understand increasingly complex and multifaceted relationships between developmental needs, attainments, and stressors over time. The ongoing focus on meaning making and connecting with others for support, guidance, and reflection amid the challenges of recovery through participation in 12-step groups not only promotes recovery but also may promote development. These elements, also core elements of Brown's model, not only promote recovery development but also may support developmental progression across multiple domains.

Applications and Implications for Prevention, Assessment, and Treatment of Substance Use Disorders

The developmental theories provide salient information for preventing the development of substance use disorders in at-risk individuals. Within this context, the lack of successfully negotiated developmental milestones is itself a risk factor for substance use. Similarly, environments that provide less-than-optimal environmental supports for development, or a lack of consistency across the environments, may also present risk factors for substance use. Particular attention is warranted for children and adolescents whose environments are less than optimal, especially if problematic substance use is also present in the family system. This information can be used to proactively select individuals for primary or secondary prevention in school-based, community-based, or faith-based settings. If these prevention programs provide consistent access to an environment that is created to provide optimal levels of support and reflection to offset the challenges inherent in the individual's primary environment, the individual may develop mechanisms for proactively coping with stressors that might otherwise be superseded by substance use (S. A. Brown et al., 2008; Schulenberg & Maggs, 2002).

Many community-based reinforcement and treatment programs, such as the Community Reinforcement and Family Training (CRAFT) model (White, 2014), use a similar framework for providing tertiary prevention and intervention services. Although these models also employ behavioral techniques such as community-based contingency management, the high level of structure, support, and opportunities for reflection align strongly with optimal environments for developmental support. These models, particularly considered parallel to Brown's model of recovery, wherein increasing structure is necessitated primarily and ultimately transitions to increased self-reflection and interdependence within the context of recovery, may support multiple developmental processes while also encouraging recovery.

In considering assessment practices through a developmental lens, it is important for practitioners to acknowledge the complex and interactive mechanisms through which development and substance use may be connected. As a result, it is important to use assessment procedures that collect both quantitative and qualitative data related to use patterns and progression, childhood and adolescent experiences and milestones, family history of substance use, coping mechanisms for addressing stressors, and other developmental factors that may contribute to or be impacted by substance use. The American Society of Addiction Medicine (ASAM; 2013) criteria provide a strong framework for conceptualizing the collection of much of this information. Additional assessment tools, such as a complete psychosocial assessment, use of reliable and valid quantitative assessment measures, and collection of data from collateral sources when the client consents for such contact to be made may also help to inform the developmental aspects connected to a substance use disorder.

In addition to these measures, dilemma discussions may be useful tools for practitioners to qualitatively assess the moral reasoning level of an individual presenting for treatment. These discussions, which focus on a scenario not involving the client, require the client to apply his or her innate moral reasoning processes to describe the dilemma, the possible solutions, the reasons for the possible solutions, and the reason for the action the individual would choose to take in the situation described (Peace, Claypoole, & Moody, 2000). This informal assessment may provide useful information on the client's current level of moral reasoning and may also highlight a discrepancy between the reasoning level and the behaviors a client has engaged in as a result of his or her substance use.

Treatment, like substance use itself, has the potential to be impacted by and to impact development throughout the treatment process. Based on an individual's developmental attainments and needs, the degree of structure, accountability, and responsibility of the individual may be adapted to optimize the balance among support, challenge, and reflection. Because the ASAM criteria are used to determine an appropriate level of care, and because these criteria generally align with developmental needs, it is likely that individuals with greater needs will be appropriately placed into treatment settings

that provide higher levels of structure and support, although this may not always be the case.

In all cases, treatment should attend to developmental needs through a balance of education, environmental support, and opportunities for self-reflection and connection with others. Integrating information on developmental processes, needs, and interactions between substance use and development may enhance the knowledge and awareness of individuals in early recovery. Providing small-group settings for the individual to reflect, connect, and explore thoughts, feelings, and beliefs promotes more complex meaning-making processes. The inherent challenge of early recovery necessitates a great deal of support, which may come from treatment, 12-step support groups, faith-based affiliations, or some other support system with which the client engages. Throughout the treatment process, the client should be supported in addressing stressors by enacting new coping mechanisms and being supported in reflecting on these experiences as part of the treatment process.

In addition to these elements, practitioners would be wise to integrate elements of morality and spiritual developmental processes into treatment to support development in these areas. Both moral and spiritual development may be impacted by substance use, and these areas in particular may be associated with guilt or shame for some clients. As a result, attending to issues of morality through the use of dilemma discussions and providing support for new ways of managing moral dilemmas may be particularly useful. Exploration of client spirituality and ongoing attention to supporting the development of a personal spiritual identity may also prove beneficial for individuals in treatment settings, particularly in settings where an emphasis is placed on a relationship with a higher power. In all cases, these approaches should be tailored to individual needs, goals, and circumstances.

Explicit attention to the developmental processes of recovery as described by Brown may help the practitioner match interventions to the individual's needs relative to his or her progression within the recovery process. Newly abstinent individuals may be incapable of developing high levels of insight, whereas individuals in ongoing recovery may have a strong need for this reflective opportunity within a helping relationship. By attending to developmental needs related to recovery—and by sharing this model with clients—helping professionals stand to effectively match interventions to client need and to demystify the challenges inherent in the recovery progression for the client.

Strengths and Weaknesses of Developmental Theories

Developmental theories possess several strengths that are particularly salient within the realm of substance use treatment. First, the multidimensional focus that attends to all elements of the biopsychosocial-spiritual model is encapsulated into developmental theories in ways unmatched by most other theoretical orientations. Second, developmental theories remain open to the possibility for change. Although an individual may present to treatment with development that has been less than optimal,

the developmental theories emphasize that development can be impacted and intervened on at any point in an individual's life. This is particularly important for individuals working in substance abuse treatment, for developmental consequences leading to and resulting from use are ubiquitous. Developmental theories also align with the 12-step model of recovery; in fact, Stephanie Brown's work has applied developmental processes to the recovery process in ways unparalleled by other models of recovery. Finally, developmental theories have been empirically supported through both qualitative and quantitative studies. Measurement tools exist for assessing ego development (the Sentence Completion Test) and moral development (the Defining Issues Test), and other developmental theories, such as faith development, are represented by measurement tools that loosely connect to these developmental milestones of the theory.

Although the strengths and utility of the developmental theories are clearly related to substance use treatment, the complexity of interactions within, between, and across developmental domains presents a challenge to conceptualizing developmental processes as linear, cause-effect relationships. Coupled with the recursive and interactive nature of substance use, development, and environmental elements, the complexity of intervening directly on developmental processes is a challenge not likely to be successfully tackled by a short-term treatment program. Nonetheless, the long-term implications and applications of developmental theories for assessing and treating substance use disorders remains an important element of long-term treatment and recovery.

Case Study Responses

Gabriel's family history of substance use and physical aggression, coupled with the chaotic environment that accompanies addiction in a family system, presents a less-than-optimal environment for supporting development in childhood, adolescence, and early adulthood. Coupled with the mismatch between this environment and Gabriel's developmental needs is increased risk taking during adolescence, which, in Gabriel's case, involved experimenting with alcohol and other drugs. Gabriel's early adult development has been negatively impacted by these earlier missed opportunities for optimal development, as evidenced by his still residing in his mother's home and his failure to maintain lasting relationships. The poor fit of the environment with Gabriel's developmental needs coupled with increased risk taking inherent in adolescence and the chance events of his father's use of cocaine with Gabriel, his parents' divorce, and his legal consequences related to his substance use demonstrate the interactional processes of development and substance use disorders.

The supportive relationship with his sponsor was a mechanism for supporting Gabriel's abstinence from substance use and provided the high degree of structure encouraged in the developmental model of recovery during the transition and early recovery stages. This relationship supported the challenges inherent in his early recovery and provided

opportunities for reflection related to his substance use and other related experiences. By encouraging Gabriel to reengage with individuals, groups, and experiences that are supportive of these developmental processes, the counselor working with Gabriel can provide ecological support for ongoing development. This approach also aligns with Brown's model of recovery development, where in the transition stage, increased connection to others, including 12-step affiliation, promotes ongoing abstinence and engagement in recovery processes and provides needed structure during cessation of substance use. In sessions, Gabriel can be further supported through the use of dilemma discussions, opportunities for reflection, discrepancy development between Gabriel's actions and his values, and exploration of developmental factors that may be connected with Gabriel's initiation and maintenance of problematic substance use patterns. As Gabriel's abstinence from substance use continues, an increasing focus on self-reflection, identity development, and developing his identity as an individual in recovery may help support his ongoing recovery development. A timeline technique, wherein Gabriel plots important milestones in his life, in his family's life, and in his substance use, may help to identify developmental stress points that represent areas for specific focus.

Because, in the current context, the developmental processes attend primarily to individual development, the addition of developmental frameworks for conceptualizing family development, such as the family life cycle (Carter & McGoldrick, 2004) may be helpful to further contextualize Gabriel's experience within his family of origin. Because problematic substance use is a systemic experience that likely spans multiple generations, viewing Gabriel's experience both individually and through a systemic lens stands to further contextualize developmental stress points for Gabriel and his entire family system. This approach would also invite the family system into the counseling process, which may be particularly impactful given Gabriel's ongoing reliance on his family as a source of support.

The strengths of the developmental approach include the focus on Gabriel as a whole person, rather than an exclusive focus on his substance use. In addition, the developmental perspective allows for synthesizing information stemming from biological, psychological, social, and spiritual experiences across the life span that may not only reflect challenges but also reflect strengths that Gabriel brings to the treatment process. The explicit focus of the developmental model of recovery on recovery-based developmental tasks fits well with Gabriel's current and future needs as he transitions from active use to abstinence and recovery. Finally, the developmental perspective aligns with the biopsychosocial-spiritual model of functioning and the ASAM criteria for assessing the severity of substance use disorders. As such, it aligns with evidence-based assessment and intervention models that support functioning both within and across domains.

Summary

Developmental theories provide mechanisms for conceptualizing the complex interactions among an individual and his or her environment across time. Developmental processes impact and are impacted by all areas of functioning, including functioning in the biological, psychological, social, and spiritual domains. As a result of the complex interplay between development and substance use, attention to these interactions is useful and important for treatment professionals to promote both short-term abstinence and long-term recovery. By attending to and raising the client's awareness of the relationship between development and substance use, the treatment professional can support the client in developing increasingly complex meaning-making systems, augmenting coping skills for managing stressors, and connecting with resources that promote development generally and recovery development specifically.

Resources for Continued Learning

Books

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Bio-Psycho Social-Spiritual Model: http://med.unr.edu/psychiatry/education/psychiatry-educational-resources/bio-psycho-social-spiritual-model

Stephanie Brown on Treating Addictions in Psychotherapy: www.psychotherapy.net/interview/stephanie-brown.

Unraveling the Mystery of Personal and Family Recovery: An Interview with Stephanie Brown, PhD: www.williamwhitepapers.com/pr/2011%20Dr.%20Stephanie%20Brown%20Interview.

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7 Attachment Theory

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Attachment theory is a developmental model of interpersonal relationships. Attachment relationships are based on early caregiving experienced by an infant. It is through these relationships that infants and children develop the ability to regulate emotional states. From an attachment perspective, psychopathology is developed from an inability to effectively regulate emotional states in a healthy manner. For example, in the most recent National Survey of Youth Data, Barfield-Cottledge (2015) reported low family attachment as a significant predictor of adolescents' report of drug and alcohol use. Specifically, adolescents who reported low family attachment were more likely to report using marijuana and drinking compared with their counterparts with high family attachment. In addition, with an adult sample, individuals classified with an insecure style of attachment reported the highest rates of a diagnosis of substance dependence and/or abuse (Caspers, Yucuis, Troutman, & Spinks, 2006). Attachment-based therapists attempt to create an empathically attuned attachment relationship with the client in order to serve as a container for the client's emotions and to provide a safe base from which the client may explore presenting issues. The discussion of attachment theory developed out of the work of psychoanalysts and developmental psychologists and therefore builds on some of the concepts from other theoretical perspectives.

Basic Tenets of the Theory

Several basic assumptions about human nature underlie attachment theory. First, attachment theory posits that early attachment relationships to caregivers directly impact brain structure and oscillatory functioning related to emotion regulation. An infant initially relies on caregivers to externally or interpersonally regulate the infant's emotional state (Bowlby, 1988). So if the infant is in distress, an attuned caregiver is able to soothe the infant by doing something like offering food, changing the baby's diaper, adding or taking off a blanket, rocking, humming, or talking to the baby. Each of these examples relates to a sensory environmental trigger (taste, temperature, movement, pressure, sound) that prompts an emotional response. Emotions and other physical sensations are located in the limbic system and are functioning at birth to help the baby communicate its needs with the world, although perhaps in a rudimentary manner. It is through this communication that the infant learns how to get physical and emotional needs met.

For optimal development, an infant must have a caregiver who demonstrates accurate empathic attunement to the baby's needs at least two thirds of the time. In Winnicott's (1953) words, the caregiver must respond with “good enough” interventions to the baby's needs. This does not mean that the caregiver is always able to choose the right intervention the first time but rather that the caregiver is responsive to the baby's

distress and attempts to identify an intervention that soothes the child. Perfect attunement is not possible, nor is it optimal because people need misattuned interactions within these caregiving relationships in order to develop frustration tolerance. So the relationship must demonstrate consistent empathically attuned experiences for the child over time. This is how neuronal networks are built and strengthened, resulting in the infant's development of internal systems for emotion regulation (Cozolino, 2010). If they have had sufficient empathically attuned caregiving relationships, infants are able to develop internal working models of those responses to emotional arousal so that they are able to self-soothe (cope) in times of stress. For instance, self-soothing behaviors of a toddler might include humming or stating, “It'll be OK” after the toddler has been hurt. The child has internalized experiences of emotional regulation experienced from caregiver(s) in such a manner that the child is able to cope or self-soothe during a stressful time.

Attachment theorists believe that movement from interpersonal (caregiver) regulation of emotion to intrapersonal (self) regulation of emotion requires that the child have sufficiently empathically attuned relationships within the first 24 to 36 months of life (Bowlby, 1969/1982, 1988; Simpson, 1999). This is considered a critical period because if they do not have these experiences with at least one caregiver, then they may not develop the ability to cope with dysregulated emotional states and may even lack the ability to empathize with others. When individuals do not have healthy attachments early in life, it may be difficult to form healthy attachments as they get older.

However, attachment theorists also believe that people are adaptive, and their behavior, including the ability to regulate emotion, is also adaptive. Individuals may have different experiences with different caregivers (e.g., mother, father, grandparent), which helps them develop situational specific internal working models of relationships, which ultimately inform their subsequent relationships with others (Simpson, 1999). For example, when an infant feels some sort of threat in his environment, he will use proximity-seeking behaviors to make sure the caregiver is still available. If the caregiver is available in a consistent manner, the infant will create a positive/secure internal working model that that infant will rely on in social situations for his understanding of intimate relationships. If the caretaker is unavailable or inconsistent, the internal working model of the infant will become skewed. This skewness will result in maladjusted behaviors in the infant's subsequent future relationships. Similarly, in therapeutic settings, individuals may develop an attachment relationship with a therapist or group members, which are able to provide a foundation for development and strengthening of new neuronal networks that represent new internal working models for them.

We assume that all people experience stressful situations, such as a significant loss, which challenge their ability to cope. When this occurs they may become deregulated or overwhelmed by emotion. In these situations people often turn to others, usually

attachment relationships, to help them through the crisis. However, people who do not have sufficiently secure attachment relationships have difficulty self-regulating when they become emotionally deregulated or are under significant stress, and they often do not feel emotionally safe to reach out to others for help in those situations (Mikulincer & Shaver, 2007). So when they become emotionally deregulated, these individuals identify unhealthy methods to help them self-soothe. Destructive methods of self-soothing include excessive use of alcohol or drugs, or other addictive behaviors such as gambling, sex, or shopping.

In optimal development, a child has at least one secure attachment relationship (Bowlby, 1988). This provides a secure base from which the child may explore the world, including making new friends and developing new significant attachment relationships. If development is less than optimal, then the child may experience caregivers as not being consistently available and internalize this experience as an insecure attachment relationship. In these instances, caregivers have generally demonstrated inconsistent attunement to their children's needs. This may have resulted from the parent's or caregiver's own insecurities about self-efficacy for parenting or from some mental or physical illness that impacted their ability to be available to the infant's distress in an optimal manner. An example of this is the result of the parent experiencing anxiety or depression around the parental relationship. Insecure attachment patterns may result in anxious attachment or avoidant attachment patterns of relating based on internal working models of these insecure attachments.

Children who consistently experienced neglect or maltreatment (abuse) early in life may not have had their emotional or physical needs met most of the time, or they were harmed, or were fearful of their caregivers. This is observed when children have a parent who was severely depressed, psychotic, or suffering with significant addiction issues (Brisch, 2012; Flores, 2004). These children may form avoidant or disorganized attachment patterns depending on the nature of the neglect or abuse experienced, whether there was an alternate caregiver who was attuned, and the timing and severity of the experiences (Lyons-Ruth & Jacobvitz, 1999). We discuss these attachment patterns in more depth shortly.

The quality of a person's attachment relationships impacts his or her need for or dependency on others. A securely attached person is effectively dependent on the attachment relationship, meaning that he or she is able to reach out for help and rely on others for social support during times of stress (Mikulincer & Shaver, 2007). Attachment theorists believe that secure attachment and autonomy are complementary experiences. Healthy securely attached people demonstrate the ability to rely on self and others in times of distress. Interdependence is reflected when a securely attached person is able to be physically separate or emotionally separate from others and continue to feel a secure consistent sense of self.

People with secure attachments are able to be in psychological conflict with someone

they have a secure attachment with while still trusting that the relationship will not disappear or that the attachment figure (e.g., spouse, friend) will not do anything physically or psychologically harmful to them. They are also able to be physically separated, such as going to school, without feeling the attachment relationship will disappear or that leaving the attachment figure will result in physical or psychological harm. Attachment needs are activated during times of uncertainty, and a person may experience fear and anxiety when he or she is physically or psychologically distanced (i.e., conflicted) from an attachment figure.

When this happens, attachment theorists believe (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969/1982) that individuals demonstrate predictable patterns of distress beginning with protest, then depression and despair, and finally detachment. In this manner, significant relational trauma may have a serious long-lasting impact on a person's functioning. For these reasons, proximity of an attachment figure or a transitional object (something that reminds one of the attachment figure) provides comfort when one feels vulnerable. An example may be a child holding on to something significant from a parent, like a favorite hat, while a parent goes on a business trip. This provides a sense of psychological connectedness for the child when the parent is not physically present.

Box 7.1 Tenets of Attachment Theory

- The desire to attach is inborn across cultures.
- Early attachment relationships impact neurological development.
- Empathically attuned caregiving relationships lay the foundation for moving from interpersonal (caregiver) regulation of emotion to intrapersonal (self) regulation of emotion.
- There are critical periods for attachment.
- Empathically attuned attachment relationships provide a secure base for a person to explore the world, experience new things, grow, and develop.
- A predictable sequence of protest, despair, and detachment follows separation from the attachment figure.
- Attachment relationships serve as internal working models for new relationships.
- Attachment may change based on the caregiver-child relationship.
- Behavior is adaptive to context and based on experience with previous attachment relationships.
- During stressful times, people who have not developed sufficiently secure attachments have not developed a method for coping with dysregulated emotions without relying on other methods. One example is addictive substances or behaviors.

Philosophical Underpinnings and Key Concepts of the Theory

The foundation of the theory developed from psychoanalyst John Bowlby's clinical work with juvenile delinquents at the London Child Guidance Center. He observed that maternal relationships resulting in neglect, separation, or loss significantly negatively impacted the boys' interpersonal development. He later studied the effects of parental attachment disruptions resulting from long-term hospitalization of toddlers. From these observational studies, he identified a predictable sequence of responding to parental separation beginning with protest behaviors, moving to demonstrations of despair, and finally detachment (Bowlby, 1969/1982; Bretherton, 1991). He further theorized that early attachment relationships are the foundation for internal working models children develop for how the world and relationships with others work and for understanding their place in the world.

Mary Ainsworth, a developmental psychologist, empirically tested Bowlby's observations using the strange situation to study the sequence of protest, despair, and detachment (Ainsworth, 1967; Ainsworth et al., 1978). Mother-infant dyads were studied in a laboratory setting. Initially the children were introduced to a toy-filled room and encouraged to explore while the mother was present. There was a trained "babysitter" in the room who was previously unknown to the child. On two occasions the mother would leave the child with the stranger for 3 minutes. Each separation was followed by a reunion between child and parent. Behavioral observations of the children's reactions were recorded and analyzed by the research team.

Ainsworth's studies were conducted in Uganda and Baltimore with nearly identical results, indicating that the desire to attach is an inborn instinct that is cross-cultural. Additionally, she concluded that the quality of caregiving was more important than the quantity of caregiving. In other words, if a mother was consistently present but not empathically attuned to her child's needs, these infants would be more likely to develop insecure attachments, whereas those whose mothers may be more attentive to the child's needs but not always physically present may be more securely attached. Ainsworth is also credited with identifying that a person's inborn attachment system can change based on responses to different caregivers (Grossmann, Grossmann, Spangler, Suess, & Unzer, 1985). From these experiments, Ainsworth identified the following attachment styles: secure, ambivalent, and avoidant.

Mary Main conducted a longitudinal study of attachment following middle-class families from infancy into adolescence (Main, Kaplan, & Cassidy, 1985). Initially a "strange situation experiment" was conducted with the infant and each parent. The strange-situation research captured an infant's reaction to reunification with its caretaker after a brief separation. An infant's reaction was classified into four patterns of reaction correlated with an attachment orientation. When the child was 6 years old, she

videotaped the family's interactions attempting to identify the internalized working models of relating that the children developed. From these studies, Main identified that the infant's strange-situation behavior toward the parent was consistent with the mental representations of the parent at age 6. In other words, the infant's reaction and attachment classification during the strange situation was correlated with the child's attachment orientation at age 6. Through this process Main documented the transition of parental interpersonal regulation of emotion for the child to intrapersonal regulation of emotion using internalized objects or mental representations of attachment relationships. However, not all the children studied in the strange-situation experiments fell into one of the previously identified attachment styles. As a result, her research team reviewed 200 strange-situation videotapes that did not fit one of the previously identified attachment styles. This led to their identifying a fourth attachment style, disorganized attachment, which is discussed in more depth shortly (Main & Solomon, 1990).

To facilitate her research, Main developed the Adult Attachment Interview (AAI), a semistructured protocol aimed at studying attachment in late adolescence and adulthood (George, Kaplan, & Main, 1985). The assessment appears to be straightforward in asking strange-situation parents to reflect on their own relationships with their parents, including loss, rejection, and separation (George et al., 1985; Slade, 2000). However, Main was attempting to access unconscious material through seemingly obvious questions. For example, the AAI asks the interviewee to describe memories of early life with parents. The interviewee responses could vary in depth and language based on attachment orientation. More than observing the answers to the questions, she observed the process the participant went through to describe his or her own parental relationships during the assessment. Additionally, she identified similarities between the child's strange-situation behavior and the parent's mental representations of attachment. In other words, in this research there seemed to be similar reactions between parents' memories of their parents and their child's reaction in the strange situation. Attachment orientations were seen through the generations when all the data were compiled together. Based on these observations, she concluded that infant nonverbal behavior may predict internal representational patterns of attachment.

Attachment Styles

There are four identified attachment styles based on the work of Bowlby, Ainsworth, and Main. Each attachment style correlates with certain behaviors of the infant during the strange situation, certain parenting behaviors, and certain adult expressions of the corresponding adult attachment style. These characteristics are briefly described next.

Secure Attachment

In the strange-situation experiments, infants who were securely attached demonstrated more informative behavior when reunited with their mother than their behavior upon separations from the mother. Although these infants were distressed, as expected by the

separations, they were easily reassured upon reuniting with their mothers because their mothers picked them up and held them to calm the babies when needed. Based on this early attachment classification, infants grow into predictable styles of attachment as adults in interpersonal and intimate relationships. Adults with secure attachment hold positive views of themselves and others and have friends who rate them as warm, intimate, confident, and involved in their relationships (Bartholomew & Horowitz, 1991).

Insecure Attachment: Anxious-Ambivalent Attachment

The first type of insecure attachment may be referred to as anxious, anxious-ambivalent, indiscriminate, or ambivalent attachment in the literature. In the strange-situation experiment, these infants would demonstrate overwhelming distress when their mothers left the room. These infants were so preoccupied with their mothers that they could not explore and play. When the mother returned, some of these infants demonstrated anger and others demonstrated passivity regarding the reunion. The angry infants would actively seek connection with the mother and then reject the mother's attempts at comforting them. The passive infants were so overwhelmed that they were not able to approach their mother for comfort they needed. Anxious-ambivalent attachments resulted from parenting that was inconsistent in being responsive to the child's needs and ultimately discouraged the child's autonomy (Ainsworth et al., 1978). Children with anxious-ambivalent attachment patterns grow up to demonstrate a preoccupied style of attachment as adults. These adults rely on emotion-focused coping strategies when faced with stress in relationships (Mikulincer & Shaver, 2007), report lower levels of self-esteem (Park, Crocker, & Vohs, 2006), and perceive themselves more negatively in intimate relationships (Bartholomew & Horowitz, 1991).

Insecure Attachment: Avoidant Attachment

Infants with avoidant attachment patterns demonstrated no distress when the mother left, no distress with the stranger, and no interest in the mother upon her return. However, these infants had similarly elevated heart rates as securely attached infants upon the mother's absence from the room. Additionally, the stress hormone cortisol was found to be elevated both prior to and after the experiment among these children (Spangler & Grossmann, 1993; Sroufe & Waters, 1977). Ainsworth et al. (1978) observed that these mothers demonstrated indifference to their children and did not demonstrate attachment behavior toward the infant. It is theorized that these infants had learned through previous comfort-seeking attempts that they would be met with rejection. The infants ultimately gave up trying to seek comfort. The mothers' state of mind impacted their ability to attune to their infants. These infants developed avoidant styles of attachment as a defense to deal with the unpredictability of the parent's behavior. Similarly, avoidant adults are more likely to rely on distance coping strategies when faced with stress or perceived pressure in relationships (Mikulincer & Shaver, 2007). These adults actually report higher levels of self-esteem (Park et al., 2006), but they hold negative views of

others in relationships (Bartholomew & Horowitz, 1991).

Disorganized Attachment

Children demonstrating disorganized attachment styles would initially respond to their mother returning to the strange-situation room with bizarre behaviors that lasted about 10 to 30 seconds and then would proceed with behaviors consistent with one of the other previously identified attachment styles. The bizarre behaviors included a “frozen scream” where a child would cover his or her mouth similar to primates studied by Darwin, freezing in place and then collapsing to the ground, or going into a trance-like state similar to dissociation (Hesse & Main, 2000). These behavioral descriptions all indicate an activation of the body's fear response.

The combination of this initial fear response followed by ambivalent or avoidant patterns of attachment behavior indicated that these children may experience their mothers as both a safe haven and as potentially dangerous. This phenomenon is supported by literature demonstrating that 82% of infants with disorganized attachment styles were identified as having experienced abuse or maltreatment (Carlson, Cicchetti, Barnett, & Braunwald, 1989). However, Main also identified that some of these children's responses developed from their experience of the parent being frightened by the child resulting in the parent withdrawing or going into a trance-like state. Fearfully attached adults exhibit both preoccupied and avoidant styles of attachment strategies in intimate relationships. Generally, they hold negative internal working models of both self and others in relationships (Bartholomew & Horowitz, 1991). These individuals are fearful of intimacy and socially avoidant.

Reflective Function and Emotion Regulation

When Bowlby served as a Freud Memorial Professor of Psychoanalysis, he inspired Peter Fonagy to further study the mental representations of attachment and how an individual's intersubjective, or how we understand ourselves, experience of self may impact attachment. Fonagy was particularly impressed by Bowlby's concern for how to positively impact disadvantaged populations. He is credited with developing the concept of awareness of oneself as a psychological being, referred to as *mentalization* (Fonagy & Target, 1997). He built on this concept to study the reflective function one uses to view oneself with psychological depth, insight, and empathy through the development of the Reflective-Functioning Scale (RFS). The RFS was created to assess the influence of attachment orientations on perception of self and others in relationships. In 1987, his research group met with 100 pregnant couples to assess each parent's state of mind as assessed by the RFS related to attachment prior to their child's birth. They later conducted a strange-situation experiment with the infants at 1 year. This study resulted in documented evidence that parents' expression of attachment orientation prior to the birth of their child accurately predicted the child's strange-situation behavior at 1 year old. Fonagy concluded that the attachment system functions so that people are able

to develop internal working models or schemas for understanding the self and others in relationships that subsequently impact their development, whether healthy or maladaptive.

Fonagy's work resulted in the development of three types of intersubjective experiences of the self in the world: psychic equivalence, pretense, and mentalizing. Each of these intersubjective modes of functioning indicates its own style of emotional regulation. An individual functioning in the mode of psychic experience understands no differentiation between his or her inner world and the external world. This individual does not have the ability to think of the self as separate from others, similar to an infant's experience of the world. A person in the mode of psychic experience is impacted immediately by others' actions and defines the self by the way he or she is treated by others. This concept may be popularized in addiction treatment culture as enmeshed relationships, lacking all boundaries between people in intimate relationships.

The opposite is true for those living in pretend mode, where a person does not allow the inner world to be impacted by external realities. Dissociation and narcissism are examples of this mode of being. This individual feels that the external reality is potentially threatening to what he or she imagines the world to be. The person blocks from conscious awareness thoughts, events, or feelings that are fearful. This concept is popularized by addiction treatment as disengaged or rigid boundaries.

Finally, the mentalizing/reflective mode allows people to identify both the self and others as separate but interrelated. This individual may self-reflect or think about thoughts and feelings, interpret experiences, and understand that events experienced are separate from a reaction to those events. These individuals are generally better able to manage emotional dysregulation in a healthy manner. An example of this is using healthy coping mechanisms when an individual experiences an unsettling event. This concept is popularly called permeable boundaries or healthy boundaries.

> Box 7.2 Jessica McClure
> A toddler named Jessica McClure fell into a well in Texas while playing near her home. Initially, first responders sent a microphone down into the well to attempt to identify whether she was alive. They heard Jessica singing quietly to herself. Person-centered therapists may say this is evidence that one has it within oneself to self-soothe. However, attachment theorists would conceptualize this behavior differently. Using the information described in this chapter, how would an attachment theorist understand Jessica's ability to self-regulate during a frightening time of her life? How and where did this skill develop? How might this story inform an addiction treatment provider's work with a client who has few resources for self-regulating dysregulated emotional states?

Fonagy used Bion's (1962/1977) concept of a mother's containment of an infant's

distressing emotions in order to reflect that caregivers are able to effectively communicate empathic attunement and demonstrate physical care for their infant. He suggests that a parent can communicate understanding of the child's distress and can help the infant regulate emotional distress either through ending the distressing stimuli (e.g., providing food, a diaper change) or through helping the infant cope with the distress (e.g., rocking, humming). Most importantly, Bion believed caregivers can recognize that infants have a mind of their own, separate from the caregiver's, and can infer the intention that underlies the parent's behavior (Dennett, 1987). Caregivers who are able to communicate empathic understanding, assist in coping, and appreciate that the child has an experience of the world separate from the caregiver reinforce the attachment relationship as secure.

Through the experience of affectively attuned interpersonal regulation of emotion, a child develops an internal representation of the self as worthy of empathic attunement and a belief that attachment relationships can be a source of support, comfort, and even pleasure. The securely attached individual, when emotionally dysregulated, is able to find a way to understand emotions, either through interpersonal attachments or through the internal schema or classification of those attachment relationships. However, if a child develops insecure attachment patterns it is in reaction to his or her internal experience of attachment relationships that are empathically misattuned and therefore have resulted in extending if not causing the child's emotional dysregulation. Insecurely attached individuals do not experience intimate relationships as a safe place to gain support, comfort, or pleasure. These individuals then do not learn to regulate emotional states in a healthy manner, so they seek “containers” for their dysregulated emotions elsewhere such as dissociation, narcissism, addictions, and unhealthy ways of relating to others.

How the Theoretical Approach Is Used by Practitioners

Mental health workers specializing in addiction treatment practicing under the guiding principles of attachment theory believe fundamentally that the therapeutic relationship can be developed as a secure base for the client's work in therapy. If the therapist successfully provides consistent accurately attuned empathic responses to the client's presenting issues, the client will be able to use the therapeutic relationship to learn to modulate challenging emotional states. A primary assumption in attachment theory is that people's interpersonal interactions are based on their attachment style, which is reflective of their sense of self. A fragmented sense of self results from insecure attachment styles. When individuals have a fragmented sense of self, they do not have the confidence to believe they are capable of coping with challenging interpersonal situations that lead to strong emotions. In this manner, attachment style dictates how a person regulates emotion (Mikulincer & Shaver, 2007). Difficulty managing dysregulated emotional states often results in maladaptive interactional patterns, which are a reflection of underlying fear, anger, and/or grief.

For those clients challenged with addiction issues, they are likely using the focus of the addiction (e.g., alcohol, food, gambling, sex) as a container for these dysregulated emotions. Therapists understand that these clients did not develop a healthy sense of self or the ability to effectively cope with dysregulated emotions through healthy empathically attuned caregiving relationships when they were young. Therefore, when they experienced complex emotions, they did not have the necessary healthy coping mechanisms to work through these emotions. Where a healthy, securely attached person would use the attachment relationship or an internal working model of that relationship to work through these emotions, insecurely attached individuals seek containers for these emotions elsewhere, such as alcohol, drugs, gambling, or food.

Because of this, these clients also have developed attachment relationships with their addictive substance or behavior. This is a complicating factor in treatment because their attachment relationship with the addiction becomes increasingly more important to the client's sense of self and inability to manage emotional states as the addiction progresses. Until clients are able to function from a secure attachment style that promotes healthy interpersonal relationships and a sense of self-efficacy for regulating emotional states, they will remain at an increased vulnerability to relapse triggers. Therefore, helping clients develop the ability to form healthy secure attachments is a major goal of therapy.

Generally, attachment-conscious therapists are aware that their clients' triggers for engaging in the addictive behavior are related to their attempts to cope with difficult emotions experienced during interpersonal relationships. Conversely, the addictive behavior(s) often negatively impact existing relationships, resulting in further damage to the client's ability to experience healthy interpersonal attachments. For example, a person who relies on alcohol as a social lubricant will choose that substance over developing a healthy relationship. People challenged with addictions demonstrate behaviors consistent with insecure attachment styles. There are multiple ways a person can experience early caregiving that result in an insecure attachment style. These experiences exist on a continuum of severity and also involve multiple methods of problematic caregiving (e.g., parental mental illness, parental addiction, physical/sexual abuse, rejection, abandonment). This means that the therapist must examine the client's experience of early and significant interpersonal relationships, so that the therapist and client can understand the client's experiences of attachment. Early relational trauma is particularly damaging to the client's sense of self and therefore must be addressed as part of addiction treatment for the client to have any real chance at a successful long-term outcome.

Because trauma work often involves working through intense emotions, the therapist must be willing and able to provide a safe holding environment for the client's intense, often negative emotions. This includes being able to tolerate a client who addresses the therapist in anger or hostility as a result of a transference reaction the client has toward

the therapist because of previous relationship ruptures. The therapist must be able to assist the client in containing these emotions during therapy sessions. This means that the therapist will help the client manage healthy emotional expression rather than using a substance to deal with emotions. In other words, addiction has been called a feeling disease because of the addict's use of substances to manage emotions. This may be accomplished through ensuring the client is able to process through the emotions experienced before leaving the session. If the client's trauma is too complex to work through completely in one session, then the therapist must be able to guide the client in some method of containing the emotion so that the client can go out and function in the world between sessions without becoming seriously emotionally dysregulated by the work done in therapy. This can be accomplished through the use of metaphors, guided imagery, ritual, or amplifying the emotion and helping the client sit in that experience. An example might be identifying a song metaphor to represent the client's current attachment pattern and asking the client to choose a new song to replace the maladaptive coping associated with the old song. If the therapist is unable to provide a successful container, a relationship rupture occurs that can jeopardize the client's success in treatment because the client will not experience therapy as a safe base from which to explore addiction.

If emotional dysregulation is directed at the therapist, he or she may also contain the client's emotion through using an interpersonal process to discuss the relationship dynamics occurring between the therapist and client in the here and now, relating the dynamics to the client's addiction issues and past relationship ruptures. In these situations, the therapist must always be cognizant of the need to be consistent in setting boundaries and limits with clients when the client oversteps in a manner that is inappropriate for the relationship (e.g., makes sexual advances, verbally threatens the therapist, or personally ridicules the therapist during a therapy group), followed by processing the interaction as it relates to the therapeutic focus for the client's work. Additionally, if the client is currently in a therapeutic milieu, the therapist may need to observe the client's interpersonal maneuvering within that system to learn more about how and why the client functions in certain ways. Similarly, the therapist must be mindful of how the client attempts to elicit interpersonal reactions from the therapist and any transference reactions the client acts out with the therapist in session. All of these methods help the therapist understand the client's unique experience of the world, sense of self, and how the client manipulates the world and other people to get needs (physical and psychological) met. Part of the therapeutic process is for therapists to observe these patterns of emotional trigger and attachment/detachment behaviors and help the client begin to think about himself or herself in these situations as a psychological being, or as an individual who can manage in a more adaptable manner. This requires the therapist to help the client develop the ability to self-reflect on thoughts, feelings, and relationships. Reflecting on the interpersonal process observed is

one method of engaging the client in self-reflecting on the emotional experience of the world and also how that experience may influence the world around the client.

In a controlled treatment setting (e.g., prison, inpatient hospitalization, residential treatment center), clients will be required to abstain from their addictive behaviors. This will necessarily create increased anxiety related to their inability to use their addiction to cope with the intense emotions that surface during treatment. If their primary addiction (e.g., alcohol) is not available to them, they may choose a secondary addiction (e.g., sex) to aid in regulating their emotional states in these situations. This is crucial to understand in that cross-addictions are further evidence of the severity of the client's insecure attachment style that the therapist must identify and address through the therapeutic relationship.

Emotion-focused therapy is an extension of attachment therapy. By focusing on emotions in sessions, the therapist can help regulate a client's emotional states interpersonally just as would occur between a caregiver and an infant. Some therapists refer to this process as reparenting. If the therapist can provide a good-enough attachment base through the corrective emotional experience of therapy, the client and therapist can safely explore maladaptive attachment strategies while reinforcing their relationship connection in therapy.

However, some clients are so challenged by their early experiences that they are completely unable to identify emotional states with feelings words. This is common in addiction treatment, and it is called alexithymia (Sifneos, 1973, 1996; Taylor, Bagby, & Parker, 1999; Vanheule, Sesmet, Meganck, & Bogaets, 2007). Alexithymic clients are not able to form secure attachment relationships because attachment is intertwined with emotion. They are so detached from emotion that they cannot even identify or label emotional states when they are happening in the moment. In these cases, the most basic therapeutic intervention may be helping these clients identify when they are having emotional reactions without judgment and then helping them learn to label the emotions with feelings words. Other clients may be able to identify emotions, but they are either overwhelmed by them, resulting in demonstration of decompensating behaviors, or fearful of them, resulting in attempts to restrict all emotional expression. These skills are developmentally similar to how children learn to identify and label emotions and then learn self-control or regulation of emotions as toddlers.

Clients who manifest these types of emotional dysregulation are likely to have significant histories of relational trauma. When this is the case, the therapist must be aware of the potential for *trauma bonding* (Carnes, 1997). Clients who have significant histories of interpersonal trauma may not have experienced any relationship that did not have a trauma component to it. This may include psychological trauma, physical trauma, and/or sexual trauma. Individuals who experience this type of trauma are more susceptible to developing new attachment relationships in therapy (group, AA, with the therapist) that are based on the common experience of trauma or on the shared

expectation of trauma in interpersonal relationships. These clients often believe their trauma experiences are excuses (not explanations) for their addictive behaviors. So the therapist must take care to identify and reframe situations where the client uses trauma as a method to enable addictive behaviors.

Clients' perceptions of rejection or abandonment by the therapist may be triggered from their relational trauma histories as well. These transference reactions may develop when the client begins to feel securely attached to the therapeutic relationship and then becomes fearful of being harmed by the relationship. Alternatively, it may develop from a therapeutic relationship rupture occurring when the therapist is empathically misattuned with the client's needs. In these situations the most important goal is for the therapist to facilitate a relationship repair that results from processing the rupture and providing a corrective emotional experience for the client. For instance, when sessions are missed the therapist should focus attention on understanding the client's feelings about the therapeutic relationship because this relationship is the chance to correct maladaptive attachment patterns. The therapist should take care to accurately reflect the client's conflicting feelings about the relationship, while providing a secure holding environment for the client to express, experience, and name these feelings. The attempts at repair will help clients replace maladaptive coping strategies with adaptive ones. Similarly, therapist absences (e.g., illness or vacation) and termination (planned or unplanned) will trigger clients' attachment-focused issues. Therapy should focus on changing interactional patterns, identify areas where clients feel their needs are not being met, and problem-solve ways to recognize those signs of distress and how to communicate those needs in a way they can be met in intimate relationships. If the client perceives that the therapist (new attachment figure) will no longer be available, this can trigger maladaptive coping strategies, such as acting out addictive behaviors. This is an assumption from the attachment model of addiction that may explain why many clients have lapses or relapses close to the end of treatment. It is a reflection of their anxiety about ending the relationship. It can be helpful for the therapist to provide a transitional object for the client, such as a rock with the word *strength* painted on it so that the client can carry it with him or her as a reminder of the work done in therapy. The therapist may also facilitate the client's termination process and internalization of the relationship and the work done in therapy through having the client keep a journal, an art project, or developing sandtrays or collages documented in pictures throughout therapy in order to help the client own his or her progress in treatment, honor the attachment relationship with the therapist, and have a transitional object that can be helpful when the client is away from treatment but having a difficult time emotionally.

Another tool that can be used to both create healthy attachments and provide ongoing interpersonal support is the client's participation in a 12-step or other support group. Attachment-focused therapists emphasize the importance of clients finding a group where they feel comfortable and can relate to the people in the group, rather than

emphasizing location or time of the group. An important component of a 12-step group that may also facilitate the attachment process is identifying and engaging a sponsor. These can provide ongoing supports for the client when the therapist is not available. However, ultimately it is the therapeutic relationship and the client's experience of that relationship that will effect lasting change. To reiterate, from an attachment perspective, emotional experiences in securely attached relationships are powerful.

Assessment and Prevention Implications

Attachment theory was formed based on ethnographic behavioral observations that led to Bowlby's initial observation of protest, despair, and detachment as a predictable series of responses to children being separated from their parents. Behavioral observations in naturalistic settings continue to be useful for assessing attachment styles. This may occur with addiction clients in their natural environments or in therapeutic settings such as residential treatment programs or psychiatric inpatient programs. Bowlby's theory was further researched using the Strange Situation Protocol (SSP; Ainsworth, 1978), which formally assessed attachment styles as secure, insecure-ambivalent, or insecure-avoidant. Finally, further review of nontraditional responses to the SSP resulted in the identification of behaviors consistent with disorganized attachment.

These attachment styles have been used to formulate several attachment measures for older adolescents or adults who are more likely to be the focus of addiction treatment. In 1987, Hazan and Shaver developed a self-report measure for romantic attachment among adolescents and adults. The assessment consists of one statement for each of the attachment styles identified by Ainsworth (secure, avoidant, and anxious-ambivalent). An earlier version asked participants to identify which statement best identified their feelings, and a later version asked them to rate their agreement with each statement. This measure postulated that securely attached individuals demonstrated low anxiety and low avoidance related to attachment relationships. Preoccupied or anxious-ambivalent attachment styles demonstrated high anxiety but low avoidance of attachment relationships. Avoidant or dismissing attachment styles reflected low anxiety but high avoidance. Fearful avoidant (disorganized) attachment styles demonstrated high anxiety and high avoidance.

The Adult Attachment Interview (AAI) previously discussed is a semistructured clinical interview with 20 questions that attempt to assess adults' internal representation of attachment relationships by asking them to recall information from their childhood (George et al., 1985). Quality and content are coded to produce one of the following attachment styles: autonomous (e.g., secure), dismissing (e.g., anxious-ambivalent), preoccupied (e.g., avoidant), and disorganized. The same attachment style coding is used by the Adult Attachment Projective Picture System (AAP) that uses eight cards with different scenes that the client tells stories about (George & West, 1999, 2012). One strength of the AAP is that it also provides information on defensive processing

patterns, attachment synchrony, and personal agency, which can be useful in treatment for adolescents and adults.

> Box 7.3 Assessing Your Attachment Style
> Go to the following website to access the Experiences in Close Relationships Revised assessment: www.web-research-design.net/cgi-bin/crq/crq.pl.
> Complete the assessment for yourself. What is your attachment style according to the assessment? How accurate do you believe it is, and why? Analyze the attachment style you have in relationship with your own psychosocial history. What are the strengths and challenges associated with this attachment style?

Bartholomew and Horowitz (1991) developed the Relationship Questionnaire (RQ-CV) that consists of four sets of statements, similar to the Hazan and Shaver questionnaire, representing each of the four adult attachment styles: secure, dismissive, preoccupied, and fearful. The difference was that this instrument assessed both thoughts about whether they were the types of people whom others wanted to support and help and their thoughts about whether they judged their attachment partner as accessible and emotionally responsive. This assessment has been validated in 62 cultures, although different cultures indicated the different categories of attachments may have different meanings than originally assumed (Schmitt et al., 2004). For this assessment, securely attached individuals demonstrated positive thoughts of themselves and their attachment relationship. Preoccupied (anxious-ambivalent) attachment styles demonstrated negative thoughts about themselves but positive thoughts about their partner. Conversely, dismissive (avoidant) attachment styles demonstrated positive thoughts of themselves but negative thoughts about their partner. Finally, fearfully (disorganized) attached individuals demonstrated negative thoughts about themselves and their partners.
The Experiences in Close Relationships (ECR) questionnaire and the revised (ECR-R) questionnaire provide measurement of two dimensions of attachment, avoidance and anxiety (Brennan, Clark, & Shaver, 1998; Fraley, Waller, & Brennan, 2000). Respondents are asked to rate the degree of their agreement with multiple statements about relationships. Questions about an individual's beliefs related to propensity to be rejected by others and self-worth are measured by the anxiety scale, and their beliefs about taking risks in approaching others are measured by the avoidance scales. These are some of the more noted formal assessments of attachment used to assist therapists in clinical situations.

> Box 7.4 Analyzing How Clinician Attachment Style May Impact Treatment
> Complete the assessment a second time as you think Gabriel would complete it. You may have to fill in some gaps in what you know about his history. What are the strengths and challenges of Gabriel's attachment style?

Analyze your attachment assessment results in relationship to his. What unique challenges might occur based on these results? How would you address this in order to provide the most competent care for Gabriel? What resources do you have available to you to address these challenges?

Although each of these formal assessments provides helpful information to clinicians, none replaces the need for the therapist to conduct a thorough clinical interview that includes questions exploring the client's experience of early attachment relationships and current experiences of attachment relationships. Additionally, attachment-informed therapists are continuously assessing client dynamics in the therapeutic relationship with the therapist and any dynamics exhibited in the therapeutic milieu of the treatment program for evidence of attachment style and evidence for change in attachment beliefs, attitudes, and behaviors.

Strengths and Weaknesses of the Theory

Attachment theory approaches can be considered evidence-based practice. The theory is based on a solid foundation of research beginning with in-depth behavioral observations, followed up with specific experimental design studies both short term and longitudinal across multiple cultures and more recently increased functional magnetic resonance imaging (fMRI) research supporting the concept of interpersonal neurobiology that is based on attachment relationships and impacts emotion regulation (Ainsworth, 1967; Ainsworth et al., 1978; Bowlby, 1984, 1988; Main et al., 1985; Main & Solomon, 1990; Perry, 2009; Siegel, 2012). This approach provides potential lasting change by treating not only the symptom (addiction) but the underlying motivational issues and resultant neurobiological structures impacted by those underlying experiences and triggers. However, attachment relationships with secondary relationships other than parents have not been adequately studied to understand potential mediating effects of these. Additionally, research on attachment-focused addiction-specific treatment is lacking.

Attachment theory approaches do not use specific techniques that are easily translated into practice for novice therapists. In order to practice from this perspective, a new therapist needs to have a substantial understanding of the underlying theoretical concepts and supervised practice in treatment of clients and in conceptualizing client dynamics. Therefore, this approach takes more time, effort, and resources to learn and carry out than do more simplified approaches to treatment. Similarly, given that building a secure base in the way of an empathically attuned therapeutic relationship is a goal of this approach, therapy cannot be completed in a strict limited number of sessions. Another complication is that many treatment facilities in which individuals with addictions are treated have high staff turnover. This necessarily reinforces insecure attachment patterns rather than building secure ones.

Case Study Responses

Gabriel experienced his early caregivers as people he could not consistently trust to provide a safe holding environment for stressful emotional states. In fact, his father's addiction and abusive behavior indicate that Gabriel likely experienced both fear and love for his father. In order to attempt to connect with his father he began using substances in order to contain dysregulated emotions. He experienced his maternal relationship as loving but inconsistent in that his mother did not provide a safe holding environment to protect Gabriel or his sister from his father's abusive behaviors. Based on his stated close relationship with his sponsor that ended abruptly and the description of short intimate relationships with romantic partners, it is likely that he demonstrates an avoidant attachment style either as primary or as secondary to a disorganized style. More assessment needs to occur to make a clear determination about this.

The most important thing for Gabriel's therapist to do is to create a safe holding environment for him in therapy. This means that the therapist must be consistent and forthright in communication with Gabriel about all aspects of therapy. Additionally, it is crucial for the therapist to conduct a thorough psychosocial evaluation to gain an understanding of Gabriel's early attachment relationships, his attachment attitudes, and his expectations of how he will be treated by others in interpersonal relationships. The limited information provided by the case study does not sufficiently provide this information.

Gabriel may demonstrate alexithymic behaviors given that he has only experienced his parents as individuals who were preoccupied with their own issues of anxiety, depression, addiction, and abuse. It is possible he did not learn how to identify the physical sensations of emotional states with feelings words. So the therapist may need to spend time initially in treatment building this understanding of emotions as feelings. The therapist may use sandtray, art, music, or other experiential means to help access emotional states in therapy, then help the client describe his bodily sensations resulting from the symbolic representation of triggering situations, and finally help him name those emotional sensations with feelings vocabulary. This will provide a foundation for communicating about emotions within interpersonal relationships. Building on this work, emotion-focused therapy techniques may then help Gabriel experience, express, and work through triggers for emotional dysregulation. By having consistent experiences in a safe empathically attuned therapeutic relationship, Gabriel will begin to build and strengthen new neural networks that support a healthier attachment style.

Gabriel likely demonstrates an emotional regulation mode of psychic experience where he does not think of himself as separate from others. This would result in Gabriel's enmeshed relationships with important others and demonstrated difficulty separating psychologically or physically from individuals such as his mother, sister, and niece. Similarly, he may also define himself as an addict without much of a foundation to build on for his nonaddictive lifestyle. In other words, he is an addict, but not an uncle, a son, or a lover of music. So the therapist may need to help Gabriel identify his personal

characteristics and develop a self-concept separate from the addiction.
Enmeshment is an important concept in that he will likely have difficulty separating and self-reflecting on his own experiences separate from important family members or other group members. This may result in his inability to move forward toward a healthy nonaddictive lifestyle. In order to address this, the therapist may need to work with Gabriel on identifying himself as separate from significant others (e.g., mother, niece, father, girlfriend, sponsor, group members). This may occur by using specific language during therapy to identify and reframe conceptualizations of relationships in a manner that clearly identifies individual experiences and roles in the family or group.
Additionally, the therapist will likely need to provide support for Gabriel in setting boundaries with significant others such as his mother and sister and perhaps other clients in group or 12-step meetings. The therapist should anticipate that Gabriel will experience increased anxiety at doing this and may need additional support and processing time in session when he attempts to set limits with significant others.
The therapist must also identify when Gabriel needs to set limits with the therapist or attempts to do so or when he asserts his needs in therapy (or avoids doing so). These are potentially powerful teachable moments for the therapist to use the here-and-now relationship to process how Gabriel's attachment style is impacting his ability to identify and meet his psychological and emotional needs. Another important therapeutic intervention that speaks to this issue is for the therapist to reiterate when the client has worked in treatment and made progress. Often a client like Gabriel will give the credit for his successes in therapy to the therapist rather than claiming them as his own. The therapist needs to consistently acknowledge that a therapist's role is to be on the journey as a guide with Gabriel, but the work done is his, and the resulting impact of that work is his as well.
Finally, termination or even separations due to weekends or vacations may be particularly difficult for Gabriel because he does not view himself as separate from other significant individuals in his life. Once Gabriel begins experiencing the therapeutic relationship as safe he may actually begin to experience an initial increase in emotional dysregulation because of the anxiety associated with giving up his fear of being hurt (emotionally or physically) by a caregiver, in this case the therapist. These points in therapy may be triggers for acting out addictive behaviors. They should be predicted in therapy as potentially difficult triggering times. When this type of trigger emerges, transitional objects or other methods of providing a physical connection to the mental representation of the safety of the relationship should be provided as one method to prevent or mitigate relapsing behavior.

Summary

Attachment theory is a developmental model based on early caregiving relationships. These early relationship experiences either help or hinder the development of emotion regulation. The principles of attachment theory can be used in addiction counseling by

helping assess the attachment styles of clients in various treatment settings, encouraging clients to form more secure attachments as they engage with a recovering community, and by assisting clients in greater emotion regulation in order to prevent relapse. By having consistent experiences in a safe empathically attuned therapeutic relationship, recovering clients can begin to build and strengthen new neural networks that support a healthier attachment style.

Resources for Continued Learning

Scholarly Journal

Bohani, Y. (2013). Substance abuse and insecure attachment styles: A relational study. LUX: A Journal of Transdisciplinary Writing and Research From Claremont Graduate University, 2, 1.

Websites

Experiences in Close Relationships—Revised Assessment: www.web-research-design.net/cgi-bin/crq/crq.pl.

Psychology Today Relationship Attachment Style Test: http://psychologytoday.tests.psychtests.com/take_test.php?idRegTest=3265.

Science Bulletins: Attachment Theory—Understanding the Essential Bond, uploaded by the American Museum of Natural History: www.youtube.com/watch?v=kwxjfuPlArY.

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8 Sociological Theory

Katie A. Lamberson

When addiction counselors provide services to an individual who struggles with an addictive disorder, factors within the individual, such as a biological predisposition and psychological concerns, deliver insight that assists in the treatment of that individual. Although individual factors provide essential knowledge into the process of addiction, the reality that individuals exist within a social environment is crucial to consider. As humans, we each identify with certain cultural, social, and familial groups, and these groups have a strong impact on our values, beliefs, and behaviors. Accordingly, even when we are working one-on-one with a client, we would not be providing holistic services without taking into account the influence of the client's social environment on his or her current experience and functioning.

Despite the advantages biological perspectives, or disease models, provide in helping addictions professionals to understand the role of the brain in the development of addiction, they do not explain why individuals who are not prescribed an addictive substance initially pick up a drink or drug nor why the disease of addiction does not follow a standardized progression for all individuals (Lewis, 2013). In addition, biological perspectives fail to explain how some individuals are able to manage addiction without the help of treatment or medication (Peele, 1985). Sociological theory provides an avenue to help us understand the social and cultural differences that explain variances among individuals. Sociological theory, as it relates to addiction counseling, attempts to answer the question of how one's social environment impacts the development of addictive disorders. More specifically, what cultural differences exist that may play a role in the development of an addiction? How do addictive behaviors facilitate our social experiences? How do messages we receive from the various social groups with which we identify impact our behaviors? How have changes in these messages over time influenced the progression of the problem of addiction in society? This chapter attempts to answer some of these pertinent questions through the examination of the history and underlying philosophy of sociological theory.

Brief History of Sociological/Cultural Influences on Addiction, Including Differences Between the United States and Other Parts of the World

Addiction is a phenomenon that has been discussed and written about in some form for centuries. In fact, the earliest written account of a drug-dependent memory, or a memory that is more easily formed when under the influence of the substance taken when the memory was created, is found in the Bible (Schnall, Saperstein, & Saperstein, 2013). In this story, Lot and his daughters seek refuge after the destruction of Sodom and Gomorrah. Believing their father to be the only male left who can repopulate the earth,

Lot's daughters use alcohol to intoxicate their father and impregnate themselves. Lot has relations with his eldest daughter on the first night, but due to his level of intoxication does not recall the events the next morning. However, on the second night, when he is intoxicated a second time in order to have relations with his younger daughter, Lot is able to recall the events of the previous night (Genesis 19:30–36).

This written account demonstrates that addiction is common across time and cultures. Conversely, what is not common is the way in which addiction is *viewed* across time and cultures. Important to the understanding of group, time, and individual differences in addiction is an exploration of the history of how each of these variables has evolved across time and cultures. Seeing beyond the lens of personal experience helps individuals to better understand how and why society works as it does, which can provide insight into resolving issues, such as addiction, with long-term results (J. Wachtel, personal communication, July 26, 2015).

It is important to consider how substance use trends vary by time and culture (see Chapter 2). Despite early reports of drug and alcohol use throughout history, it was the shift in legal policy and social views of substance use in the 19th century that gave rise to sociological research on the subject. During this time, philosophical beliefs about substance use led to changes in laws that enforced strict controls over the use of substances (Goode, 2006). The temperance movement of the 19th century represents a change in social views toward abstinence from alcohol. Similarly, Prohibition in the United States during the early 20th century banned the sale and consumption of alcohol. Prior to these times, a majority of drug and alcohol consumption was unregulated, and social views were such that these behaviors were tolerated and not necessarily considered deviant (Goode, 2006). These new opinions and policies led sociological researchers to explore the ways in which social forces influence an individual's substance use. Substance use became inherently deviant as suddenly drinking and using drugs was against the law.

As legal policies and societal views on substance use began to shift, different cultures demonstrated different responses. In the second half of the 20th century, the United States adopted a punitive stance toward those who deviated from the law by using substances. On the other hand, U.S. capitalist marketing strategies targeted certain populations with the promotion of specific drugs attempting to portray the use of substances in a positive light. For example, whereas Camel cigarettes promoted tobacco use among children using Joe Camel, Virginia Slims focused their marketing on women. Additionally, Newport cigarettes and low-cost alcohol primarily targeted use among black and low-income populations. The capitalist philosophy of private and corporate production and distribution, coupled with the belief in individual rights, created a conflict in the U.S. stance on substance use. Individuals within these cultural groups may have been torn between using substances and succumbing to the deviant culture or not using substances and going against behaviors that were seemingly valued by their

cultural group. This dichotomy in the U.S. belief system begs the question, is deviant behavior, such as addiction, essential to the maintenance of capitalist culture? Alternatively, Great Britain viewed substance use as a medical concern, acknowledging the need to intervene with those who used, but from a treatment standpoint (Goode, 2006). Researchers used these vast differences in approach as a method of explaining how social factors impact the development and progression of problematic substance use and other deviant behaviors. Individuals using substances in the United States were labeled deviant, whereas those in Great Britain were not. Although such labels are socially constructed, they can significantly influence the way in which an individual views himself or herself and is viewed by society. By labeling individuals using substances as deviant, the United States stigmatized substance use and created a new social group. The existence of deviant labels for these individuals made it easier for them to assimilate into the drug culture. Britain, on the other hand, provided treatment without such a label, allowing individuals to identify in other ways (Goode, 2006).

It is clear that history is fraught with evidence of dynamic social and cultural values that influenced, and continue to influence, substance use behaviors. The United States continues to place legal restrictions on the age at which individuals can purchase tobacco and alcohol, emphasizing that, at least in this country, use of these substances prior to those ages is considered legally deviant. Other countries hold different values, which lead to different restrictions. Understanding these historical trends provides a basis for conceptualizing clients using a sociological framework.

Basic Tenets of the Theory

The beginnings of sociological theories of addiction are rooted in the need to understand differences in addictive behaviors between and among cultures, social groups, individuals, and drug classifications. An individual may have a predisposition toward drug or alcohol use, but without an opportunity to use, exposure to use, and availability of drugs and alcohol, this predisposition alone is not enough to develop addiction (Goode, 2006). Sociological theory considers the macroenvironment, or the "bigger picture" of addiction. A commonly heard phrase in the addictions world is *recreational use*. This phrase innately suggests a strong social connection in the use of substances. Examination of the macroenvironment distinguishes how trends that exist across drugs, time, and social and cultural groups impact an individual's use patterns (Thombs, 1999). An individual's values and beliefs play an important role in how counselors provide treatment, but equally important is the understanding of the root of those values and beliefs, which generally are best understood within the context of social and cultural norms and values.

According to Thombs (1999), four sociological functions of substance abuse exist. Knowledge of these functions can help addiction counselors to understand an individual's substance use as a function of his or her social environment. When a counselor works individually with a client, he or she is often restricted to only the

information provided by the client. This can create blinders for the counselor in that it limits understanding of the problem to the individual. Yet individuals exist in social groups, so how can a counselor fully understand an individual without understanding the various social groups with which he or she identifies? Counselors can use the following four functions as a road map for understanding the purpose substance use behaviors might serve for a particular individual.

Facilitation of Social Interaction

First, substance use serves to facilitate social interaction (Thombs, 1999). Many individuals report use of drugs or alcohol in order to lower their inhibitions. In other words, individuals who may feel some form of anxiety or nervousness in certain social situations will experience a decrease or absence of these sensations following ingestion of a substance. This is because many drugs, including alcohol, have a physiological impact on the inhibitory synapses present in the brain (Doweiko, 2011). Consequently, the processes in the brain that restrict human behavior (e.g., tell us not to accept a ride home from a stranger) are weakened as a result of the intake of a drug. Although this may on the surface appear a negative consequence to substance use, consider the teenage girl who is feeling too anxious to talk to the teenage boy she has a crush on at a party. For this girl, lowered inhibitions will decrease her experience of feelings of anxiety and may allow her to more comfortably talk to the boy.

Generally speaking, alcohol and drugs activate the pleasure center of the brain (Doweiko, 2011). Feelings of increased pleasure also help to overcome barriers that may hinder individuals from interacting with others. Imagine a couple going on a date for the first time. Dating is a situation that can create intense vulnerability for the individuals involved. Drinking alcohol on the date helps the couple to feel more comfortable communicating with one another on this vulnerable level. Additionally, drinking alcohol on the date creates a shared experience that gives the couple a common bond that can give them a starting place for creating depth in the relationship (Thombs, 1999).

To Provide Release From Social Obligations

According to Thombs (1999), a second function of addiction is to provide a release from normal social obligations. Individuals are faced with a plethora of daily responsibilities, including social, occupational, familial, and personal obligations. These duties can be overwhelming and may lead people to seek a temporary respite from the demands of everyday life. Substance use is thought to provide this respite both mentally and behaviorally. Drinking or taking drugs, whether alone or in a group setting, not only allows a person the temporary relief from participating in required responsibilities but can also provide mental relief by distracting the mind from acknowledging the need to complete certain tasks.

From this perspective, it seems likely that the more role obligations an individual

encounters, the more this social function comes into play. Indeed, juggling multiple responsibilities can be difficult; however, when working with clients, it is important for the counselor to consider how the client perceives these responsibilities. For example, Client A enters treatment describing minimal daily tasks and responsibilities yet views this small number of tasks as highly stressful and anxiety provoking, whereas Client B presents with numerous daily obligations that appear difficult to manage, but the client describes a minimal amount of stress associated with these obligations. Understanding the client's perception and experience of stress related to daily obligations allows counselors to appreciate the role of this social function in the client's use of substances. Clients A and B demonstrate the role that values and beliefs have in sociological theory. At times, cultural values dictate when the use of substances as temporary relief from social obligations is considered acceptable. According to achievement anxiety theory, an individual's fear of failure fuels addiction (Misra, 1980). In other words, individuals experience higher levels of anxiety when they perceive more pressure to succeed and produce (Thombs, 1999). In this case, addictive behaviors offer a respite from feelings of anxiety generated from beliefs and values that one must be high achieving. This theory may help counselors better understand Internet gaming as a potential addiction. Kardefelt-Winther (2014) has argued a significant relationship between high levels of stress, a desire to escape the demands of stress, and excessive participation in Internet gaming.

Box 8.1 The Case of Bill and Sam

Bill and Sam present for counseling after arrests for driving while impaired (DWI). Bill is a white male who self-identifies as middle class. Bill works as a CEO and has a wife and three children. Sam is a black male from a low-income neighborhood. He is unemployed and has a wife and three children. During intake, Bill insists that he does not have a problem with alcohol; he simply uses it to “relax” at the end of a hard day of work. Sam also reports that he has his drinking under control. He occasionally has a drink at the end of a long day of searching for work. He states he has been looking for a job for 2 years, with no luck.

What stereotypes or beliefs might impact the way these two men are viewed? How might that impact the treatment they receive?

Cultural norms also influence the utility of addictive behaviors as a temporary escape from social obligations. In individualistic cultures, such as the United States and Canada, individuals are viewed as autonomous and self-sufficient, and their value and worth are based mainly on their individual accomplishment (Williams, 1965). This places tremendous pressure on an individual to be successful. In contrast, those from collectivist cultures, such as Africa and Latin America, are seen as part of a larger network, allowing for more reliance on others to help create success (Triandis, 1995).

Although the United States as a nation is considered individualistic, individual variations in need for autonomy and social relationships exist. The large U.S. immigrant population means that individuals with roots in collectivist cultures are residing in an individualistic culture. The clash between individual beliefs and societal values may make it difficult for those individuals to reconcile how to navigate social obligations. The need for a time-out from social obligations may be more prevalent in those individualistic cultures where individuals attempt to fulfill all role obligations without assistance. In these cultures, society may be held responsible for the rate of addiction because of the pressure it places on individuals to achieve (Thombs, 1999). On the other hand, in collectivist cultures, drinking may be more often related to formation of social bonds that facilitate shared experiences among groups.

Promotion of Group Solidarity

A third sociological function of addiction is to promote cohesion and solidarity among social or ethnic groups (Thombs, 1999). Values and norms related to addictive behaviors vary across social and cultural groups. Individuals who choose to engage or not engage in these behaviors may make such a choice based on personal values that stem from group norms. In fact, social and cultural groups are thought to have a significant influence on their members' substance use behaviors. Native Americans condone the use of certain hallucinogenic drugs as a method of undergoing profound spiritual encounters. The various religious groups provide a spectrum of cultural norms related to consumption of alcohol. According to the Islamic faith, alcohol is strictly forbidden, unlike in the Jewish faith, which allows for moderate drinking so long as it is done responsibly and not to excess (see Chapter 2). In contrast, the Catholic faith places few restrictions on drinking behaviors.

A group in which rates of drug and alcohol use are becoming particularly high is that of adolescents and transition-aged youth (individuals aged 16–25). According to the National Survey of Drug Use and Health (NSDUH), 21% of individuals aged 18 to 25 report illicit drug use and 40% report binge drinking in the last month (Substance Abuse and Mental Health Services Administration [SAMHSA], 2013), rates consistently higher than in other age-groups (National Institute on Drug Abuse [NIDA], 2014). Moreover, substance use disorders are among the most common mental health diagnoses in this age-group (Davis, 2003). Researchers who examine substance use in adolescents and young adults report that perceptions of reality have a stronger impact on symptoms than objective reality (e.g., Yahav, 2006). This finding may be explained, at least in part, by social norm theory. According to social norm theory, students often overestimate the amount of alcohol they believe their peers ingest and view their peers as having more liberal and accepting views of alcohol use behaviors (Berkowitz, 2004). Proponents of social norm theory hypothesize that students will increase their drinking in efforts to bond with their peers based on their perceptions of peer behavior. The fact that the rates of substance use in adolescence and early adulthood do not

continue into older age-groups highlights the social changes that occur across groups and time. What is acceptable in one social group may be frowned on in another. Binge drinking at a fraternity party may be considered normal, whereas binge drinking at the office Christmas party may not. These differences in group norms encourage behavior changes as individuals age and/or as they move out of one social group and into another. Thus, the way in which we understand and treat adolescent substance use should differ from the way in which we understand and treat adult substance use.

It is important to remember that the social groups with which we identify are dynamic, that is, they are constantly changing. Because of this, there may be times when the norms of one group conflict with the norms of another. If drinking is considered the norm on a particular college campus, yet is forbidden in the Islamic faith, it could be difficult for a Muslim college student at that university to feel a sense of cohesion with both groups. Thus, in order to understand the influence social and cultural groups have on addiction, it is also important to understand the impact of the interactions between the various groups with which one identifies.

Repudiation of Middle-Class Values

The final sociological function of addictive behavior is the repudiation of middle-class values (Thombs, 1999). According to Thombs, drug subcultures have been established and maintained as a method of turning their backs on establishment values. Individuals who use drugs desire to deviate from traditional values and create their own culture that allows and cherishes a different lifestyle.

We have seen that throughout history, some cultures have taken a punitive stance toward alcohol and drug abuse. With this stance come those who wish to rebel against the punitive nature and do things against the grain of normal society. As history has progressed we have seen trends in the groups and places where drug use has been the most prominent. In the past, drug use was most common among the minority ghetto population; however, as the availability of and exposure to drugs has expanded, drug subcultures have evolved as well (Thombs, 1999).

Adolescent Drug Subculture

As stated, one of the more prominent subcultures in today's society is the adolescent drug subculture. As children move into adolescence, the influence of the assorted social groups to which they belong begins to shift from strong family influence to strong peer influence (Borsari & Carey, 2001). As adolescents attempt to foster their own autonomy, they begin to rely on peers as a primary influential factor in their thinking and behavior. Adolescents, when surrounded by peers who approve of drug use, may be more likely to experiment with drugs, even when they come from families who strongly disapprove of drug use. In this sense, adolescents are torn between the parent culture and the youth culture.

Youth culture is characterized by expectations peers have for one another's behaviors

(Thombs, 1999). In the United States, parent culture expects children to avoid drugs and alcohol, a fact highlighted by the legal drinking and tobacco ages. Accordingly, in efforts to foster independence from parents and develop cohesion within their peer groups, adolescents may attempt to deviate from parental expectations. In countries with differing parental expectations surrounding substance use, such as European countries with lower legal drinking ages, adolescent drug subcultures may not be as prominent.
The four sociological functions provide insight into the impact of the macroenvironment on individual addiction. However, it is equally important to note that this relationship is bidirectional, meaning the existence and maintenance of addiction also impact the macroenvironment. The public health model of addiction helps counselors to understand the ways in which individual addiction influences the overall health of society, which emphasizes the potential large-scale social validity of using this model.

Public Health Model of Addiction

The public health model of addiction emphasizes the overarching impact of addiction on the general public, rather than the impact on the individual. According to this model, individual factors are not sufficient for understanding how and why addiction occurs, but rather, the interaction between multiple factors must be considered (Thombs & Osborn, 2013). Holistic explanation of addiction as a public health concern is described using a three-prong approach that includes the interaction between the agent (i.e., substances), the host (i.e., individuals), and the environment (i.e., culture, values, norms). From this perspective, each factor is necessary, but not sufficient on its own, in the development of addiction (Thombs & Osborn, 2013). For example, the agent must be available, but simple availability does not ultimately result in addiction. Rather, addiction occurs when the agent is available *and* specific individual factors of the host (e.g., genetic predisposition, psychological characteristics, attitudes) and environmental considerations (e.g., cultural group, norms and values) interact in such a way as to support addiction.
Because the public health model emphasizes the interaction among the agent, host, and environment, prevention and intervention can occur at any of those levels. As counselors, we may work with an individual in hopes of creating systemic change in the environment. We may also focus on the impact of public policy in order to enact individual change. The goal of the public health model is not to eliminate addiction but to focus on a harm reduction approach that limits the overall impact of addiction on society.
The four sociological functions of substance abuse and the public health model recognize that cultural norms determine, at least in part, what is acceptable behavior and what is pathological behavior. These functions are derived from concepts underlying several sociological theories. The following section briefly discusses each of the theories that influence sociological perspectives on addiction.

Philosophical Underpinnings and Key Concepts of the Theory

History provides a glimpse into past trends that impact current values, norms, and behaviors related to addiction. Equally important in the understanding of the way in which social and cultural factors impact addiction is the examination of theory. Theories assist counselors in comprehending and conceptualizing addiction. They allow for integration of aspects of the human experience that provides counselors with a road map for understanding, interpreting, and treating addiction. Aspects of various sociological theories offer a basis for understanding a sociological theory of addiction. Addiction is considered a social deviance, that is, addictive behaviors are behaviors that stray from acceptable social norms. As a consequence, the sociological theories that help to explain addiction are rooted in the concept of social deviance.

Social Control

Social control theory seeks to explain not why individuals deviate from societal norms but rather why individuals are pulled to conform to societal norms (Goode, 2006). In essence, deviation from social and cultural norms is considered natural and reasonable. When an individual is confronted with the decision to violate a group norm, both inner controls and outer controls come into play (Henslin, 2004). Inner controls refer to an individual's internal sense of morality and conscience, whereas outer controls refer to the influence of the groups with which we identify (Henslin, 2004). According to social control theory, violations of norms occur when an individual does not feel invested in a social group (Goode, 2006). Those individuals who feel a strong sense of connection to a particular social group do not want to jeopardize group cohesion by deviating from group norms. On the other hand, individuals who feel isolated or disconnected from social and cultural groups may be more likely to engage in addictive behaviors, because they feel a weak sense of loyalty to adhering to group norms.

Remember that one social function of substance use is the facilitation of social bonds. It is easy to imagine how an individual who feels disconnected from a social group and subsequently uses substances may continue to use as feelings of connectedness to a new group develop. Use of substances provides the shared experience and connection previously missing from that individual's life. Further, as this trend continues, new drug subcultures are likely to be established. Now not only are individuals increasing social bonds, but they are also going against the norms of the original social group in which no connection was felt.

Social Learning Theory

In opposition to social control theory is social learning theory. Unlike social control theory, social learning theory does not consider deviant behaviors to be natural or understandable. Rather, according to social learning theory, behaviors that violate

norms must be learned (Goode, 2006). As stated, a sociological theory of addiction expands on other theories by recognizing the importance of availability and exposure to substances. The more readily available a drug is, and the more an individual is exposed to drinking or using (e.g., through the media, friend groups, cultural practices), the more opportunity that individual has to learn the positive value of substance use. Consequently, simple exposure to drug and alcohol use is not sufficient to develop an addiction. More important to the learning of a behavior is the perception of the behavior as serving some positive purpose in the individual's life.

> Box 8.2 Substance Abuse and Gender
> Researchers have found differences in the way substance abuse presents across genders. Men are primary abusers of alcohol and are more likely to drink in social situations. Additionally, men have increased rates of externalizing and blaming as compared with women and often experience more legal ramifications due to their using (Briggs, 2012).

Consider Ryan, a young man who grew up watching his father drink alcohol heavily. Ryan was exposed to alcohol use at an early age; however, he was also exposed to frequent arguments between his mother and father, his father's irritable mood, his father's difficulty in getting up each morning for work, and an absence of quality time spent with his father. Despite the early availability and exposure to alcohol in Ryan's life, he may abstain from alcohol use due to the negative associations he has with the drug.

Social Conflict Theory

According to social conflict theory, addiction is related to inequalities that exist between diverse social groups (Goode, 2006). From a conflict theory perspective, the various social groups in existence are in constant competition with one another (Henslin, 2004), and drug and alcohol use is more likely to be sustained in groups of lower class, income, and power (Goode, 2006). Proponents of this theory align with previous beliefs about drug subcultures existing and surviving in minority neighborhoods; however, they fail to take into account current cultural and regional differences that stray from historical trends. In fact, recent researchers suggest that individuals of both low and high socioeconomic status (SES) are at increased risk for developing problematic patterns of substance use depending on the substance. More specifically, individuals of low SES use marijuana at higher rates, whereas cocaine is more prevalent in individuals of high SES (Stone, Becker, Huber, & Catalano, 2012). In addition, being a white male is also considered a risk factor for developing a substance use disorder, disproving the notion that substance use is more common in minority neighborhoods (Stone et al., 2012).

Each of the theories just discussed provides theoretical assumptions as to why addiction is considered a social deviance. They also offer philosophies behind current

perspectives on sociological factors related to addiction. Finally, they present essential ideas to consider when providing counseling to an individual struggling with addiction. Although each theory approaches the way we think about addiction somewhat differently, one thing they each have in common is that addictive behavior is characterized as a deviation from the norm. Norms, however, vary by group and time. Accordingly, norms are socially constructed and are not fixed, and because of their dynamic nature, individual perceptions of norms vary based on personal experience. These realities demonstrate that although one of the main goals of the counselor working from a sociological framework is to understand the client's experience of social and cultural groups, another imperative goal is for the counselor to understand his or her own experience of acceptable norms based on the counselor's identification with social and cultural groups.

How the Theoretical Approach Is Used by Practitioners

One of the main constructs emphasized in sociological theory is the concept of values. Personal, social, and cultural values impact an individual's behavior and are important to consider when working with a client. Further, our own behaviors as counselors are also impacted by the values we have, regardless of their origin; thus, the first step in using sociological theory when working with clients is to "check" our own personal values. Self-awareness of our own value judgments and biases is essential to effective counseling. What values do we hold around addictive behaviors? Where do those values come from? Do they differ if a client is drinking alcohol, using drugs, or gambling? How are our values impacting the way we view the client? Are we eliciting from the client his or her values about the addictive behavior or making assumptions based on our own beliefs? The relationship between client and counselor is interactional. It is based on the interactions between the client and counselor, and that interaction will present differently for each and every client the counselor serves. Awareness of these differences allows the counselor to provide treatment services based on the needs of the client, rather than the assumptions of the counselor. Counselors working in the addictions field often experience what they call client resistance, meaning they perceive the client to be challenging or opposing treatment. From a sociological perspective, resistance may be the result of a conflict between the differing values of a counselor or referral source and client (Thombs, 1999). Clients will be more open to change if the reason for change comes from within themselves rather than from the counselor (Miller & Rollnick, 2013). Motivational interviewing is a technique that assists counselors in eliciting change from the client and avoiding imposing reasons for change (Miller & Rollnick, 2013).

Box 8.3 Managing Values: The Case of Natalie

Many times, clients are referred for services from a third party, such as a family member, the courts, or the Department of Children's Services (DCS).

In these cases, a third set of values comes into the counseling relationship, which can be difficult to manage. For example, reflect on the following:
Natalie presents for counseling for her addiction to opiates with a referral from DCS. The DCS referral states that in order to regain custody of her children, Natalie must remain abstinent from all substances. Natalie reports that she is ambivalent about wanting to discontinue using her drug of choice; however, she passionately states that she wants to do whatever it takes to get her children back.
What value conflicts exist in this situation?
How might you, as the counselor, work with Natalie in accordance with her values?

Another defense mechanism discussed prom-inently in the addictions field is denial. Denial refers to a defense mechanism in which an individual unconsciously refuses to acknowledge something (Kosslyn & Rosenberg, 2004). In addictions treatment, this is often seen in the form of the individual refusing to admit to having a problem with an addictive behavior. From a sociological perspective, rather than viewing denial as a defense mechanism, counselors view denial as the client's refusal to embrace the values of the counselor or referral source (Thombs, 1999).

Addictions counselors who work from a sociological perspective recognize that individual treatment should be multidimensional (Thombs, 1999). In other words, counselors must examine the various factors at play for an individual in order to possess a holistic understanding of the addictive behavior. Factors outside of the individual, including social and cultural factors, must be considered to effectively treat addictive behaviors. Considering such factors can help counselors to understand the *why* behind behavior. If behavior serves a purpose for an individual, it is the job of the counselor to understand what positive purpose addictive behaviors serve for that individual. For example, Irish Catholics are known historically as having higher rates of alcohol abuse (see Chapter 2). On the surface, social norms dictate that this is either “good” or “bad” behavior; however, when culture is considered, the why behind the behavior makes the norm less black-and-white. For Irish Catholics, drinking alcohol was a method of coping with oppression (Thombs, 1999). Similarly, drug dealing as part of gang membership is not valued by a majority of society. When a counselor adopts the values of the majority and does not consider the reasons behind the behavior, he or she may miss the fact that by joining a gang and dealing drugs, the client has gained a sense of community, power, and economic well-being. By ignoring these positive consequences to the behavior, a counselor may encounter resistance when the client's values do not coincide with those of the counselor.

Assessment and Prevention Implications

Sociological theory offers insight into assessment and preventative strategies employed

by counselors. Sociological theory is concerned with socially constructed concepts; thus it is important to consider the social construction of our diagnostic system. When counselors diagnose a client, they are putting a label on that client based on diagnostic criteria. These diagnostic criteria are constructed based on social norms (Thombs, 1999), norms that may or may not reflect the values of the client. Additionally, counselor interpretation of diagnostic criteria is rooted in personal values. Although some might argue it's a bit of a stretch, from a sociological standpoint, diagnoses can be thought of as being based more on opinion than on fact. Labeling a client with a diagnosis can impact the client's self-concept in a way that is in conflict with the values of his or her social group. Self-awareness of our personal values and openness to learning the client's values will impact the way in which we assess and diagnose addictive disorders.

Knowledge of drug subcultures provides an opening for prevention strategies. Adolescents, in particular, are a crucial focus for prevention. The use of drugs and alcohol as a method of fostering cohesion with a peer group is particularly dangerous for adolescents because their brains are not fully developed. This lack of development means that early substance use can affect brain development in a way that leaves adolescents more susceptible to developing a biological addiction in the future (Wilens & Rosenbau, 2013). Early intervention with this more vulnerable population may help to decrease rates of problematic substance use in adulthood. Understanding the social factors involved in adolescent substance use can help prevention efforts to target a specific population by understanding the positive consequences perceived by the group and targeting healthier behaviors to promote group values.

Strengths and Weaknesses of the Theory

Sociological theory rose in acceptance as a method of understanding addiction as researchers began to recognize that biological perspectives did not take into account discrepancies in the way in which addiction manifests across individuals (Goode, 2006). Differences evident in the process and progression of addiction stimulated a need for a more multidimensional approach to conceptualizing client substance use. The emphasis on examining the various factors present outside of the individual that influence internal experiences and behaviors is a main strength of sociological theory. Sociological conceptualizations of substance use allow for treatment that can impact both internal and external aspects of a client's life by broadening the scope of treatment and considering a client's external experience (Thombs, 1999).

Another major strength emphasized by proponents of sociological theory is its transferability across diverse cultures. Sociological theory opens the door for multicultural considerations by examining a client's macroenvironment. The theory is derived from the notion that personal, group, societal, and cultural norms and values affect individual behavior (Thombs, 1999); thus, the very nature of the theory highlights the importance of cultural differences. At the root of the theory, counselors are

encouraged to examine an individual as he or she exists within his or her personal multicultural society and to conceptualize addictive behavior as a function of these social groups. Further, sociological theory requires the counselor to examine his or her own culture and its impact on the counseling process.

As time progresses, society undergoes significant shifts and changes. When these changes occur, oftentimes theoretical underpinnings can become irrelevant. Sociological theory, however, underscores the dynamic nature of society, and in its essence, it upholds the dynamic nature by consistently exploring cultural shifts and their impact on client behavior. For example, when researchers determined that a biological predisposition to substance abuse was not sufficient to explain addiction, sociological theorists filled this gap by examining the role of availability, exposure, and values (Goode, 2006). Recognizing the ever-changing nature of societal beliefs, norms, and values lends sociological theory an appropriate perspective across time, cultures, and individuals.

Despite the noted strengths sociological theory brings to the treatment of substance use disorders, it is hindered by some limitations. First, although sociological theory provides a potential multicultural lens from which to conceptualize clients, it does not provide direct intervention strategies for treatment (Thombs, 1999). Once a counselor begins to understand a substance use problem from a sociological perspective, alternative techniques and interventions are necessary to help in moving a client toward change.

Second, as one of the common goals of individuals seeking substance use treatment is change, it is difficult to instill systemic change with sociological theory (Thombs, 1999). Although social groups and cultures are dynamic, it can be difficult, if not impossible, for one person to change the values and norms of an entire cultural group. Thus, if fostering change means changing group values, change could be unfeasible to achieve.

Finally, sociological theory is solely concerned with extrinsic motivation for behavior, and although intrinsic motivation may be influenced by external factors, counselors must also consider individual factors and internal experiences. Biological and psychological models of addiction should not be discounted but rather taken together with sociological models in order to conceive a comprehensive picture of client presenting concerns.

Case Study Responses

From a sociological perspective, the counselor would explore the various groups and cultures that may influence Gabriel's substance use behaviors. Additionally, the counselor will want to examine the interplay between groups and Gabriel's report of values based on his identification within certain groups. The counselor working with Gabriel would be interested in exploring how Gabriel's association with each of these groups played a role in both developing and maintaining his use of alcohol and marijuana.

Gabriel's identification as biracial allows the counselor to consider knowledge of substance use patterns in both African American and Native American cultures. More importantly, however, the counselor will want to elicit Gabriel's views of the values of those two groups and explore how he navigates potentially conflicting values between the groups. In addition, what perceptions does society have of these two groups that might impact Gabriel's behaviors?

Gabriel reports being raised in a small, rural community. Drug trends vary by region, with marijuana and alcohol being common in rural settings. The counselor will need to consider messages Gabriel received about using alcohol and marijuana from others in his community. If rates of alcohol and marijuana use are high within the community, perhaps Gabriel uses these substances as a way of identifying with his community. If he has witnessed others using alcohol and marijuana throughout his lifetime, his use could be a learned behavior. Gabriel reports two unsuccessful attempts at treatment, so the counselor may consider the resources that are or are not available to him in his community upon discharge. If Gabriel is surrounded by an environment that does not provide the resources or support he needs, his sobriety will be more difficult. However, Gabriel's account of remaining abstinent for 7 weeks due to his involvement in Alcoholics Anonymous suggests some available resources in the community and the importance of this resource to Gabriel's sobriety. His success in AA may imply to the counselor that group cohesion and bonding are important to Gabriel. Finding new groups or new methods of bonding within current social groups may help Gabriel to maintain his sobriety.

Gabriel provides significant detail and information regarding his family, demonstrating the importance of this social group in his life. Gabriel grew up watching his father use substances, so using may be an effort to bond with his father or simply a behavior he learned from him. Gabriel reports not feeling accepted by his father; thus, using substances with him may help him feel more comfortable interacting with him and may increase his feelings of bonding and acceptance when around him. On the other hand, using alcohol and marijuana is not a way of bonding with his niece, which may create a values conflict for Gabriel. From a sociological standpoint, the counselor should attempt to understand the positive consequences of drinking and using drugs in order to better understand Gabriel's values and the purpose behind his behavior.

Gabriel's legal history highlights the role of the law in his substance use. In the eyes of the law, his behavior is considered deviant. Self-identification as deviant, or being labeled by another as deviant, may lead Gabriel to assimilate into the culture of others who are labeled as such. Assimilation into this group can provide him with the group connectedness that he strives to achieve in various aspects of his life.

Finally, Gabriel describes some personal confusion related to his sexuality. He identifies struggles in past relationships with women and is questioning his sexual orientation. Feeling connected to others appears to be important in Gabriel's life. In

terms of his sexuality, Gabriel is feeling disconnected from himself, which makes it difficult for him to identify with a particular group. Part of Gabriel's questioning of his sexuality may be related to conflicting values he holds for himself based on the social factors in his life. Gabriel's use of substances could be a way of coping with his questioning, and the counselor may focus on exploring his values in order to help clarify his feelings.

Despite the depth and breadth sociological theory provides the counselor in conceptualizing Gabriel's substance use problem, the theory is limited in its ability to provide suggestions for direct intervention. Once the counselor fully comprehends Gabriel's use from a sociological standpoint, he or she must use other theoretical techniques to provide appropriate interventions. When choosing interventions, the counselor will want to determine strategies that will maintain the multicultural sensitivity that sociological theory offers. Additionally, Gabriel struggles with co-occurring mental health concerns; however, sociological theory provides little insight into psychological aspects of substance use.

Summary

Sociological theory of addiction is a perspective that conceptualizes client addiction by examining external forces that influence behavior. Proponents of the theory posit that addiction is a function of our social and cultural environments. From this perspective, addiction serves four functions: to facilitate social interaction, to provide a release from social obligations, to promote group cohesion, and to repudiate middle-class values (Thombs, 2006).

Resources for Continued Learning

Books

Capuzzi, D., & Stauffer, M. D. (Eds.). (2012). Foundations of addictions counseling (2nd ed.). Boston: Pearson.

Lewis, T. F. (2013). Substance abuse and addiction treatment: Practical application of counseling theory. Boston: Pearson.

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Websites

National Institute on Drug Abuse: Trends & Statistics: www.drugabuse.gov/related-topics/trends-statistics.

Substance Abuse and Mental Health Services Administration: www.samhsa.gov/topics.

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9 Family Systems Theory

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According to the National Council on Alcoholism and Drug Dependence (NCADD; 2015), addiction is a family disease that affects people of all ages, including young children, adolescents, emerging adults, adult children, spouses, parents, siblings, extended family, and friends. In essence, substance use disorder (SUD) touches the entire family (Lander, Howsare, & Byrne, 2013). Approximately one third of all U.S. households are impacted by addiction (Facing Addiction, 2015). For instance, there are an estimated 8.3 million children below age 18 each year who live in a home where at least one adult has abused or is dependent on drugs and/or alcohol (Substance Abuse and Mental Health Services Administration [SAMHSA], 2009). Children who grow up in a household where addiction is present may experience intrapersonal and interpersonal challenges later in life (Hook, 2012; Lander et al., 2013). Spouses and other family members also may experience stressors as a result of the substance abuse of their partner or loved one (O'Farrell & Clements, 2012) or process addictions (e.g., sex addiction [Ford, Durtshi, & Franklin, 2012; Hentsch-Cowles & Brock, 2013] and gambling addiction [Polychronopoulos, Carlisle, Carlisle, & Kirk-Jenkins, 2014]). Without therapeutic assistance, the financial, physical, and emotional impact of addiction on the person with substance use disorder and their family can endure for decades (NCADD, 2015). Beyond the cost of sustaining an addiction, addictions are expensive for families who incur health care expenses for treatment and who may experience a loss of income from the family member who is actively using or in treatment (Juhnke & Hagedorn, 2006). In addition to potential financial instability, family dynamics and family functioning are likely impaired when a family member has a substance or process addiction (Hook, 2012). Addiction can cause emotional and physical strain on relationships that may lead to family estrangement or relationship dissolution (Hook, 2012; Rowe, 2012).

Conversely, addressing family dynamics and improving family interactions may support the recovery process. Inclusion of families in the treatment process is critical, because there is both a family environment and a genetic component to addictions; these often lead to a transgenerational effect of addiction (Cook, 2007; Lander et al., 2013; NCADD, 2015; Rowe, 2012; Yohn, Bartolomei, & Blendy, 2015). Family addictions counseling typically includes therapeutic goals such as relapse prevention, improved family communication, and reestablishment of trust (Lambert, Carmichael, & Williams, 2016). Whereas a multitude of theoretical approaches can be used for case conceptualization and treatment interventions for clients who have SUD and their families, this chapter focuses on an overview of family systems theory as applicable to

addictions counseling. Related treatment approaches to mediate the long-term harmful effects of substance use and process addictions for families are provided in addition to a response to the case study from a systems theoretical perspective and resources for both clients and professionals.

Basic Tenets of the Theory

Family systems theory (FST) proposes that the system is a whole and that its objects, attributes, and environment can be understood only as a function of the whole system; further, the characters are the sum of the components that belong to the whole of its parts (Gladding, 2014). FST focuses on how individuals relate to and influence one another within a system through a feedback loop, with the intention of systemic change positively promoting behavioral changes in an individual or a family (Lambert et al., 2016). FST focuses on interactions within the family and has much utility in couples or family counseling where a SUD is a presenting concern (O'Farrell & Clements, 2012). "According to family systems theory, a family needs stability, order, and consistency in order to survive and fulfill its function" (Senreich, 2010, p. 428). FST examines the function of the addiction within the family, as well as related family dynamics including family rules, roles, boundaries, problem solving, and communication (Hook, 2012; Miller, 2015). Because FST emphasizes communication as a regulatory process, verbal and nonverbal communications among family members bidirectionally influence the system in a continual feedback loop (Lambert et al., 2016). In sum, behaviors, communications, interactions, and dynamics between family members influence family functioning for better or for worse.

Within a family addiction systemic approach, the primary organizing factor can become the substance abuse and the related system's (e.g., the family) adaptations to and accommodations for the family member with a SUD (Zimic & Jukic, 2012). Identifying and changing family interactions that contribute to or sustain a SUD is key to this theoretical approach (O'Farrell & Clements, 2012). Thus, systemic treatment interventions for SUD focus on "helping the family develop new ways of interacting that improve functioning of family members and support the individual's drug-free lifestyle" (Rowe, 2012, p. 61). FST, regardless of the therapeutic model, suggests that an individual must be conceptualized and treated in relation to how the individual functions within his or her family system (Lander et al., 2013).

Various systemic approaches that stem from FST can be used in addictions counseling, including solution-focused counseling, cognitive-behavioral family therapy, structural family counseling, extended family systems counseling, and modified intergenerational family-of-origin therapy (Juhnke & Hagedorn, 2006). Gladding (2014) included additional suggested family therapy approaches: structural-strategic family therapy, Bowen family therapy, behavioral family therapy, Adlerian therapy, and multifamily therapy. Additional family approaches include strategic, experiential, and multisystemic family systems therapy models (Lander et al., 2013). Cook (2007) also suggested the

use of Bowen family systems theory to assess and treat SUD by individuals as they examine their function or role within their family of origin.
These theoretical approaches can be combined with modalities such as multifamily group counseling or community support groups (Lambert et al., 2016). For more information about common family systems theories, see Exhibit 9.1.

Theoretical orientation	Adlerian family therapy	Multigenerational family therapy	Human validation process model	Experiential/ symbolic family therapy	Structural family therapy	Strategic family therapy
Key figure	Alfred Adler	Murray Bowen	Virginia Satir	Carl Whitaker	Salvador Minuchin	Jay Haley
Focus	Present with reference to the past	Past and present including three generations	Here and now	Present	Past and present	Present and future
Role of therapist	Educator, collaborator	Guide, teacher	Facilitator, model for congruence	Coach, challenger	Promoter of change through enactments	Director of change, problem solver
Role of family	Parents become leaders of their family, change negative patterns	Change the individual with reference to the system	Promote growth and connection, attain congruency in communication	Promote creativity	Promote change in the family structure	Change patterns through interruption
Technique	Constellation, goal development, natural consequence	Differentiation and understanding through the cognitive process	Status quo through chaos to new integrations	Change occurs through therapeutic confrontation	Identification of core negative interactional pattern (CNIP), set boundaries	Action-oriented directives and paradox

Adapted from Lewis, Dana, and Blevins, 2007

Beyond systems theory, there are different approaches to accomplishing therapeutic goals in treatment of the addicted family. For example, within the disease model each family member is encouraged to reflect on his or her own issues (NCADD, 2015). Conversely, the behavioral model focuses on specific behaviors the family engages in that are precursors to the addictive behavior or reinforce use/behavior (Miller, 2015). Interpersonal behaviors that can be addressed in this approach include communication with family members (Miller, 2015). Case conceptualizations and treatment plans can also include an integrative theoretical approach; for instance, both behavioral therapy and systems theory can be used in concert.

Philosophical Underpinnings and Key Concepts of the Theory

One advantage of systems theory is its ability to aid in conceptualizing a multidisciplinary framework for individualized and normative exploration of the relationship between systems and the behaviors they represent (Berger, 2011). Systems theories render the complex dynamics of human biopsychosociocultural phenomena in the natural and human-made environments (Berger, 2011; Gladding, 2014). FST provides such an approach and can consequently be considered an entry a counselor may use that can be conceptualized to work with all individuals of the family system to reframe negative patterns of behavior.

Systemic and Behavioral Theoretical Approach

The family is a system that works systemically on a complex interwoven set of behaviors (Zimic & Jukic, 2012). Behaviors may foster stability in the relationship, and the behavior of substance use may also serve to maintain homeostasis within the family (Miller, 2015). Thus, behavioral therapeutic approaches may be helpful in providing family or couples addictions counseling, whereby relapse prevention is supported through improvements to relationships and communication (O'Farrell & Clements, 2012). In fact, the combination of behavioral and systemic approaches in working with couples and families has been demonstrated to effectively engage the person with a SUD in treatment and improve clinical outcomes with adult clients (Rowe, 2012).

The Center for Substance Abuse Treatment (CSAT; 2004) discussed circular causality, which states that if a member of the family changes his or her behavior it causes others in the same system to have the same effect. When the other members create that secondary change in the pattern, it can perpetuate a negative ongoing sequence of events (CSAT, 2004). This suggests that knowing which behavior came first is unattainable.

Key Concepts

Gladding (2014) reported that families attempt to engage in systemic regulation to maintain balance, or *homeostasis*. Homeostasis is the balance of communication, and with this, when there is a SUD presenting in the family, a predictability of family roles follows (CSAT, 2004). “The idea of homeostasis is key to understanding the effect of SUDs on the family in that each family member tends to function in such a way that keeps the whole system in balance even if it is not healthy for specific individuals” (Lander et al., 2013, p. 196).

The family is a system with a set of *boundaries* organized into a set of subsystems that correspond to current behaviors in the system (Zimic & Jukic, 2012). Boundaries can assist families in differentiating roles and functions of family members, which allows families to function more effectively (Goldenberg & Goldenberg, 2013). Enmeshment occurs when boundaries are too close, whereas disengagement occurs when boundaries are distant (Lambert et al., 2016). Boundaries can differentiate subsystems within the family:

> In a healthy family, boundaries surround the parental subsystem and the child subsystem by keeping them separate. In a family with a parent who has a SUD, boundaries around the parental and child subsystems are typically permeable as the parental subsystem does not function well as a cohesive unit. Boundaries around the family itself are rigid to maintain the family secret of substance abuse. Healthy boundaries are important in the normal development of a family and children. (Lander et al., 2013, p. 196)

When boundaries are not healthy, maladaptive family roles ensue for family members. Sharon Wegscheider-Cruse's (1976) seminal work presented six survival roles that are

widely used today in predicting patterns of behavior (Gladding, 2014; see Exhibit 9.2). For example, healthy families are able to maintain homeostasis with effective boundaries and positive feedback with behaviors, interactions, and communication; whereas families where SUD exists may have to regain homeostasis after substance use ends as a major shift in family roles and dynamics occurs during the recovery process (Lander et al., 2013).

The addict—The person with addiction is the center. Recovery is focused on this person, yet there may be a more prominent person in the family system to involve in treatment.
The hero—The individual who must make the family look good, as if the problem does not exist. Often the oldest child.
The mascot—This is the role of "jester." Can be negative humor that can hinder the recovery process.
The lost child—This family member does not cause problems and avoids conversation about recovery. Instead this member sacrifices self-needs. Often the middle child.
The scapegoat—Often rebellious, he or she will divert attention away from the addiction recovery.
The caretaker—Makes all other roles possible. Keeps homeostasis in the family and will make excuses for behaviors.

Adapted from Gladding, 2014; Murphy, 1984; Satir, 1972; Wegscheider-Cruse, 1976

The by-products of being in a relationship with someone who has an addiction can include enabling and codependence (Hook, 2012). *Enabling behaviors* may become central to the family functioning, with homeostasis developing around that individual's SUD (Zimic & Jukic, 2012). "Enabling is a form of accommodation that protects the individual with the SUD from fully experiencing the consequences of his or her substance use" (Lander et al., 2013, p. 202). As defined by Doweiko (2009), *codependence* describes the overinvolvement or overfunctioning of a partner in a relationship with someone who has a SUD; behaviors such as excessive caregiving of the person with a SUD are often tied to the partner's own self-worth. The concept of codependence is a critical reason for including families and significant others in the treatment process for addictions (Senreich, 2010). Enabling and codependent behaviors can undermine treatment for SUD; thus, a family systemic approach can address these behaviors and engage family members in a healthy recovery process.

There are different approaches in treating the addicted family; however, the definition of family must first be established before an approach can be taken. What is a family? Today's definition of a family is not the same as even one decade ago. Today, we must take into account all of the varying family dynamics in traditional and nontraditional families (see Exhibit 9.3). Along with the definition of family, no one family member will be ready to change at the same time as other family members (Carlson, Sperry, &

Lewis, 2005). Thus, the stages in family recovery are not set in stone and should be considered more cyclical than linear.

Nuclear family—Married father and mother with children.
Single-parent family—One parent solely responsible for care of child or children. Could be biological, adoptive, or kinship.
Blended family—Remarried couple when at least one has a child from a previous relationship.
Dual-career family—Both couples work and commute to their work with a high commitment. Dual-income, no kids (DINK) is a substantial population. Those with dual-career families who have children also thrive in this family style.
Childfree family—Couples who choose not to have children.
Gay/lesbian family—Same-sex couples with or without children from a previous marriage. They may also have had a child together resulting from adoption, artificial insemination, or an arranged planned pregnancy.
Special needs child/children—Families who have children with special needs with physical or intellectual disabilities. Parents suffer grief and loss at having a child with a disability.
Aging family—Headed by at least one parent 65 years of age or older. The families are dealing with their own aging issues and are continuing to care for "boomerang" children or their grandchildren.
Multigenerational family—This household includes a child, a parent, and a grandparent.
Grandparent-headed family—Most of these households are taking care of grandchildren as a result of their own children's divorce, substance abuse, mental health, incarceration, or other issue.
Military family—Military families face stressors such as moving, leave of family members, finding new support systems, and rebuilding a sense of community. This may have a severe impact on developing children in the home. These issues may become more severe if the deployment of the mother or father is dangerous.

Adapted from Gladding, 2014

Stages in Family Recovery

Gladding (2014) posited that SUDs are not an individual issue but a family disease. This suggests that the addiction impacts more than just the person with the substance use disorder. It implies that the family and friends in the ecosystem of the individual are likely to suffer due to the behaviors presented by the addiction, further suggesting that the children of the person with the addiction will suffer the most. This may be extraordinarily devastating to the family, causing a great deal of dysfunction as the members of the environmental unit attempt to navigate their own dysfunction within the family system (Gladding, 2014). When the family member with the SUD becomes willing to enter recovery, the family must learn to rebuild their life; they will have to adopt a new life that may be filled with a great deal of fear coming from a previous one filled with chaos. The stages in family recovery include making initial systemic changes

(e.g., confrontation and/or disengagement), adjusting to early recovery, and maintenance of family change.

Making Initial Systemic Changes

The counselor will engage the family in interrupting negative patterns that have become the norm in family functioning. The role of the counselor will be to aid the family members to work on positive alternatives to negative interactional patterns of behaviors (Carlson et al., 2005).

The goals of family therapy will differ based on the needs of the family during treatment. Prochaska, DiClemente, and Norcross (1992) established the stages of change model: precontemplation, contemplation, preparation, action, and maintenance. This applies to the family system because the family must understand how their loved one will enter into their own stages of change. Conversely, when the family member with the addiction is undergoing change, the family will also enter into a complex set of stages and change. Possible family stages include confrontation, disengagement, adjusting to early recovery, and maintenance of family change.

Confrontation

The confrontation phase, created by Johnson (1973) specifically for alcoholism, is still widely used today. A group of friends, family, and allies gather to confront the identified patient (IP) to encourage treatment. During this phase, the group will present detailed documentation substantiating the weight and effect the IP's substance abuse has had on their lives (Carlson et al., 2005). The purpose of this phase is to help the IP identify that his or her drinking or illicit drug use is the origin of the familial complaint.

Disengagement

If the confrontation phase is not appropriate or was unsuccessful, the initial systemic change may begin with disengagement. This phase encourages the family members to increase self-care in their lives by eradicating the negative interactional patterns around the SUD and the user. This change allows the family to heal, learn positive family functioning skills, and cope with the current situation. This phase may also force the hand of the IP with a SUD to change because his or her codependence support has disengaged (Carlson et al., 2005).

Community Reinforcement and Family Training (CRAFT)

This approach is an alternative to both *confrontation* and *disengagement* (Carlson et al., 2005). Smith and Meyers (2009) describe a key component of CRAFT as working specifically with concerned significant others (CSOs) to elicit positive interactions with their family member who has the SUD. The goal is to ultimately have the IP with the SUD enter treatment, yet initially therapeutic work is done with family member(s) without the person with a SUD present (Smith & Meyers, 2009). The CRAFT approach includes education of the CSO on how to reinforce positive behavior, both his or her own and that of the person with a SUD. For instance, a CSO is taught how and when to

communicate with the family member who has a SUD to foster productive communications and behaviors, rather than engaging in codependent or negative interactions.

For example, CRAFT may teach family members to understand their loved one's triggers to SUD and to learn a motivational approach in which to communicate with their family member with positive interactions. In addition, the approach may teach the family how to use problem-solving skills to increase their own skill set with self-care and positive reinforcement and become aware of safety issues. Problem-solving skills may increase the influence of getting their loved one to become willing to accept the recovery process. One advantage to the CRAFT approach is that skill development can be geared to both the member of the family with the SUD and the family as a whole. This two-pronged approach may increase the likelihood of a positive treatment outcome for the family, given the systemic approach to their treatment with an emphasis on a strength-based, optimistic recovery process.

Adjusting to Early Recovery

The counselor is in a position to aid the family coping with the crisis of raw sobriety. Families have developed a complicated interwoven system of communication around family members with a SUD, and when sobriety is achieved, new problem-solving skills and accommodations need to take place. The complications and negative emotions surrounding the SUD still remain prevalent at this stage, and a new homeostasis may be challenging to attain. To progress, the family must focus on short-term concrete goals by making small and attainable changes in the family structure, allowing family members to address their own problems and concerns (Carlson et al., 2005).

Maintenance of Family Change

Long-term family therapy also has applicability for assisting families making in-depth systemic changes to increase positivity and foster a healthy environment. Many approaches may be useful to comprehensive systemic change. The most frequently used family therapy substance abuse treatment theoretical orientations are Adlerian family therapy, multigenerational family therapy, the human validation process model, experiential/symbolic family therapy, structural family therapy, and strategic family therapy (Carlson et al., 2005).

How the Theoretical Approach Is Used by Practitioners

The counselor must implement the ACA (American Counseling Association) Code of Ethics (ACA, 2014) when working with families impacted by addiction. Counselors must acquire knowledge about SUD within the family context and gain competencies that include a multifaceted integration of therapeutic interventions. The Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment (CSAT; 2006a) developed a set of knowledge, skills, and attitudes that must accompany the work of a counselor working with families suffering through the disease of addiction

based on four transdisciplinary foundations and eight practice dimensions. In addition, each competency has a set of knowledge, skills, and attitudes that must be understood to be efficacious in treatment, and these competencies are embedded within transdisciplinary foundations and practice dimensions (CSAT, 2006a).

Transdisciplinary foundations

All treatment providers, despite the field of origin, must have an underlying understanding of addiction, which includes the current and cutting-edge evidence-based models and theories and the wide-ranging effect substance abuse disorders have on the family system. Professionals must have firsthand knowledge of the social atmosphere that affects the treatment and recovery process for the individual and his or her family as a whole (Perkinson, Jongsma, & Bruce, 2014). They must also be able to tailor the needs of the client and family with an individualized plan with a variety of strategies to face all challenges related to changing negative behaviors (CSAT, 2006a; Perkinson et al., 2014). CSAT (2006a) proposed four transdisciplinary foundations that underlie all addictions counseling interventions: understanding addiction, treatment knowledge, application to practice, and professional readiness.

Understanding addiction

SAMHSA recommends that a counselor understand addiction, including knowledge and application of both theoretical models applicable to family addiction treatment. The counselor must be open to theoretical orientations that differ from his or her own viewpoint and appreciate the complexity of addiction as it afflicts a family system. Additional competencies include recognizing the complex context in which substance abuse exists: culturally, economically, socially, and politically (CSAT, 2006a).

Treatment knowledge

Counselors need to explore the resiliency factors, as well as risk factors, within an environment of an IP with a SUD. The counselor should understand the impact of a psychoactive substance on emotional and physiological responses during the recovery process (Perkinson et al., 2014). Likewise, counselors need to know how to tailor and implement comorbidity treatment when SUD occurs alongside other medical and/or mental health issues. In order to best provide individualized services, a full evaluation must occur prior to proposing a judgment of a clinical evaluation. It should be known that an interdisciplinary team must be involved in the evaluation process to ensure differentiation between SUD from other mental health or medical conditions (CSAT, 2006a). Further, a full medical exam is recommended to evaluate possible side effects from SUD (e.g., liver disease, malnutrition) or to discern if the person with a SUD has been consciously or unconsciously self-medicating for a mental or physical impairment. Family involvement, if at all possible, may be helpful to provide relevant information for the assessment process, given that the IP with a SUD may not have full memories or accurate timelines of symptoms (Perkinson et al., 2014).

Application to practice

Counselors must understand the current diagnostic criteria for SUD (American Psychiatric Association [APA], 2013) in addition to using placement criteria for appropriate treatment services for SUD based on severity level (CSAT, 2006a). Furthermore, treatment approaches need to be matched with the IP's current stage of change (CSAT, 2006a; Prochaska et al., 1992). Likewise, family counselors continually can evaluate the present stage of change for the system as a whole.

Professional readiness

Counselors must customize treatment interventions based on the cultural background of the client and his or her family. Family counselors may encounter family systems that include multiple cultures, races, religions, socioeconomic status (SES), and ethnicities. The professional must be willing to attend supervision, understand policies and procedures for working with clients through crisis, and be open to participate in interventions approaches. The professional must also understand that he or she must adhere to all ethical and professional standards that apply to the professional's field of origin (CSAT, 2006a).

Counselors should be aware of evidence-based practice and requirements/limitations that may accompany use of health insurance. Whereas the counselor can certainly be an advocate for IPs with a SUD to receive treatment, family counselors also can coach family members to become advocates when seeking coverage of full treatment. Additionally, family counselors can provide low-cost treatment alternatives and support group community resources to support the IP and family during the recovery process (CSAT, 2006a).

Practice dimensions

As previously mentioned, there are eight practice dimensions developed by CSAT: (a) clinical evaluation; (b) treatment planning; (c) referral service coordination; (d) service coordination; (e) counseling; (f) client, family, and community education; (g) documentation; and (h) professional and ethical obligations. Practice dimensions depend on a counselor's success in his or her ability to gain the competencies that underlie that dimension (CSAT, 2006a). Further, CSAT (2006a) states that every dimension is required in order for a treatment provider to be effective with a client with an addiction or their family. For the purpose of this chapter, these eight practice dimensions are discussed from the perspective of counselors who provide family addictions counseling using a systemic approach.

Clinical evaluation

Screening is the course of action taken as the counselor, the client, and other concerned family or individuals review the immediate issue, symptoms, or other relevant information to determine the most efficacious course of action (CSAT, 2006a). “The earlier we can intervene in the progression of an SUD, the better the outcomes for all

family members" (Lander et al., 2013, p. 204). Assessment is ongoing where the counselor communicates with the client, agencies, or other concerned family and/or individuals for evaluation and treatment planning of the client's progress (CSAT, 2006a).

Treatment planning

The customized treatment plan is a comprehensive written document that identifies the treatment goals in measurable, attainable, and time-sensitive steps that have written expected outcomes. In addition to specifying the SUD and related issues for the individual, family relational issues, family structure, and environment can also be included (CSAT, 2006a). Miller (2015) suggests that the counselor ascertain how substances are used by the family system before selecting the appropriate intervention. Counselors can incorporate stages of change and treatment implications for the client and family as part of the treatment plan (CSAT, 2006a).

Referral service coordination

Counselors use the natural support systems and community resources to accomplish therapeutic goals set in the treatment plan. Further, counselors need to be aware of community resources for all family members. An interdisciplinary process and collaborative relationships with other agencies will assist the client and his or her family to receive comprehensive treatment services and support. Counselors may need to serve as advocates for clients and families to navigate these external resources for systemic interventions (CSAT, 2006a).

Service coordination

Counselors are not typically tasked with the role of case management. However, they do have a unique opportunity to coordinate services provided to clients and families impacted by SUD. This collaboration with other providers and agencies can promote a coordinated effort throughout clinical evaluation of the client and family, treatment services, and ancillary and postdischarge resources to maintain recovery efforts (CSAT, 2006a). Counselors can shift some of the service coordination to clients and families to educate and empower them to engage with their treatment team and community resources for long-term management of the SUD in remission and the corresponding lasting consequences.

Counseling

Evidence-based, theory-driven counseling should be a cooperative process that drives the client's progress toward individual and family treatment goals. When developing short-term objectives, the client and family's immediate needs should be incorporated. Family addictions counselors need a working knowledge of (a) transference, countertransference, and vicarious trauma; (b) the stages of change model; (c) the family interactional patterns on substance abuse; (d) how substance abuse affects the family patterns; and (e) promoting positive client behaviors and changes while discouraging

negative behaviors. Counselors may employ a systems theoretical model, basic attending skills, motivational interviewing, crisis management, and behavioral principles (CSAT, 2006a). Finally, counselors should continue to evaluate which theoretical approach will best support clients with a SUD and the family through recovery and beyond (Lawson, Lambert, & Gressard, 2011).

Client, family, and community education

The client, family, and community education is the process of providing families and significant others with information on the risk factors related to their loved one's substance abuse, as well as resources to aid in their own recovery process. In large part, families need to understand the integral role they play in recognizing the signs of active SUD, seeking and obtaining treatment, and nurturing the recovery process. Counselors can incorporate families in developing culturally sensitive environmental strategies and relapse prevention plans, in conjunction with a continuum of maintenance care that supports both the individual with a SUD and the family (CSAT, 2006a).

Documentation

Counselors are required to document treatment from the time of intake to discharge. Recording treatment goals and progress can facilitate treatment collaboration, yet all regulations and ethical guidelines must be maintained to ensure confidentiality (CSAT, 2006a). When the IP with a SUD is a minor, counselors must pay special attention to state and national regulations as they pertain to parents' rights to access adolescent treatment files (Lambert, 2011).

Professional and ethical obligations

The counselor will understand the obligation of adhering to and accepting ethical and behavioral standards of conduct set forth by the governing bodies of counseling and will engage in continuing professional development related to both family counseling and substance abuse counseling to ensure that he or she is operating within his or her scope of practice (ACA, 2014; CSAT, 2006a). In other words, counselors who provide family counseling to families impacted by addictions must have training in both substance abuse and family counseling treatment strategies (Miller, 2015). Additionally, professional counselors subscribe to the notion of client autonomy (ACA, 2014). From a systems perspective, the client is the entire family (Corey & Corey, 2011). Thus, a family addiction counselor may feel torn honoring autonomy when the client who is the IP with a SUD and the client's family have different treatment goals. Thus, counselors must be aware of clients' rights and responsibilities regarding care (CSAT, 2006a). When ethical dilemmas arise for the family addictions counselor, supervision, consultation, and continuing education prove invaluable resources (ACA, 2014; CSAT, 2006a).

Children and Adolescents

When working with families, the counselor may have to shift treatment approaches

based on which family member has the SUD. For example, the behaviors of the family are significantly different if the parent is the client presenting with the SUD than if a child or adolescent is the identified client with a SUD (Lander et al., 2013). When a parent has a SUD, children are often parentified and take on the adult role of caregiver for themselves, younger siblings, and even the parent with a SUD (Gladding, 2014; Lander et al., 2013; Sang, Cederbaum, & Hurlburt, 2014). In the short term, the parent-child role reversal can cause inequilibrium within the family system, with children responsible for life tasks beyond their years (Lambert et al., 2016). In the long term, children who step into this adult role before they are developmentally ready to do so may have challenges throughout their life establishing healthy boundaries and losing self to take care of others' needs (Lander et al., 2013). Furthermore, counselors should remember that those children who grew up within a family where a parent had a SUD are more likely to develop a SUD themselves, given the transgenerational effect (Cook, 2007; Lander et al., 2013; NCADD, 2015; Rowe, 2012; Yohn et al., 2015).

Box 9.1 Class Activity: Family Addiction Genogram

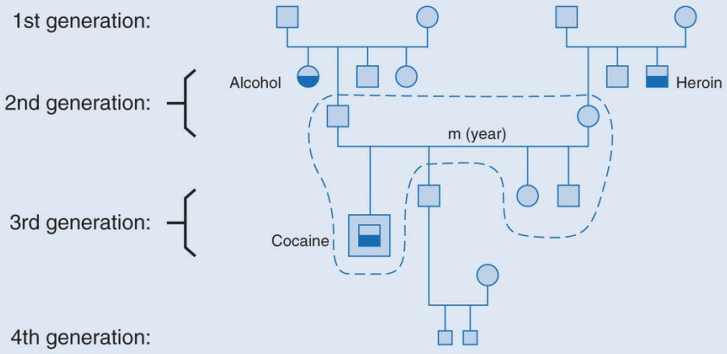
Family genograms provide a pictorial representation of family structure and can include additional information such as family interactions, mental health issues, and physical health issues. Often clients, and students, are surprised at the prevalence of addiction in one's extended family after conducting this exercise. In addition to including typical genealogical data (i.e., births, marriages, divorces, and deaths), develop a family genogram for your own family and include denotations for estrangement, conflicts, and other family interactions. To denote addiction, blacken the lower half of the square or circle (Cook, 2007). If a person is in recovery from the addiction, only blacken one fourth of the lower portion of a square or circle. For those unconfirmed cases of addiction, use diagonal lines to shade in the lower half or fourth of the bottom. Be sure to specify any deaths that were related to substance use or a process addiction. Interview family members and fill in as much information as possible. Please see the following formatting guide, typical symbols used, and a sample genogram completed using a fictitious family.

Format and Symbols for Family Genogram

The genogram is useful for engaging the client and significant family members in a discussion of important family relationships. Squares and circles identify parents, siblings, and other household members, and an enclosed square or circle identifies the client. Marital status is represented by unique symbols, such as diagonal lines for separation and divorce. Different types of connecting lines reflect the nature of relationships among household members. For instance, one solid line represents a distant relationship between two individuals; three solid lines represent a very

close relationship. Other key data, such as arrest information, are written on the genogram as appropriate.

Format for Family Genogram

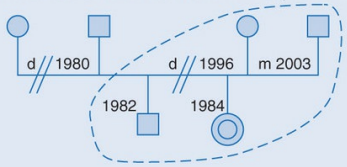


Symbols Useful for Genograms

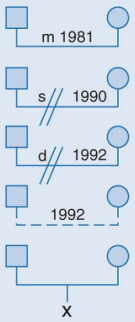
Symbols

- = male
- = female
- = client
- = alcohol or drug abuse (indicate drug of abuse)
- = mental or physical illness
- = alcohol or drug abuse and mental or physical problems
- = deceased

Members of client's household (dotted lines):

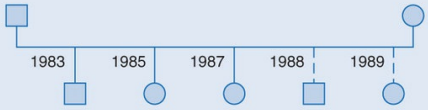


Relationships



- Marriage (give year)
- Marital separation (give year)
- Divorce (give year)
- Living together relationship or liaison (give year)
- Induced abortion

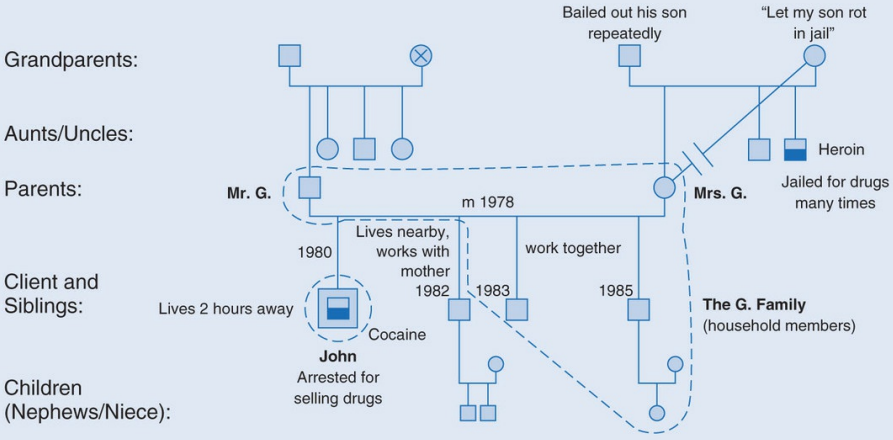
Children: List in birth order with birth year
Adopted or foster children = dotted line
Note any changes in custody



Family Interaction Patterns (nature of relationships)

- Distant
- Very close
- Estranged/cut off
- Conflictual
- Fused and conflictual (a bond of ongoing conflict that is mutually satisfying and/or rewarding)

Client John G. and His Family



Source: CSAT, 2006b.

When adolescents are the identified client with a SUD, the focus shifts. Similar to with adults, a combined individual and systemic treatment approach can lead to positive treatment outcomes for adolescents (Rowe, 2012). In a study examining the effectiveness of individual cognitive behavioral therapy and multidimensional family therapy, the combination of both approaches led to sustained long-term reduction of drug use and less impairment for adolescents when compared with those who only had the individual cognitive behavioral therapy (Liddle, Dakof, Turner, Henderson, & Greenbaum, 2008). Beyond behaviors and family functioning, environmental factors contributing to family stress also need to be accounted for in the case conceptualization and treatment plan for adolescents with a SUD, because myriad stressors (e.g., financial difficulties, marital conflict/divorce, relocation, chronic illness) could be a risk factor for adolescent substance use (Sang et al., 2014). Oftentimes, family circumstances are beyond the control of the adolescent, which leads to further complications when providing services for a minor. Parents also may feel helpless or at a loss for how to help their adolescent or emerging adult with a SUD, and they may end up enabling the behaviors by eliminating natural consequences of the SUD. In addition to parents being involved in adolescent-focused family therapy, parents may need to do their own therapeutic work either in individual sessions or through family 12-step programs (e.g., Al-Anon, Nar-Anon) for parents to learn "they did not cause the SUD, nor can they control it or cure it" (Lander et al., 2013, p. 202).

Trauma

Trauma often accompanies addictions; thus, counselors may need to include processing the trauma as a family therapy treatment goal (Hook, 2012). By doing so, counselors can assist families to reauthor the narrative of the trauma, as well as to develop coping and relaxation skills through the implementation of trauma-focused family cognitive-behavioral therapy in relation to the addiction (Lambert et al., 2016). Furthermore, families may have accrued multigenerational trauma along with transgenerational substance use (Lander et al., 2013).

Strengths and Weaknesses of the Theory

One major strength of family systems theory is that the approach can be used with individual clients and families in case conceptualization (Lambert et al., 2016). When working with a family, the identified client may or may not be the person with the addiction. For instance, a counselor may be working with a child whose parent has a substance use disorder. Alternatively, parents may seek assistance in help with their adolescent who has begun using a substance or engaging in unhealthy behavioral patterns (e.g., overuse of the Internet, gambling). Likewise, one person of a couple may seek counseling services after learning that his or her partner is engaging in repeated sexual behaviors on the Internet or with another person outside of the couple

relationship.
In general, treating the entire family in session allows for a richer understanding of multiple perspectives, which may lead to enhanced and expedited treatment outcomes (Lambert et al., 2016). Similarly, Senreich (2010) found that LGBTQ (lesbian, gay, bisexual, transgender, and queer or questioning) clients who invited their partner to treatment were more apt to complete the treatment program, have a higher rate of abstinence at the end of treatment, and view treatment more positively than those LGBTQ clients who did not invite their significant other. Family members can serve as key motivators and supports for a client to engage in treatment and continue in the recovery process (Hook, 2012).
However, from a strength-based counseling approach, the client with an addiction and counselor can collaborate on selecting family members to include in session who are able to proactively participate in treatment and be supportive of the recovery process (Miller, 2015). For example, family members who are actively using substances themselves may elicit a relapse for the client (Lander et al., 2013). Family members can be triggers in and of themselves; they may be unwilling or unable to contribute to the counseling process. Further, "family members may inadvertently sabotage treatment with their own behaviors as they respond to the change in the individual using substances. These behaviors can be seen as an attempt to maintain the comfortable equilibrium of the system because as one person changes it upsets the equilibrium of the whole family system including extended family relationships" (Lander et al., 2013, p. 197). Thus, a challenge with FST is incorporating family members in treatment who will readily engage and not compromise the recovery efforts.

Case Study Responses

Gabriel and his family would benefit from a counselor who provides family addiction counseling using a systemic approach. This is because Gabriel's substance abuse is not an individual issue but a family disease that has impacted many generations in his family. Given this, family systems theory can be used to conceptualize dynamics between Gabriel's family members and among his different systems (interpersonal, work, school, community) to understand the whole system regarding Gabriel's substance abuse. The maladaptive homeostasis in the family has riddled the family for years as Gabriel grew up in a household where substance use was the selected method for dealing with problems. This has resulted in intrapersonal and interpersonal challenges in his life as Gabriel has had limited healthy models of communication, decision making, and problem solving.
Gabriel's family members are also experiencing stressors as a result of his substance abuse, particularly his mother, sister, and niece. Thus, the family functioning within his immediate family and lack of personal relationships are impaired due to his substance addiction. As a result, Gabriel's addiction is causing emotional and physical strains on his family and friends that is leading to estrangement from both groups. Whereas

Gabriel exhibits strength in recognizing the need to address his addiction, his systems seem to have historically enabled his behavior and may have contributed to his relapses.

In working with Gabriel using family systems theory, the counselor would need to address his family dynamics and work on improving family interactions with his parents, sibling, and niece. Transcending the development of Gabriel's family dynamics and interactions is the objective of establishing homeostasis for his family. This includes examining trust levels among his immediate family members to ascertain sources of insecurity, anxieties, and lack of confidence in each other; assessing communication patterns and improving communication channels; understanding maladaptive boundaries that have fostered enmeshment and disengagement; and empowering his family members to gain insight into their role in his relapse prevention. Working toward a healthy homeostasis will allow each of Gabriel's family members to understand how they function in the whole system, resist enabling and codependent behaviors, and identify their role in contributing to a balanced family system.

Whereas several family system theoretical approaches can be considered when working with Gabriel, the following is an implementation of the practice dimensions developed by CSAT. When these dimensions are used, family systems therapy will be most effective in addressing Gabriel's addiction. In conducting a clinical evaluation screening of Gabriel, it would appear the immediate issue is the family's dysfunctional state and inability to address depressive symptoms that have plagued the family for generations. As a result, the family seeks out unhealthy ways to survive and/or cope: (a) Mom enabled Gabriel's father while married, (b) Dad uses alcohol and drugs, (c) his sister seeks out men with emotional issues, (d) several family members are substance users, (e) Gabriel has multiple unhealthy relationships with women, and (f) Gabriel has self-medicated with marijuana and alcohol—both of which are depressants—for years. Gabriel and his sister have been most vulnerable because they were children of a father who had a substance use disorder, which likely caused them to poorly manage their own dysfunctions within this family system. Furthermore, additional family addiction dynamics to consider are the role race, ethnicity, cultural values, geographical location, gender, and spirituality may play in the familial dysfunctions and depressive symptoms.

When developing a treatment plan for Gabriel and his family, we must consider how and when substances were used and how and when other unhealthy behaviors were used by Gabriel, his father, mother, and sister, and others in his family system so appropriate interventions can be made considering the whole system. Based on this, (a) measurable, (b) attainable, and (c) time-sensitive short- and long-term treatment goals would be developed for Gabriel and his family and implemented via regular and ongoing counseling. For family recovery, the counselor will need to build a relationship with Gabriel and each family member, while also sharing clinical knowledge of family addictions via psychoeducation throughout the stages of counseling. This is important in

that both environmental and genetic predispositions impact Gabriel in his unhealthy coping mechanisms. These family sessions may initially include only Gabriel, his mother, and sister but eventually could include his father, if his father does not compromise the recovery efforts. His niece may be included as appropriate in sessions; throughout treatment she may also serve as a primary motivator because she is the one person with whom he consistently attempts to abstain. Beyond the initial inpatient substance use treatment for Gabriel, short-term family goals include building trust, improving communication, establishing adaptive family roles, developing routines (including at home or via volunteering, school, or work), establishing relationships with other healthy individuals, and engaging in physical activities to stimulate the biological component of the biopsychosociocultural human nature.

Long-term family goals include obtaining outpatient substance use treatment (including individual and family sessions), abstaining from substances, maintaining healthy homeostasis, and using community resources like support groups, mentors, and sponsors. In relation to maintaining his sobriety, Gabriel also would benefit from processing his own identity development as related to his sexuality, ethnic background, and cultural beliefs, while also considering the role of family in fostering or prohibiting his sexual identity. Understanding who he is as a person, as a family member, and as a member of his community may help him address struggles that trigger his substance use. This individual insight could then contribute to family insight regarding any collective cultural dynamics the family needs to process as a whole system.

When assessing Gabriel's natural support systems and community resources we can see that Gabriel's mother is already committed to the family's recovery by attending Al-Anon meetings and trying to develop healthier boundaries with his substance use behavior. Gabriel's niece can also serve as leverage for Gabriel to feel unconditionally loved while also committing him to extracurricular activities that keep him away from substances and more physically active. In addition to inpatient and outpatient substance use treatment, support groups in the surrounding Appalachia area should be identified, which would allow Gabriel to experience universality and gain support from others. Gabriel could attend support groups related to his own addictions (e.g., Alcoholics Anonymous, Marijuana Anonymous, Sex Addicts Anonymous), as well as Adult Children of Alcoholics. Identifying ways to give back to the community and having employment in a healthy environment that is considerate of his past legal challenges will also give Gabriel more routines and less downtime to use substances. Additional counseling may be needed for co-occurring disorders if the anxiety and obsessive-compulsive symptoms remain following a period of sobriety, and the family can support his treatment for those disorders, which may in fact be additional triggers for his substance use. To maintain Gabriel and his family's recovery efforts, the counselor should collaborate with those who are part of the treatment process to foster transparency and coordination from beginning to end. We would also empower his

mother and sister to support these coordination efforts, for them to have buy-in and feel empowered in the treatment process for Gabriel. The latter is especially important with the family systems approach, because his family will play a critical role in long-term management of Gabriel's relapse prevention.

However, in order for family systems therapy to be effective with Gabriel's addiction, the family needs to establish stability in their daily routines, have a sense of order in roles and responsibilities at home, and strive to be consistent in their coping mechanisms to prevent triggers. Resources and commitments are needed by the whole system for this approach to be most effective for Gabriel, and ideally, all his family members need to be ready to change. Gabriel's father may be the outlier in the family system; thus we may see family recovery as more cyclical than linear until his father is committed to the recovery process as well. In addition, with Gabriel's commitment, his family will most likely have to adjust to a different lifestyle, which could provoke fear associated with change. Unfortunately, if the family continues to accommodate Gabriel in his substance use, negative family interactions will only intensify and the family system will not thrive.

The strength of family addiction counseling using a systemic approach is that a multidisciplinary framework can be used when conceptualizing Gabriel and his family's dysfunctions. All aspects of Gabriel's environment are considered in the assessment and treatment in order for the functions of the addiction to be considered in context. By seeing Gabriel's addiction as a family addiction, several perspectives of his recovery-committed family members are allowed, which expands and perhaps even expedites the next course of action to help Gabriel transition into recovery and prevent relapses.

Summary

Addictions impact the entire family system. Counselors who provide services to those with SUD must consider the reciprocal relationship between family genetics and environments, as well as how an individual's family can potentially impact treatment positively or negatively (Lander et al., 2013). Family systems theory provides a model for conceptualizing the family roles, rules, and interactions that influence treatment for both the individual with a SUD and the family. Families should be encouraged to take an active part in the treatment and recovery process when it is beneficial to clients who have a SUD and promote the maintenance of healthy behaviors, reactions, and interactions (CSAT, 2006a). The stages in family recovery, treatment interventions, and ethical challenges were discussed from a systems perspective.

Resources for Continued Learning

For Families

Adult Children of Alcoholics: www.adultchildren.org.

Al-Anon & Alateen: www.al-anon.alateen.org.

Co-Anon (cocaine): www.co-anon.org.

Codependents Anonymous: http://coda.org.
Families Anonymous: www.familiesanonymous.org.
Gam-Anon (gambling): www.gamblersanonymous.org/ga/content/gam-anon-help-family-friends.
Nar-Anon Family Groups (narcotics): www.naranon.org.
National Council on Alcoholism and Drug Dependence: www.ncadd.org.
Substance Abuse and Mental Health Services Administration. (2008). *What is substance abuse treatment? A booklet for families.* http://store.samhsa.gov/product/What-Is-Substance-Abuse-Treatment-A-Booklet-for-Families/SMA14–4126.
Substance Abuse and Mental Health Services Administration. (2013). *Family therapy can help: For people in recovery from mental illness or addiction.* http://store.samhsa.gov/product/Family-Therapy-Can-Help-For-People-in-Recovery-From-Mental-Illness-or-Addiction/SMA15-4784.
S-Anon (sex addiction): www.sanon.org.
Substance Abuse and Mental Health Services Administration: http://recoverymonth.gov.

For Counselors

American Association for Marriage and Family Therapy: www.aamft.org.
Center for Substance Abuse Treatment: www.samhsa.gov/about-us/who-we-are/offices-centers/csat.
International Association of Addiction and Offender Counselors (IAAOC): www.iaaoc.org.
International Association of Marriage and Family Counselors: www.iamfconline.org.
National Association for Alcoholism and Drug Abuse Counselors: http://naadac.org.
National Center on Substance Abuse and Child Welfare (NCSACS): http://ncsacw.samhsa.gov.
National Institute on Drug Abuse: www.nida.nih.gov.
National Registry of Evidence-Based Programs and Practices: www.nrepp.samhsa.gov.
Substance Abuse and Mental Health Services Administration: www.samhsa.gov.
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Here are a few genogram software programs:
www.genogramanalytics.com

www.genopro.com/genogram
www.smartdraw.com

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10 Transtheoretical Model for Change

Daniel Gutierrez
Astra B. Czerny

It is hard to imagine that any form of addiction counseling could be successful without the client experiencing some kind of transformational change. Change is essential to the recovery process, but what exactly contributes to a client's ability to change? Whereas it is true that life involves a certain amount of change whether it is wanted or not, it is also true that there is much in our clients' lives that is beyond their ability to change or control. Harnessing the ability to engender change in our clients is ultimately what counseling and therapy is all about.

The question of what exactly contributes to the *intentional* process of change is one that researchers Prochaska, Norcross, and DiClemente (1994) have spent much of their lives examining. Their six-stage theory of change, often referred to as the stages of change model, is more widely known as the transtheoretical model (TTM), aptly named because the model is not theoretically dependent. Rather, addictions counselors can use it across a broad spectrum of theoretical orientations. The premise of the model is that the right kind of change can happen when an individual is socially, psychologically, and behaviorally ready for it. As such, a counselor's ability to gauge appropriately the level of readiness for change that a particular client might demonstrate is an important part of this theory.

Basic Tenets of the Theory

Addiction counselors have used the TTM to help clients overcome their problems and transform their behaviors (DiClemente & Prochaska, 1998; Prochaska, DiClemente, & Norcross, 1992). TTM is composed of six stages of change readiness essential to the process of change. Each of the stages also includes processes of change that contribute to change progress. The processes of change are addressed in more detail later in this chapter. Briefly, however, the processes of change are the interventions therapists use to elicit change. These processes help the client address the tasks needed for the client to move from one stage of change to the next. Accordingly, as clients move through the stages, the therapeutic relationship also deepens (Prochaska & Norcross, 2001). The client is encouraged to examine his or her own behavior through the processes used by the counselor; the counselor's stance is nonjudgmental, supportive, and caring. Thus, the TTM is helpful as clients address their problems and enhances the therapeutic relationship regardless of theoretical orientation used by the counselor.

The stages are *precontemplation*, *contemplation*, *preparation*, *action*, *maintenance*, and *termination*. Each stage is an important part of the process and cannot be skipped over. Whereas some individuals might experience the stages as linear (transitioning from one stage to the next sequentially), it is more likely that individuals will experience the stages as being recursive in nature and that previous stages may need to

be revisited before the ability to move permanently to the next stage is achieved. It is also possible that an individual will be at a different stage of change for different problems simultaneously. Regardless, understanding this model can help individuals (and counselors) navigate the process of change regardless of their stage.

Precontemplation

The first stage, precontemplation, is essentially the lack of awareness that a problem exists. Precontemplators do not intend to change because they do not think they have an issue that needs addressing. Resistance to change is at the heart of this stage. Precontemplators deny having a problem. If an individual in this stage presents for therapy, it is often because friends and family members have coerced or nagged the individual into going. Often, they simply want the finger pointing or criticizing to stop. Precontemplators will work very hard to resist change and stay in a place of ignorance (Prochaska et al., 1994). They will avoid conversations about the problem, they will disregard the information presented about the problem, and they will, in general, do everything they can to stay in a place of blissful denial that a problem exists. In fact, many precontemplators think others are the problem and will work hard to get others to change rather than facing the need for their own change.

Conversely, it is possible to encounter some people in the precontemplation stage who are willing to admit that they *wish* they could change without having any intention or commitment to do so. In general, if clients express that they may have some faults, but that there is nothing they can do, then they are in the precontemplation stage. If a precontemplator manages to change his or her behavior at all, it is usually to appease the criticisms of others (Prochaska et al., 1992). Once that stops, however, precontemplators often quickly return to their previous behavior(s).

Contemplation

Contemplation is the stage in which the awareness of the problem has shifted. Contemplators know there is a problem. They also are able to admit that they want the problem to change. In general, though, they are not ready to take those steps. You may hear an individual in the contemplation stage say something like, “I am so tired of this,” or “I can't take it anymore.” Contemplators know that at some point in the near future they will need to address their problem. Because of this, they often spend time trying to understand their problem by gathering information, weighing the pros and cons of how to address it, examining the energy needed to accomplish change, and in general talking about change. However, they are not ready to make a commitment. Contemplators know what they need to do; they just are not ready to do it.

In fact, some contemplators can spend years in the contemplation stage. This is typical. Sometimes individuals might fear that they will not be successful if they begin to take the necessary steps to change. Others spend so much time investigating change options that they inadvertently remain stuck on the problem rather than focusing on a solution.

Individuals who successfully move out of the contemplation stage begin to do two things differently. First, they begin to think about solutions rather than problems, and second, they begin to be more focused on the future than on the past (Prochaska et al., 1994).

Preparation

Individuals in the preparation stage have made a commitment (intention) to taking action (behavioral criteria) at some point in the next month. They may also be those individuals who have unsuccessfully taken action at some point in the previous year and are now ready to do so again. That does not mean that these individuals might not still have some ambivalence that needs to be resolved regarding their commitment to change. For example, if a man decides to quit smoking on Monday, he may still spend significant time and energy between now and Monday convincing himself that he is doing the right thing.

Some individuals in the preparation stage have already made slight behavior modifications, such as decreasing the number of video games they play or limiting the time they spend online. Awareness of the problem in the preparation stage is high, and many individuals are eager with anticipation. It is important not to underestimate the value of adequate preparation, however. Individuals who spend the necessary time preparing and planning for their desired change are better equipped when temptation occurs.

Action

The action stage is a busy one. In this stage, individuals modify their behaviors and environments to achieve the desired change. The action stage demands high energy in terms of outward behavior, time, and commitment. The stage garners the most attention and praise from others. It is important to remember, however, that individuals have invested significant time and energy into reaching the action stage of change even if that is not immediately visible. In addition, counseling programs that do not take into consideration the steps necessary to reach the action stage (i.e., programs that are geared to individuals who have already reached the action stage) may be disappointed when individuals are unable to maintain change or behavior modification simply because the program failed to meet them at their stage of readiness. One should remember that whereas praise from others in the action stage is important, it might be even more needed as individuals move from precontemplation to contemplation or from contemplation to preparation.

By definition, individuals are considered to be in the action stage if they have modified their behavior for anywhere from 1 day to 6 months. Whereas the outward appearance of change is the hallmark of this stage, other changes are occurring as well that are important to mention. Individuals in this stage continue to increase and change their awareness of their problem; their self-image, emotions, thinking, and self-esteem are also changing. Whereas this stage is important in terms of outward behavior and

transformation, it is by no means the end of the change process.

Maintenance

The importance of the maintenance stage cannot be overstated. For some, this stage may last 6 months, whereas for others it will last a lifetime. The maintenance stage is challenging, because in this stage individuals must work to prevent slips and relapses. This stage is a continuation of the change process. Change does not cease to occur in the maintenance stage; rather, new behaviors are continuously adjusted to minimize the chance of relapse. For some it is the most difficult because it is in this stage that the learning and awareness from the previous stages must be consolidated and internalized. Relapse may be inevitable for some during the maintenance stage. It is important here to consider the difference between a slip and a relapse. A slip is less serious in that the negative impact on the individual is not devastating. The individual can quickly recover and return to the action or maintenance stage. Relapse, however, is the return to the addiction. Prochaska et al. (1994) prefer the term *recycle* as opposed to *relapse*. Recycle implies that learning and new opportunities are possible and can be followed by action. This is an important distinction given the recursive nature of the change process.

Termination

Termination is the ultimate goal for those seeking change. In termination, the former behavior or addiction no longer presents a challenge, temptation, or threat. The concept of termination has caused significant debate, because many believe that for some individuals the goal of termination is not possible. In such cases, the alternative is lifelong maintenance, even if the level of wariness begins to decrease over time. Whereas it is true that some individuals can achieve termination, as with cigarette smoking where there is no longer a craving or trigger to smoke under any circumstance, for others the temptation is present given the appropriate environment. Thus, some researchers have argued for a five-stage model that does not include a termination stage. Later in this chapter, we revisit this topic and discuss those problems that might be better suited for long-term maintenance versus termination.

The stages are the foundation of the TTM. Knowing them and being able to identify the stage of an individual or client is only the beginning, however. Once the stage is identified, it is important to align that stage with the appropriate change process or processes. What works best in one stage may actually be detrimental in another. In order to increase an individual's chance of success, the right therapeutic processes must be used in the appropriate stage.

Philosophical Underpinnings and Key Concepts of the Theory

When James Prochaska set out to determine the nature of intentional change, he first

tried to identify the common principles and processes of change from all of the major therapies (Prochaska et al., 1994). He completed a cross-examination of the major schools of psychological thought with the intention to integrate the major processes into one cohesive theory. After reviewing the data, Prochaska found that there were nine major commonly used change processes. He defined a change process as "any activity that you initiate to help modify your thinking, feeling, or behavior" (Prochaska et al., 1994, p. 25). The processes of change that have received the most theoretical and empirical support since they were first discovered (Norcross, Krebs, & Prochaska, 2011a) and those we discuss here are *consciousness raising*, *emotional arousal*, *self-reevaluation*, *self-liberation*, *stimulus control*, *counterconditioning*, and *reinforcement* (see Exhibit 10.1). These processes are not specific techniques; rather, they are broad strategies that may be composed of a seemingly endless number of techniques. For example, the use of a token economy, in which individuals earn small rewards to help them achieve goals, is an example of a technique that would fall within the change process of reinforcement.

Change Process	Description
Consciousness raising	Bringing information that helps the individual understand his or her problem better. May be conscious or unconscious information that is brought to the forefront of the individual's awareness.
Emotional arousal	Often referred to as dramatic relief or catharsis. Similar to consciousness raising but on a more felt, visceral level.
Self-reevaluation	The reevaluation of identity, self-esteem, and confidence as the individual moves through the process of change.
Self-liberation	The belief that the individual can change; the willingness to commit and recommit as necessary. Also known as willpower.
Stimulus control	Limiting exposure to certain people, places, or things that might increase an individual's desire to use.
Counterconditioning	Replacing old, unhealthy behaviors with new, healthier behaviors.
Reinforcement	Using rewards to reinforce new behaviors. Can also be used to shape new behaviors slowly over time.

As stated earlier, some of the change processes are more appropriate for certain stages than others. Conversely, implementing the wrong process at the wrong time will decrease an individual's potential for success. Thus, an understanding of the different processes, as well as knowing in which stage that process is most likely to be helpful, is essential to assisting clients in overcoming their addictions and successfully transition through the change.

The first change process, consciousness raising, is one of the most commonly used

change processes. Consciousness raising is essentially the raising of awareness, or making the unconscious conscious. It has its roots in Freudian psychoanalysis (Prochaska et al., 1994). This process is not unique to psychoanalysis, however. All of the major theories attempt to increase a client's awareness in one way or another. Any information that helps clients to understand their problems better is helpful and increases the chance for success. As such, consciousness raising is not always uncovering unconscious awareness but rather includes any information that helps clients adjust their behaviors and accomplish their goals.

Emotional arousal, sometimes referred to as dramatic relief, is similar to consciousness raising, but it occurs on a more emotional or visceral level. Another word for emotional arousal is *catharsis*—the sudden and often unexpected release of repressed emotions. Emotional arousal can occur when an individual experiences an "aha" moment, such as when a friend or acquaintance is impacted negatively by the same problem as the client. For example, in the case study, Gabriel's niece has pleaded with him to stop using many times without much success. However, if Gabriel were to learn that his niece had been tempted to try smoking marijuana by a friend at school, it might make a difference in his desire to stop. This can also occur after more traumatic situations, such as if a person's friend is involved in a drunk driving accident and that tragedy motivates the person to stop drinking. When awareness is increased and activates a depth of feeling, clients are more able and willing to change.

The next change process, self-reevaluation, is an important part of the overall change process and may occur in several of the stages. The act of change is profound. Individuals will find that they need to reevaluate—or even renegotiate—their identities as well as their levels of self-esteem and confidence as they move through the stages of change. They may also need to reevaluate their values and how they see themselves engaging with the world. The process of self-reevaluation will most likely continue throughout the entire change process but may be more important in the early stages.

The process of self-liberation is essentially the belief that an individual can change his or her behavior. It is the belief that such a commitment—and recommitment when necessary—is possible. Norcross et al. (2011a) describe this belief as *willpower*. However, some individuals tend to rely excessively on this process. According to the researchers, when one process is overly relied on, it can lead to relapse (or recycling). As such, it is important that self-liberation be enhanced by engaging in activities such as participation in Alcoholics Anonymous (AA) and by increasing the number of choices that clients have to maximize their chances for success.

Stimulus control modifies the cues and triggers related to problem behaviors. Reinforcement—or reward—modifies the consequences that follow by helping individuals implement and *reinforce* new behavioral patterns. Reward systems have often been combined with punishment systems; however, punishment systems tend to lead to temporary change. If we want to change behavior permanently, it must include

rewards and reinforcements (Prochaska et al., 1994). Moderating self-talk to be positive and empowering, the use of contracts that promote new behaviors, and using step-by-step approaches (versus quitting all at once) are useful reward techniques that positively influence the change process.

Counterconditioning is the process of finding healthier behaviors to engage in, while minimizing or stopping unhealthy behaviors. It is common for individuals who are seeking to terminate an undesirable behavior to compensate by replacing it with a more desirable or socially acceptable behavior. In addition, many addictive behaviors have beneficial outcomes such as helping with stress or coping. Individuals who are giving up unhealthy behaviors will need to find other behaviors to replace them. Examples of good counterconditioning behaviors are active diversion (staying busy, or refocusing energy), exercise, relaxation techniques (such as breathing or mindfulness), reframing (the act of identifying negative self-talk and reframing those thoughts into more empowering, positive messages), and assertiveness training.

Individuals who are seeking change are often very careful about their environments. For example, a man who is trying to quit smoking will most likely not go outside with coworkers on a smoke break. In fact, he might not even watch from a distance as someone else lights a cigarette. If his smoking habit was related to certain activities, such as social drinking or that first cup of coffee in the morning, he might not engage in any of those activities either as they would represent a potential situation in which the desire to smoke would be elicited. For some individuals, engaging socially with friends who were associated with the undesired behavior is unadvisable. Such individuals may go out of their way to avoid certain places, people, or situations, which is the essence of stimulus control. They may also alter relationships to maximize their chances for success.

How the Approach Is Used by Practitioners

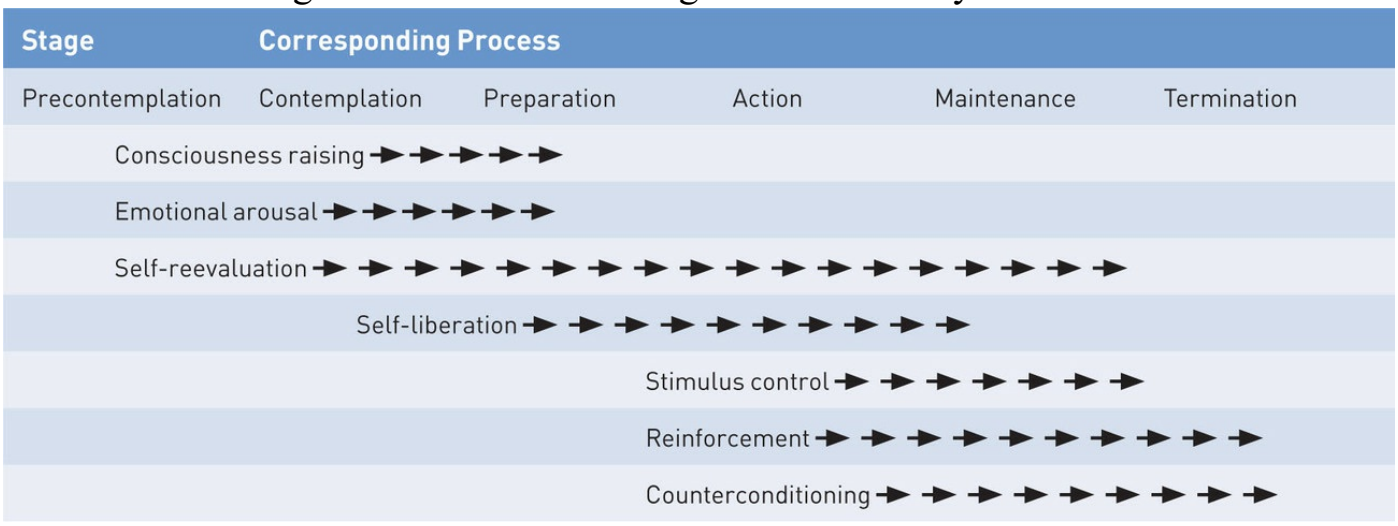
The stages of change are essentially *when* people change; the processes of change give us the *how*. The change processes are most effective when the right ones are used at the right time. According to Norcross et al. (2011b), the processes traditionally associated with experiential, cognitive, and psychoanalytic theories are best used in the earlier stages (precontemplation and contemplation), whereas those more commonly associated with existential and behavioral traditions are better used in the later stages (action and maintenance). In studying self-changers (those individuals who successfully change without entering into treatment), the developers of the TTM found that individuals who did not successfully change generally mismatched their stage with the inappropriate process. For example, using consciousness raising and self-reevaluation during the action stage is like trying to modify behavior by becoming more aware of it. Simply being more aware of something does not necessarily mean it is going to change. Conversely, using processes that work better in the later stages (such as reinforcement and counterconditioning) when an individual is still in the early stages of contemplation

or preparation will not work either. That would be akin to riding a horse without understanding why you need a saddle.

> Box 10.1 Myths of Change
> Common myths about change include such adages as "Change is simple," "All it takes is willpower," or "People don't really change." However, the fact is that people can and do change, although change is anything but simple. And whereas willpower plays a role in change success, it is but one of several change processes that make change possible. In addition, societal myths regarding change and addiction, specifically, tend to see addiction and recovery as "on" or "off" as opposed to a complex process that is not necessarily linear in nature (DiClemente, 2003). It is important that counselors consider these myths and use caution when making inferences about change that might inadvertently hinder client success.

Exhibit 10.2 shows the various processes and the stages in which they are most effective. Consciousness raising in the early stages of change (precontemplation and contemplation) helps clients increase their awareness of the impact of their own behaviors on self and others. In precontemplation, however, the very nature of the stage implies resistance and denial. This may not always be true, though. Precontemplators are often earnestly struggling with their problems and doing the best they can to cope. They are also often extremely demoralized. This may be especially true if others have judged them as being incapable of changing. In essence, many precontemplators have given up. The question, then, is how to help someone who is in precontemplation.

Exhibit 10.2 Change Processes and the Stages in Which They Are Most Useful



Precontemplators often rely on defenses that protect them and keep them in homeostasis. Defenses in general can be positive in that they protect individuals from being overwhelmed or flooded by external stimuli. They help individuals avoid—although only temporarily—unpleasant emotions or thoughts. They can also keep individuals stuck. Precontemplators seem to be adept at a number of defenses. First, they tend to

deny or minimize their problems. They simply do not want to see what is really happening. They are not able to connect with their felt experience. Rather, they live behind a facade of disconnection that keeps them blissfully ignorant of their own reality. Second, precontemplators tend to rationalize and even intellectualize their problems. They find adult-like ways to explain their behavior. For example, an adult survivor of childhood abuse might use her experience as a way to justify her doting behavior toward her own children. When counterarguments become too heated, precontemplators intellectualize their problems and thereby distance themselves from the personal impact of their own behaviors.

> Box 10.2 Forcing Change?
> The question of ethical treatment often comes up when counselors work with clients who are in precontemplation. How ethical is it to advocate and push for change if our clients do not want to change? Or what if the client says that he or she wants to change but feels that the real problem lies outside of his or her own behavior? The resistance and denial of the need for change in the precontemplation stage has led some individuals (family members and friends, policymakers, and even counselors) to confront their clients in increasingly aggressive and unhelpful ways. DiClemente (2003) argues for a "tough love stance" that allows natural consequences to occur rather than a confrontational stance to increase problem awareness. Whereas counselors and family members cannot change the individual with the problem, they can accomplish much by allowing the client to deal with the consequences of his or her behavior at the same time that the therapist helps the client's awareness of those negative consequences increase. Keeping this approach in mind can also be helpful when working with family members and loved ones who are frustrated with precontemplator behaviors.

Precontemplators are also particularly adept at projecting and displacing their problems to other things and people. They are essentially able to mount a good offense. For example, Gabriel's mother, who recently started attending Al-Anon meetings, has started to set boundaries around Gabriel's substance use in the home. Rather than comply with his mother's demands, however, Gabriel mounts an offensive attack against his mother and her inability to understand how lonely and unaccepted he feels by his father. He blames her for making the situation worse for him, because smoking marijuana is the one thing that helps him feel better. Over time, Gabriel's approach becomes his best defense. The more he can blame his mom for not understanding, for being uncaring or insensitive, the more freedom he has to continue his behavior without having to face the need for change.

The converse to projection and displacement is internalization, which is the last defense that precontemplators tend to use. Rather than dealing with negative experiences and

emotions in healthy ways, some precontemplators begin to internalize their behavior, believing that no one else is responsible for their suffering. Over time, this leads to self-blame, low self-esteem, and depression. Precontemplators who internalize simply do not believe they are capable of successfully changing.

Consciousness raising is the first step in helping a precontemplator move to contemplation. Helping individuals recognize their defenses and giving them information regarding their problem is central to increasing awareness. Counselors should highlight and discuss the advantages of changing. Helping individuals connect with their felt experience, the here-and-now of their reality, and the benefits of counseling are great ways to start helping clients increase awareness.

Emotional arousal (or dramatic relief) can be helpful in this process, especially in getting clients to connect more with their emotions and experience. This might include anticipatory grief, that is, the fear of letting go of a coping skill or habit that has provided comfort for years. It might also include discussions regarding the consequences of not changing. Emotional arousal can be increased by using video clips or documentaries, which subsequently can also provide significant additional information for individuals regarding their problem behaviors. Experiential techniques such as saving the cigarette butts and ashes from one day of smoking in a jar can also be helpful. The aim here is not to shame the client but rather to bring awareness and connection to emotion and decrease defensiveness in the safety of the counseling setting.

Once an individual moves to contemplation, the change process may shift more heavily to self-reevaluation. The increasing awareness that change is needed has an impact on the client's beliefs regarding self and others. How does the client envision the future? In contemplation, clients become more comfortable talking about their problems. Nevertheless, they are not necessarily ready for action yet either. Thus, contemplation is a stage in which consciousness raising is just as important as in the previous precontemplation stage.

A word of caution here: Some contemplators struggle with the comfort of this stage and their subsequent ambivalence regarding change. If a person is going to be stuck in a stage, it will most likely happen in the contemplation stage. Chronic contemplators may become overly comfortable with the warmth of the therapeutic relationship. They may also be experiencing very real anxiety about changing. Remember, contemplators want to change, but they are not necessarily ready for action. However, the biggest mistake a counselor can make is allowing a client to become a chronic contemplator. If your client seems to be waiting for the perfect moment to change, is looking for absolute certainty that change is the right thing, or begins to engage in wishful thinking (e.g., “I wish I could eat as much as I want and never get fat”), then you might be dealing with a chronic contemplator. The antidote is the increasing awareness of the problem *and* the solution prior to engaging in action. If the awareness of both is not there, then any action taken is likely to be only temporary and unsuccessful.

As individuals move to the preparation stage, they will become increasingly more confident that their decision to change is the right one. The differences between contemplation and preparation are subtle, however. The reevaluation of self and one's problem continues during the preparation stage, but the focus begins to shift to the future and is less oriented to the problematic past. This can seem daunting for some, for the future may at times appear uncertain. During this stage, however, change becomes a priority, and the image of what can be if change is successful provides hope and renewed energy. Rather than focusing on the problematic past, individuals' focus in preparation is on finding appropriate actions that will help them overcome their problems in the future. It is important while in the preparation stage that individuals take the appropriate time to create a plan, rather than jumping prematurely into action. Individuals in the preparation stage might feel overly eager to move into action, but moving through preparation too quickly can lead to failure. In preparation, it is important to focus on the tools one might need to be successful in action. For example, someone might purchase a food scale if he or she is counting calories or attend several different Alcoholics Anonymous meetings to find one that feels right.

Once adequate planning has occurred, an individual is ready to move into the action stage. Of course, there are no guarantees that a person will be successful, even when sufficient preparation has taken place. However, if there is enough commitment to the change process, every setback will be a source of new information and learning, which in turn will be helpful in getting back to the action stage as quickly as possible.

As stated earlier, being unsuccessful in this stage can occur if an individual has not adequately prepared for it. Laying sufficient groundwork for action in the preparation stage is a large contributor to successful change. Similarly, an individual who wants to change but is not willing to make the difficult and challenging sacrifices necessary for change to occur will struggle to maintain new behaviors during the action stage. There is no magic trick, or shortcut, to complex behavioral change. The action stage demands commitment and energy. As such, using the change processes of reinforcement or rewards and counterconditioning become extremely important during action.

Using positive self-talk, such as congratulating yourself for breathing deeply and relaxing or for not giving in to a temptation, reinforces new behaviors and makes success more likely. We all have that inner, critical parent voice that quickly is able to point out our flaws and failures. However, punishment is not a good moderator of problem behavior (DiClemente, 2003). Rather, positive self-talk reinforces new behavioral patterns and has the added benefit of bolstering self-esteem. Using contracts (either formal or informal), allowing yourself to gradually change a behavior over time (i.e., using a step-by-step approach, sometimes referred to as behavior shaping), or doing something nice for yourself in return for not giving in to the problem behavior are all examples of reinforcements and rewards.

Counterconditioning, which is the ability to replace unhealthy behaviors with healthy

ones, is one of the more powerful change processes available to us (DiClemente, 2003; Prochaska et al., 1992). Sometimes when we are faced with having to change a problem behavior, we unintentionally replace it with another problem behavior. For example, Mary is trying to lose weight. She is concerned about spending too much time in her house tempted by food. Therefore, she starts to go out shopping every day and eventually finds that she is spending money she does not necessarily have to spend. This in turn could dramatically increase her stress, which could lead to making it more difficult for her to resist the temptation to overeat. Change is stressful, so finding ways to engage in new, healthy behaviors is what counterconditioning is all about. Some successful counterconditioning techniques include active diversion (keeping busy or distracted, refocusing energy), exercise, relaxation techniques (such as breathing, progressive muscle relaxation, or mindfulness), and counterthinking or reframing (turning negative thoughts into empowering, positive statements).

The action stage can last from several months to as long as 6 months. As new behaviors become familiar and routine, a person enters the maintenance stage. Maintenance is much more than just maintaining new behaviors, however. In this stage, individuals work to avoid relapse. That means that they remain aware that they are vulnerable to old behaviors, especially under certain circumstances. The main challenges to maintenance are social pressure, internal changes (such as overconfidence or self-blame), and special occasions. Whereas one might be tempted to think of maintenance as being less challenging than action, the fact is that maintenance is not just maintaining change but maintaining the use of the change processes as well. Being aware of triggers and avoiding people, places, or things that could result in temptation is just as important in maintenance as it is in the action stage. Counterconditioning continues to be important during this stage as individuals create new lifestyles that support their desired behavioral changes.

Recycling (or relapse) is more of a risk in the early maintenance stage. However, some individuals will always be vulnerable to their old behavior. Should relapse occur, it is helpful to engage in a period of self-reevaluation. Whereas it might seem natural to engage in high levels of self-blame, it is more effective to spend some time going back, perhaps, to preparation and evaluate, revise, and adjust one's plan in hopes of being more successful based on one's new understanding of self. The nature of change—as mentioned earlier in this chapter—is recursive in that we might need to take a step back in order to take two steps forward.

Termination

How does one know when termination is appropriate? Whereas some individuals might not feel comfortable with the idea of terminating from maintenance, for others it is the final stage in a long journey of transformation. Termination is demonstrated when an individual no longer identifies with a self-image that includes the problem behavior but rather with a new self-image and a healthier lifestyle that does not include the problem.

In addition, there should be no temptation to slip into old behaviors under any circumstance or in any situation. Finally, there should be a new or renewed self-confidence and self-efficacy that the old problem is truly outdated. This level of confidence is genuine. You simply know that the problem is behind you. It is possible, however, that even after 10 or 20 years of not engaging in a problem behavior, one still does not solidly believe that one is free and clear of danger or temptation. Termination is not recommended for those individuals, and it is perfectly okay to stay in maintenance for as long as one feels it is necessary.

Counselor's Stance

Clients will spiral in and out of the stages of change. In one session, the client may demonstrate clearly that he or she is ready to make a commitment toward change and prepare for action, but in the next session, that same client could revert to previous behavior and even begin to question whether change is really needed. The counselor's relational stance should shift as a client moves through the stages of change. In the earlier stages, the therapist's role is almost parental in nature, not very different than one would be with an adolescent child. That stance is nurturing and firm understanding but knowledgeable of the dangers inherent in some behaviors. As the client moves toward contemplation, the therapist may take on a more Socratic role, encouraging the client to self-reflect and examine his or her behavior and goals. As the client transitions into preparation, the therapist will help the client by coaching and encouraging the development of a plan and helping the client prepare for pitfalls and triggers. Finally, as the client moves into action and maintenance, the therapist becomes more like a consultant, providing expertise and advice as necessary but allowing the client to develop more and more autonomy as time goes by and the client moves closer to termination (Norcross et al., 2011b).

Assessment and Prevention Implications

So how do counselors know what stage of change their clients are in? You might think the most logical approach is to listen to their client's story and pay close attention to how much they talk about change (i.e., change talk). However, whereas change talk is an ample predictor of treatment outcomes (Gaume, Bertholet, Faouzi, Gmel, & Daeppen, 2013; Glynn & Moyers, 2010; Miller & Rollnick, 2004), studies suggest it is not a good predictor of the specific stage of change (Hallgren & Moyers, 2011; Miller & Rollnick, 2004; Rollnick, 1998). In other words, the frequency of change talk is a better indicator that clients are transitioning through the stages of change and not that they are at or in any specific stage (Rollnick, 1998).

Arguably, a better approach to assessing client stage of change is to use a formal written or computerized instrument (Hallgren & Moyers, 2011). Counselors can administer such an instrument at any point in the counseling process to get a snapshot of where the client is in relation to the TTM. Then, counselors can ensure that they use interventions and

strategies that are most appropriate for the client's reported stage of change. This approach might be especially beneficial during the first counseling session, when a counselor is trying to determine the best course of treatment for a client.

Several researchers have created assessment instruments that aid in the process of identifying a client's stage on the TTM. DiClemente and Hughes (1990) developed the first TTM assessment and called it the University of Rhode Island Change Assessment (URICA). The URICA is a broad self-report assessment created to assess clients' readiness to change in relation to any behavior (DiClemente & Hughes, 1990). Pantalon, Nich, Franckforter, and Carroll (2002) reported that the psychometric properties of the URICA are well within the acceptable and favorable range, indicating that the URICA is a consistent and valid measure. The URICA provides four separate subscale scores —*precontemplation*, *contemplation*, *action*, and *maintenance*. DiClemente, Schlundt, and Gemmell (2004) suggest that to determine a total score for the URICA one would subtract the precontemplation score from an average of the other three subscales. The URICA's total score ranges from −2 to 14. Individuals who score below 8 on the URICA are categorized as being in precontemplation, 8 to 11 as being in contemplation, and above 11 as being in preparation.

Another TTM assessment tool with equally positive psychometrics is the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES; Miller & Tonigan, 1996). Unlike the URICA, the SOCRATES focuses solely on substance abuse. The SOCRATES comes in two versions: (a) the SOCRATES 8D, which focuses on drug use, and (b) the SOCRATES 8A, which focuses on alcoholism. Additionally, there are several older versions of the SOCRATES (7A, 7D) that are longer and have versions designed to be used with the significant other of addicted partners (7A-SO-M; 7A-SO-F). The SOCRATES is also available in Spanish.

Like the URICA, the SOCRATES is scored by adding up the scores of three subscales —*recognition*, *ambivalence*, and *taking steps*. If someone scores high on the recognition subscale it indicates that he or she acknowledges a problem with substance misuse. If the client scores high on the ambivalence scale it suggests that the client is wondering if he or she has a problem (contemplation stage). And a high score on the taking steps scale indicates that the test taker is already committing to some positive changes. The authors of the SOCRATES state that these subscales do tend to predict positive change, but they recommend that counselors examine and review how clients score individual items to get the deepest understanding of their readiness for change (Miller & Tonigan, 1996).

Rollnick, Heather, Gold, and Hall (1992) thought that, in addition to the comprehensive profiles provided by the SOCRATES and the URICA, there was a need for a brief and simple assessment tool that helping professionals could administer in medical settings. Thus, they created the Readiness to Change Questionnaire (RTCQ; Rollnick et al., 1992). The RTCQ consists of 12 questions and has demonstrated satisfactory

psychometric properties (Rollnick et al., 1992). Each question has five possible responses ranging from strongly disagree to strongly agree. If a test taker selects strongly disagree it is scored as a −2, disagree is −1, unsure is 0, agree is +1, and strongly agree is +2. The RTCQ has three subscales—*precontemplation*, *contemplation*, and *action*. The subscale with the highest score represents the test taker's stage of change.

Because clients tend to spiral in and out of the different stages of change, it can be difficult for counselors to assess confidently clients' readiness to change. The previously mentioned assessments offer the most useful method of recognizing where clients are in relation to the stages of change in that present moment. Perhaps the most beneficial use of these assessments is right before a client enters into treatment (to determine where to begin services) or toward the end of treatment (to determine readiness for termination). In any case, an appropriate assessment of a client's stage of change can help counselors gain a deeper insight into their client's struggle, and that, in itself, is very useful.

Strengths and Weaknesses of the Theory

One of the reasons the TTM rose quickly to popularity is because it confirmed the belief that some clients are more ready to change than others (Herzog, 2005). Counselors believed this to be inherently true, but the TTM represented the first measurable, linear, and functional description of how individuals change. Other models of change emerged in the literature but were discounted or discarded due to the popularity of the TTM (Herzog, 2005). Thus, when the TTM emerged in the literature, clinicians touted it as being an innovative and dynamic approach.

Researchers also became interested in the TTM, and it became the topic of volumes of research, including investigations on matching clients to stages, counseling dropout rates, treatment outcomes, and the relationship between the stages and the change processes (Norcross et al., 2011a). There are more than 1,500 studies on the TTM, and the findings generally state that the TTM reliably predicts client outcomes, tailoring treatment, and dropout rates (Noar, Benac, & Harris, 2007; Norcross et al., 2011a).

Another strength of the TTM is its ability to easily integrate into any theory. The transtheoretical nature of the TTM allows counselors from any school of thought to assess a client's readiness to change without conflicting with another approach to therapy, and by doing so the TTM lends itself well to theoretical integration (Petrocelli, 2002). Additionally, the developmental design of the TTM underscores the importance of not treating all clients as if they are already in the action stage of change (Norcross et al., 2011a). According to Norcross and colleagues, only 20% of clients enter treatment in the action stage, indicating that counselors that approach all clients with an action-oriented program are going to be ineffective 80% of the time. Mismatching approach and stage also runs the risk of damaging the therapeutic relationship.

On the other hand, one of the limitations to the TTM is the difficulty of empirically

distinguishing between the stages (Lambert, 2013). Even with formal assessments like the URICA and the SOCRATES it can be difficult for counselors and researchers to determine which client fits into which stage, and some have argued that the cutoff scores assigned by the assessments are flawed (Callaghan & Taylor, 2006). The TTM is also in need of research that is more experimental. The majority of the TTM research is based on predictive hypotheses (i.e., that stage of change can predict outcome). Experimental research that compares clients matched to treatments with unmatched clients is scarce and shows little difference between matched and unmatched interventions (Norcross et al., 2011a). This gap in the literature has led some to argue that this model be disregarded until it has been tested with more scientific rigor (Herzog, 2005; West, 2005). There is also a lack of research on the stages of change among different cultures and with low-income individuals. The tools and questions used to assign individuals to stages are often not validated and have significantly misclassified minorities and women when compared with men on the stages of change (Suminski & Petosa, 2002). Whereas researchers are working to cross-culturally validate the stages of change assessments, counselors must take culture and socioeconomic status into account when attempting to identify and match a client to a stage of change. Culture is a crucial component of clients' lives and will certainly influence their motivation and readiness to change.

Case Study Responses

From a TTM perspective, an addictions counselor would be most interested in Gabriel's readiness for change. Unlike with other theoretical approaches, TTM counselors would spend less time focused on the factors that led to Gabriel developing the addiction (e.g., his anxiety, difficulty with relationships, or family of origin) and focus more on behavioral change. Gabriel has had a persistent period of drug use with little evidence of awareness or a commitment to sobriety. His previous attempts at treatment, his past participation in AA, and his ability to remain abstinent after treatment for 7 weeks are indicative of someone who is aware of having a problem, but his present inability to remain off drugs and alcohol for more than 3 days demonstrates a lack of preparation. Therefore, it appears that Gabriel is in the *contemplation* stage of change.

Without a formal assessment, it is difficult to know for certain, but if Gabriel is in the contemplation stage of change, he is likely to be questioning his ability to commit to change. In the past, he was able to move from precontemplation to action, but it appears that certain life events (e.g., breakup with his girlfriend) may have weakened his resolve and he recycled back to the earlier stage. This is a normal pattern for most individuals seeking behavioral change, and the best course of action is not to dwell on the past but instead to focus on the future.

Knowing that Gabriel is in the contemplation stage of change should help his counselor identify the best course of action. His counselor would focus on raising Gabriel's self-

awareness by reflecting feeling and meaning and guiding him through self-evaluation (Norcross et al., 2011a). The goal of this approach would be to help Gabriel look at his problems and think about how he feels they are affecting his hopes, dreams, and desires for the future. It is crucial that the counselor remain aware of how challenging the contemplation stage can be and the importance of building a strong therapeutic bond for the work that lies ahead. The counselor should first build an alliance with Gabriel and explore his personal beliefs and values regarding his future. By reflecting the client's feelings and using Socratic questioning, the counselor can enter into a deep therapeutic relationship with Gabriel. The counselor may spend some time discussing the benefits Gabriel experienced from remaining sober in the past and how maintaining sobriety could increase those benefits and connect him with his goals. While building this strong relationship that will provide Gabriel with a corrective emotional experience, the counselor should help Gabriel evaluate his situation with an emphasis on how his current situation impedes or helps him reach his desired future. The aim of the therapeutic encounter at this point should be to support Gabriel in reevaluating his life and helping him move toward preparation.

During the preparation stage, the counselor would change his or her stance slightly. Gabriel's counselor would continue to foster therapeutic rapport and self-evaluation; the counselor would also focus on Gabriel's decision-making skills. At this stage, Gabriel would begin to demonstrate willpower and a desire to change. Gabriel's counselor can serve as a coach who helps Gabriel make good decisions by providing supportive feedback. Given Gabriel's experience recycling through the stages, it might behoove the counselor to discuss with Gabriel what factors (e.g., breakup with girlfriend) kept him from staying committed and how he could mitigate those factors in the future. Moreover, Gabriel and his counselor could discuss what worked in the past and how he could implement those same successful strategies again today.

The transition from contemplation to preparation will also involve the processing of a lot of emotion and grieving. In order for Gabriel to change, he has to leave behind a lifelong relationship with drugs and alcohol. He will also have to revisit many potentially traumatic memories that the alcohol and drugs have been keeping away and to confront the issues that drugs and alcohol have helped him to avoid. It would be normal for Gabriel to be scared of change. Gabriel's counselor should anticipate this reaction and use techniques like psychodrama and role-playing and help Gabriel express and experience his feelings about change. This could potentially be a very emotional and difficult process for Gabriel, but by ensuring that he is well prepared for the action phase, the counselor increases the likelihood of a successful outcome.

In the past, Gabriel has attempted to quit and discovered that he was not ready to maintain abstinence and subsequently relapsed. The TTM would benefit Gabriel by focusing attention on his readiness to change and ensuring he is well prepared before taking action. Unfortunately, the TTM would not attend to Gabriel's obsessive-

compulsive or anxiety disorder, nor would it focus on his social stressors, but it *would* focus on his ability to change his addictive behavior. Like any other approach, the TTM is not without its flaws, but in the case of Gabriel we believe it could be extremely beneficial.

Summary

The question of how people change is an important one in addictions treatment. The TTM provides counselors with a clear understanding of the developmental nature of change. This allows counselors to offer clients focused and evidence-based interventions that help them to move toward change and avoid the pitfalls associated with frustrating an unready client. Thus, the five stages of change and the process of change delineated by the TTM constitute a vital tool for counselors hoping to help clients enter into recovery.

Resources for Continued Learning

Books

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11 Motivational Interviewing in the Treatment of Substance Abuse and Dependence

Todd F. Lewis

Motivational interviewing (MI) has grown into a popular, evidenced-based approach for treating substance use and addiction issues. Indeed, MI began as an approach designed to reduce resistance and increase intrinsic motivation to change *substance abuse behavior*. Since its creation, MI has amassed more than 200 clinical trials (Rollnick, 2010) showing general support for its effectiveness across a range of presenting problems (Miller & Rollnick, 2002; Miller & Rose, 2009; Rosengren, 2009). The definition of MI has gone through many iterations (Miller & Rollnick, 1991; Miller & Rollnick, 2002; Miller & Rollnick, 2013) and is currently defined as

> a collaborative, goal-oriented style of communication with particular attention to language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion. (Miller & Rollnick, 2013, p. 29)

The basic structure of MI first appeared in the early 1980s based on the work of William R. Miller as a response to what were considered overly confrontational approaches to substance abuse treatment. These approaches were based on the following assumptions: (a) that clients are flawed, and the clinician knows what to do to fix them; (b) clients have little to offer in their own care; (c) severe confrontational strategies are needed to address denial; and (d) admission that one is an addict is a prerequisite for behavior change (Lewis, 2014). Harsh confrontations, breaking down denial, and forcing one to admit he or she was an addict or alcoholic only engendered resistance and usually did more harm than good. Through training other practitioners and his own clinical experiences, Miller realized that he had the basics of an approach based on empathy and collaboration that could be applied to those struggling with substance abuse issues. By asking open questions, affirming, reflecting, and avoiding the "righting reflex," he found clients tended to show less resistance, were more open to change, and increased their own motivation. Miller's (1983) work led to the first article on MI in the journal *Behavioural Psychotherapy*.

In this chapter, I begin with a description of the basic tenets of MI, followed by philosophical underpinnings and key concepts of the approach. I then turn to assessment, intervention, and prevention implications based on MI. Strengths and weaknesses of the approach are discussed, followed by responses to the case study introduced in the beginning of the text. Finally, a list of resources is provided for those interested in training or learning more about MI.

Basic Tenets of the Theory

This section provides information on the importance of ambivalence, the goals of MI, ways to implement MI, and basic tenets of the approach. These discussion points provide the reader with a basic outline of what MI practitioners are focused on when using MI and how they go about implementing it in their practice.

Importance of Ambivalence

A major contribution of MI to substance abuse treatment is recognizing the importance of ambivalence about changing behavior. Anytime a person contemplates change, particularly change that has some emotional reaction, ambivalence is probably going to be present; it's only natural that one would feel two ways about stopping a long-term behavior or habit. Traditionally, clients who were ambivalent about change were labeled as resistant and in need of correction, usually by way of punishment or harsh confrontation. From the MI perspective, ambivalence is observed as a natural reaction to change. It seems silly, for example, to assume that those addicted to alcohol or drugs would have *no second thoughts* about changing a long-standing habit of abusing substances; instead of shaming clients, MI practitioners recognize, explore, and help resolve ambivalence, freeing up energy for client change.

Goals of MI

Three primary goals guide the MI practitioner. Indeed, many of the techniques discussed later are generally aligned with one or more of the following MI goals. The first goal is to help clients increase intrinsic motivation to change substance abuse behavior. Motivation generated from within, where clients make their own arguments for change, can have a greater bearing on behavior than motivation from the outside (Plotnik, 1993). MI practitioners emphasize this distinction and use strategies to help clients look internally for the energy and motivation to accomplish their goals.

According to Sheldon and Elliot (1998), extrinsic motivation is related to a sense of external control that stimulates action, whereas intrinsic motivation is related to a client's own sense of autonomy, a key underpinning of MI spirit (discussed later). Individual behavior change motivated through a sense of autonomy (i.e., intrinsic motivation) is a stronger form of motivation and generally leads to accomplishment of goals. MI practitioners emphasize helping clients build intrinsic motivation by resolving ambivalence and refocusing their efforts on desires, needs, and reasons for change, all the while supporting a sense of client choice and control (i.e., autonomy) over their actions.

A second goal of MI is to help lower resistance/discord. (In their most recent edition, Miller and Rollnick [2013] do away with the word *resistance* preferring instead to use the term *discord*, reflecting the interpersonal nature of what counselors have traditionally called client resistance. However, in this chapter I use the terms interchangeably.) Lower resistance opens space for new thoughts, behaviors, and possibilities in the client's life.

The third goal of MI is to help clients resolve ambivalence. As noted, ambivalence refers to feeling two ways about changing some habit or behavior. For example, a client may know that if he continues to drink, he may suffer severe consequences. At the same time, he enjoys how alcohol takes away his problems and makes him feel calm and less shy. It's as if he is being pulled in two different directions. This polarity plays a key role in why people stay fixed within their problematic behaviors (Miller & Rollnick, 2002). The MI practitioner uses strategies to help clients explore and resolve this ambivalence, allowing them to move more freely in a direction of change.

Ways to Implement MI

Motivational interviewing can be used as a stand-alone strategy, as an initial strategy to increase motivation and lower resistance, or as a strategy to come back to as needed (Lewis, 2014). As a stand-alone approach, pure MI is typically used as a brief (e.g., 3–5 sessions) counseling modality, although long-term use of MI is possible. As an initial strategy, MI can be used to help increase motivation and lower resistance. Without first addressing the vital issue of client motivation, the counselor risks applying strategies when the client is not ready to take action. Once motivation increases and resistance lowers, the practitioner can then move on to other approaches designed to facilitate change.

MI can be used on an as-needed basis. Throughout the course of counseling, motivation may ebb and flow, rarely remaining static. Even within a single session, clients may waffle between high and low levels of motivation (Lewis, 2014). For example, I have worked with clients struggling with substance addiction who seem motivated to change in one session and a week later have lost their will to change. I found myself coming back to MI on an as-needed basis, whenever motivational issues appeared to impede progress.

Philosophical Underpinnings and Key Concepts of the Theory

Although elements of client-centered therapy influenced MI, the approach is *not* the same as client-centered counseling. MI is gentle in its style but also has a directional/persuasive quality to its application (Miller & Rollnick, 1991). This directional aspect allows practitioners to elicit and strengthen motivation, moving it beyond a strictly client-centered approach. Nonetheless, the impact of client-centered counseling, especially empathic listening, was a skill initially incorporated into the MI approach. Other early influences on MI were findings from motivational psychology and the transtheoretical theory of change (Miller & Rollnick, 2013; Prochaska, DiClemente, & Norcross, 1992). More recently, MI has emphasized research on the language of change and change talk. Miller, Moyers, and Rollnick (2013) described MI as influenced by a coming together of two components: client-centered counseling and conversations about change.

MI Spirit

When Miller and Rollnick (2013) began training service providers in MI, they tended to focus on the technical aspects of the approach and noticed that many trainees became quite adept at using the skills. However, they also discovered that something was missing from their practice. It wasn't that trainees were "doing" MI wrong, just that the practice seemed overly technical and perhaps was missing the right mind-set at the heart of MI. This training experience prompted the development of *MI spirit*, an underlying mind-set (or heart-set [Miller & Rollnick, 2013]) infused throughout all MI practice. The foundation of MI is a therapeutic posture that is collaborative, evocative, accepting, and compassionate. Taken together, these "habits" make up what is called the spirit of MI, or MI spirit. Indeed, the principles, processes, and techniques of MI are consistent with MI spirit; trainers in the application of MI often teach MI spirit at the beginning before covering more technical aspects of MI.

The four components of MI spirit are partnership (or collaboration), evocation, acceptance, and compassion (Miller & Rollnick, 2013). In an MI session, the clinician takes a stance of curiosity and coconstructs agendas, goals, and discussions in a *collaborative* nature. In addition, emphasis is placed on what clients bring to the table, especially ideas, attitudes, and barriers related to changing behavior (*evocation*). The MI clinician strives to show accurate empathy, honor absolute worth, affirm client strengths, and stress client autonomy. Together, these four actions constitute *acceptance*. Finally, clinicians adopt the stance of *compassion*, or actively promoting the client's welfare. Note that this is not the same as having a personal feeling or feeling strong emotions for the client; rather, compassion entails serving for our client's benefit and giving importance to the client's needs (Miller & Rollnick, 2013). MI is not an approach with an abundance of techniques; MI spirit reminds clinicians that an overreliance on techniques may miss the larger perspective and philosophy upon which MI operates. Rollnick (2010) likens MI spirit to the ingredients in a good recipe. The analogy is fitting; too much spice in a soup upsets the whole recipe whereas too little provides not enough color, texture, or taste. In MI, too little collaboration or not enough emphasis on the client's ideas about change can spoil the recipe (session). Reflecting on MI spirit can be helpful when things seem amiss in a counseling session. Often, strengthening collaboration, evoking ideas from the client, offering acceptance and affirmations, and showing compassion can strengthen rapport and serve as a foundation for further counseling work. MI spirit is the foundation for good clinical practice (Rollnick, 2010).

Principles of MI

Miller and Rollnick (1991, 2002) originally outlined five principles of motivational interviewing. These principles are more akin to *actions* practitioners prioritize when reducing resistance and helping individuals strengthen their internal motivation to change. Following are the five principles of MI and a brief description of each.

1. *Avoiding argumentation*. It goes without saying, but arguing with clients is never a good idea. Severe confrontations or accusations only engender discord and force ambivalent clients to strengthen their rationale for *not* changing (assuming the practitioner is arguing for change). Whereas avoiding arguments may seem obvious, argumentation can be subtle. Using persuasion, lecturing, not listening, and offering unsolicited advice may unintentionally create an argumentative atmosphere (Lewis, 2014).
2. *Rolling with resistance.* Too much resistance negatively impacts client progress toward change. MI practitioners respect that clients feel reluctant or ambivalent about changing. These are not opposed but acknowledged as normal reactions to social, biological, and environmental contingencies. MI practitioners "roll" with resistance by offering hope, reflecting feelings, and staying consistent with MI spirit (Lewis, 2014).
3. *Expressing empathy*. Empathy is considered one of the most important ingredients of MI; one would be hard-pressed to practice MI without sufficient empathy. The importance of empathic listening is one mantra that has been consistent through the development and growth of MI. Providing an atmosphere of acceptance frees clients to explore change—their desire for change, abilities to change if they want to, and reasons for change. Although practitioners can convey empathy in many ways, reflective statements are a main strategy (Lewis, 2014).
4. *Developing discrepancy*. When clients experience a discrepancy between goals or values and current behaviors, they are usually motivated to reduce this discrepancy. Often, reducing discrepancy entails changing poor habits or harmful behaviors to better match one's goals and/or values. In MI, the goal is to develop or illuminate discrepancies so that clients can become more aware of the apparent contradiction. For example, assume a client says that he values family and hard work but continues to drink a 12-pack of beer every night. The MI practitioner might reflect, "You value hard work and family and at the same time drink a 12-pack every night. I am curious what that means to you." In most situations, the client will recognize the discrepancy and internal struggle to change. Thus, a little discrepancy can go a long way. MI practitioners help develop discrepancy within the client by exploring (a) values and goals and (b) how current behaviors either fit or do not fit within these goals and values (Lewis, 2014).
5. *Supporting self-efficacy*. The fifth principle entails supporting the client's confidence in her ability to make changes. MI practitioners convey hope and optimism, tapping into an important common factor in therapeutic change (Hubble, Duncan, Miller, & Wampold, 2010). Self-efficacy becomes the focus when clients recognize the importance of change but lack the internal confidence to do so. Brainstorming, forming allies, and exploring past successes are some of the ways practitioners might enhance self-efficacy.

Miller and Rollnick recently have moved away from listing specific principles to infusing them throughout their writings (see Miller & Rollnick, 2013). MI has been significantly refined within the last 15 to 20 years based on the vast array of clinical research. Yet the original principles continue to provide an important foundation in MI practice. More recent versions of the MI principles have stressed the acronym RULE (Rollnick, 2010). Briefly, RULE stands for

1. *Resisting the righting reflex*. It is human nature to want to make better, to fix, or to make right. Indeed, this may be why many enter the helping professions and is a noble pursuit. However, practitioners can sometimes be their own worst enemy by the *methods* they use to help. MI practitioners try to rein in the "righting reflex," which involves behaviors such as giving unsolicited advice, lecturing, using "should" language, and persuading.
2. *Understanding the client's own motivations*. The client brings a wealth of knowledge and experience to the counseling session. Eliciting from the client his or her own thoughts, ideas, and motivations for change can save time and brings a valuable perspective to the counseling process.
3. *Listen with empathy*. See discussion of expressing empathy earlier.
4. *Empower the client*. Similar to supporting self-efficacy noted earlier.

Assessment and Prevention Implications

MI practitioners are free to use any substance abuse assessment strategies they deem appropriate. Feedback from assessments provides a critical and important component in the MI assessment process. Miller and Rollnick (1991) stressed the importance of nonjudgmental feedback in helping clients become aware of the detrimental effects of their substance use. MI practitioners also assess readiness to change and motivation levels. In this section, I discuss processes for assessing client motivation, methods for providing client feedback, and the four processes of MI. Through this discussion, assessment, prevention, and intervention implications are highlighted.

Importance and Confidence

A useful conceptualization of motivation is to think of behavior change in terms of importance (i.e., how important is changing one's substance abuse to the client) and confidence (i.e., how confident is the client that he or she could change substance abuse if he or she wanted; Miller & Rollnick, 2002). Assessing both concepts helps the practitioner better understand where to focus energy and where potential barriers lie. For example, if a client does not believe it is important to change but is confident that he could if he wanted to, the practitioner needs to focus on increasing the importance of change. Conversely, if the client knows it is important to change but does know how, then increasing confidence becomes the counseling focus. If these considerations are ignored, the practitioner risks creating a mismatch between counseling strategies and client motivation level.

Increasing Importance

Clients who are low on importance would be considered precontemplative; they don't see themselves as having a substance abuse problem, deny they are at risk, and see little value in counseling. Indeed, MI was developed, in part, as a method to address high resistance/discord in the counseling session. From an MI perspective, it is imperative to assess how important change is to the client. Moving too fast with techniques and strategies, which are designed for clients who are ready to change, is usually met with considerable resistance. The following are some strategies practitioners can use to help clients explore, process, and increase importance.

1. *Roll with resistance*. Handling resistance in a confrontational manner usually engenders more resistance. Clients are more likely to consider change and increase importance if they feel they are a part of the solution and do not feel minimized or put down.
2. *Querying extremes* (*worst case/best case outcomes*; Cole, 2008). These questions encourage clients to think ahead and imagine what life would be like if they maintained the status quo (not change) or made significant changes to their substance use. Example questions include these: "What would be the *best-case* scenario if you did not change your alcohol use? What would be the *best-case* scenario if you did change your alcohol use? What would be the *worst-case* scenario if you did not change your alcohol use? What would be the *worst-case* scenario if you did change your alcohol use?" Clients often have a difficult time thinking of best-case scenarios of continued substance use. Conversely, when reflecting on worst-case scenarios of continued substance use, clients often mention a litany of probable consequences. After reflecting on these questions, clients may be more likely to give more weight in the direction of change (Lewis, 2014).
3. *Develop discrepancies.* Discrepancies include inconsistencies between goals or values and substance-using behaviors. MI practitioners are always searching for discrepancies. When appropriately highlighted, discrepancies can be used as a powerful tool to increase motivation (Miller & Rollnick, 2013). For example, a client who sees more clearly how his or her cocaine use interferes with the goal of being a better parent may give greater importance to stopping.
4. *Use the importance ruler exercise* (Miller & Rollnick, 2002). This exercise is based on a simple assessment question: "On a scale of 1 to 10, with 1 being not important and 10 being very important, how important is changing your cocaine use to you?" Whatever number the client provides, always follow up with asking why the number is not *lower*. For example, if the client says "4," the practitioner follows up with, "What makes it a 4 instead of a 2?" This follow-up method allows the client to acknowledge some importance of changing that is already present and from which the client can build. A second follow-up question is,

"What would it take to move it from a 4 to a 5?" Here, the practitioner encourages the client to think through consequences that would tick the importance number up. Often, either severe consequences are already happening or the client is moving in that direction. Simply reflecting on these possibilities can foster greater reflection on client substance use. If the client reports a low number (below 5), additional time should focus on the importance issue. If the client gives a higher rating, then moving to other strategies may be more useful (Lewis, 2014).

5. *What is important to the client and negotiation.* There are moments in counseling when clients are highly resistant to any discussion about substance use. In these situations, it is helpful to inquire about what is important for the client to talk about in the moment. For example, a client may have zero intention of talking about marijuana use but does want to talk about her deteriorating and unhappy relationship with her husband. The client may be oblivious to the connection between her marijuana use and relationship troubles, but to push the issue would only engender resistance. Focusing on what is important to the client honors what concerns her and builds rapport. By remaining curious and employing skillful use of open questions, affirmations, reflections, and summaries (OARS, discussed shortly), it is quite likely the subject of marijuana use will *eventually* emerge, especially if a connection can be made with other problems in her life. Another strategy is to negotiate with the client the topics for discussion. If the practitioner agrees to discuss the client's relationship issues, perhaps the client can agree to address her marijuana use. (See Miller and Rollnick [2013] for an excellent discussion on focusing in a counseling session.)
   Readers may be concerned that if the focus is not on substance use, the "real" issue is never addressed. In my experience, substance abuse can be so intertwined into one's life that it is next to impossible to avoid the topic in counseling. Using skillful MI, substance abuse can be fully explored, even if the client is initially reluctant to discuss these issues.
6. *Explore clients' perspectives on why they are in counseling.* Clients who abuse substances are often shunned by law enforcement, the courts, family members, peers, and society. In other words, there is little opportunity to tell their side of the story. In addition, other parties are not interested in hearing their stories because they are viewed as untrustworthy. Unfortunately, these reactions from others, however justified, serve only to strengthen client resistance. From an MI perspective, client stories are honored and encouraged, where practitioners listen intently with what brought clients into counseling. MI practitioners adopt a position of curiosity and respectfully explore the meaning of the events that got clients into trouble. The point is that if provided an atmosphere of acceptance, resistance is lowered, and clients become more willing to consider change (Lewis, 2014).

Enhancing Confidence

It may seem ironic that many clients clearly see the importance of changing their substance use and yet for some reason cannot make substantive changes. In these situations, the issue is not importance or even feelings of ambivalence but usually one of confidence. In other words, clients might simply not know how to change or feel diminished self-efficacy in their recovery, refusal skills, or ability to cope if they lived without substances. I have had many clients addicted to a range of substances score relatively high on the importance ruler, fully aware of the negative fallout of their substance use, and yet continue to use substances in a devastating fashion. They struggle with the question of "how do I stop?"

The reader should not assume that once importance is high, MI becomes easier in that motivation has increased, resistance has lessened, and ambivalence is less of an issue. In reality, enhancing confidence remains a challenge—practitioners need to continue using MI strategies and be aware that motivation can wax and wane throughout a client's care. Clients may know intuitively that what they are doing is harmful, but this does not automatically mean they know *how* to go about changing. Focusing clinical attention on the issue of confidence can be well worth the effort.

The following are several strategies, adapted from the work of Miller and Rollnick (2002) and Cole (2006), that practitioners can use to build confidence.

1. *Personal support systems.* Knowing someone is in their corner can be reassuring for clients. This builds confidence by knowing that their allies will be with them no matter what. I try to ask clients, "Who has got your back?" or "Who can be a good support for you?" Clients are encouraged to reach out to this person for support should they need it.
2. *Past successful attempts at change.* Confidence grows when one is successful at change. Clients can usually remember a time when they were successful, either at stopping substance use or making some other significant life changes. I recall seeing a client who was sober for *7 years* before returning to drinking. In counseling, I made it a point to explore the client's past success at remaining sober. Many of the strategies the client used at that time had been forgotten, only to be rediscovered through client-counselor explorations.
3. *Focusing on ability and strengths.* Exploring abilities and strengths can help remind clients about the internal resources they already have to stop using drugs. Persistence, discipline, faith, positive habits, and desire to be a good (mother, father, son, daughter, employee, human) are some examples. Explore these with open-ended questions, which encourage clients to expand their responses.
4. *Use the confidence ruler exercise.* As with increasing importance, clients can be asked how strong their confidence is on a scale of 1 (low confidence) to 10 (high confidence). If clients are low on confidence, the practitioner can explore ways to move up the ruler.
5. *Exploring barriers*. Barriers to change can include negative peer pressure,

stress from multiple sources, physiological reactions (e.g., craving), negative emotions, negative thinking, and poor relationships (Lewis, 2014). Practitioners need to help clients explore these barriers and, if possible, brainstorm ways to overcome them. Confidence is increased when clients can anticipate and plan for barriers getting in the way of recovery.

6. *Information and advice in an MI-consistent manner.* Giving information and advice gets a bad rap. After all, practitioners do have expertise to offer clients, so why should they not be able to offer it? The issue is not so much the information offered but the *manner* in which it is offered. For example, giving unsolicited advice and believing the practitioner is the expert on the client will most likely backfire and increase resistance. Unsolicited advice goes against the grain of MI spirit by not honoring the knowledge, skills, and positive traits the client brings to the table. Providing information and advice in an MI-consistent way, however, can offer clients ideas to enhance confidence. In addition, clients who are low on confidence often desire ideas to help them reach their recovery goals. In the end, clients ultimately decide whether to use the advice—their autonomy is respected throughout the entire process.

Giving information and advice about a range of topics and resources can correct inaccurate information and strengthen confidence. The key to offering information and advice in an MI-consistent way is to *ask the client for permission* first. The elicit-provide-elicit model (Rollnick, Mason, & Butler, 1999) is an example of what this might look like. The first step is to ask what the client already knows (elicit), then provide information (with permission; provide), and then elicit from the client what he or she thinks about the information just provided (elicit). This pattern continues as long as needed (Lewis, 2014).

Rosengren (2009) provided several recommendations for giving information and advice, using the acronym FOCUS: (a) *F*irst, ask permission; (b) *O*ffer ideas rather than forcing ideas; (c) be *C*oncise, keeping comments to brief chunks of information; (d) *U*se a “menu of options” ; and (e) *S*olicit the client's ideas and meaning he or she makes of the information.

Using a menu of options refers to offering a few suggestions from which the client can choose, similar to how he or she might choose from a restaurant menu (Miller & Rollnick, 1991). This method avoids the problem of unnecessarily limiting the client to one option. A menu allows clients to choose the best treatment or strategy fit and promotes a sense of freedom. For example, clients may be offered a choice among individual, group, family, or combination of approaches in a substance abuse treatment facility. Other options might entail goals, such as total abstinence, gradual reduction in use, or harm reduction. In some situations, a menu may not be feasible. For example, in the case of a client who has abused alcohol for several years, has physiological damage, and is diagnosed with a severe alcohol use disorder, the options for treatment

are understandably limited. In these instances, it is best to be honest with the client and emphasize personal choice (Cole, 2008).

7. *Envisioning change and anticipating challenges.* Confidence is increased when clients can visualize the steps needed to realize a successful recovery from addiction. Hypothetical questions such as "Picture yourself a year from now and you have successfully abstained from heroin. What steps would you have taken to accomplish this goal? What challenges did you have to overcome and how did you do it?" Encouraging clients to imagine how their life would be different without substance use, especially the benefits, can build a mind-set consistent with recovery. What thoughts and behaviors are needed for a successful recovery? Anticipated challenges should be explored; clients who articulate a clear path and strategies to address challenges build momentum and increase confidence.

Box 11.1 Practicing OARS

From an MI perspective, one can't get enough practice in the basic skills (OARS). Within MI, OARS is used strategically throughout the four processes. I call this exercise the round-robin, adapted from the work of Cole (2008), and it is best used with small groups of five or six people. As an educator, I also like to join the round-robin to get some practice in myself!

The exercise begins by instructing the group to sit in a circle. One member agrees to be the client and is instructed to start talking about some change he or she feels ambivalent about making. It is best if the scenarios are real; however, I do give the option to make up a role to play if a member wishes. The client then begins talking, and, when he or she stops, the person to the right responds with a simple or complex reflection. The client then says what comes naturally and again stops. The next person to the right then responds with another reflection. The client again speaks and pauses, and the next person in the circle responds with any of the OARS skills. This pattern continues until all "counselors" have responded twice.

The round-robin is an excellent way to practice skills, and I have observed that many students reluctant to try them out gain considerable confidence through this simple exercise. Variations of the round-robin include incorporating all MI skills, encouraging members to keep a 2:1 ratio of reflections to questions, and requiring only reflections. Coaching and feedback are provided along the way.

Four Processes of MI

The four processes of MI provide a description of what the approach looks like clinically. These processes include engaging, focusing, evoking, and planning. Ideally, practitioners move in a linear process by first engaging with the client, establishing

focus in the session, evoking change talk from the client, and then setting up a plan to change. In reality, however, these processes are much more fluid in that the practitioner moves back and forth between and among processes depending on the clinical situation. A brief description of each process is stated next.

Engaging Process

The first step in the clinical use of MI is to engage the client with the purpose of understanding his or her wants and needs, conveying spirit, and developing a working relationship (Miller & Rollnick, 2013). During this phase the practitioner uses the core skills of asking *o*pen questions, *a*ffirming the client's strengths, *r*eflective listening, and providing *s*ummaries (OARS) and transitions to guide the conversation along a path toward finding a focus for the visit. Other skills used during the engaging process include providing information and advice to the client, although, as noted earlier, neither should be offered without first asking permission.

Focusing Process

The global purpose in using MI is to facilitate internalized behavior change. For our purposes, the primary behavior of interest is substance abuse and addiction; however, there are many times when clinicians use MI in part to help a client discern other important behavior changes related to mental health. Once this focus is determined, the counseling session turns into the work of building motivation and strengthening importance, confidence, and readiness to make that specific change.

Evoking Process

The evoking process is an essential stage in preparing people for change and is unique to MI. It centers on the concept of *change talk*, which is language clients use to indicate they are either preparing for or committed to change (Miller & Rollnick, 2013). For example, a client might state, “I really want to stop my pain pill addiction.” This statement suggests the client has some desire to quit. MI practitioners explore this language in depth by asking the client to elaborate, remaining curious, and reflecting the client's own language back to him or her. The opposite of change talk is “sustain talk,” where the client suggests that he or she does not want to change. Because sustain talk represents the other side of ambivalence, practitioners also explore this side, but the balance of attention leans toward change talk. Over time, the MI practitioner brings together all the client's change talk in the form of a summary. Although change talk is emphasized, the client still has autonomy in making any behavior change.

MI trainers are often asked what happens when the client does not offer any change talk. First, it is rare that a client offers *no* change talk or is 100% against changing. That is, most clients present with at least some ambivalence. Practitioners need to listen carefully to client language, paying attention to any hint of possible change. When change talk is offered, MI practitioners shift their focus to explore it in more detail. However, the general rule is that if no change talk is offered, then practitioners *elicit* it

from their clients (hence, the evoking process of MI). Amrhein, Miller, Yahne, Knupsky, and Hochstein (2004) discovered six main types of change talk, the first four of which are *desire* to change ("I want to stop drinking"); *ability* to change ("I have what it takes to stop"); *reasons* for change ("If I stop, I'll get to see my kids again"); and *need* for change ("Stopping is important to me and my family or I will lose them"). The first letter in each of these words spells the acronym DARN (Miller & Rollnick, 2013). Questions based on DARN are used as a mnemonic method for eliciting change talk:

D—"Why do you want to change your cocaine use?"

A—"What abilities within you suggest you could cut down on your cocaine use?"

R—"What are some reasons for stopping your cocaine use?"

N—"Why would you need to make a change in your cocaine use?"

Two additional forms of change talk are *commitment language* and *taking steps* toward change. These are thought to be a stronger form of change talk, called mobilizing change talk (Miller & Rollnick, 2013). The following are questions designed to elicit mobilizing change talk:

C—"How strong is your commitment to changing your marijuana use?"

T&S—"What steps have you taken already to curb your drinking?"

Note that any response to these questions will *probably elicit change talk*, although the client remains free to respond however he or she sees fit. It's worth repeating: Once change talk is offered, the practitioner must focus on exploring it further.

During the evoking process, one objective of the practitioner is to help individuals resolve the ambivalence between two competing, and often contradictory, types of behavior. In general, when change talk shifts from general statements about why a change is important (e.g., "I'll be healthier if I stop using") to specific statements about making the change ("I am going to an AA meeting tonight"), the individual begins to envision the change and may seek information and recommendations for how to make the change feasible.

Box 11.2 A Simple Exercise in Reflective Listening

MI practitioners place a premium on reflective listening throughout the four processes of MI. This is because it is a key strategy for conveying empathy and MI spirit.

As a general rule of thumb, counselors should aim for two reflections for every question, with a 3:1 ratio being the gold standard (Cole, 2008).

What is interesting about reflective listening is that it is *deceptively hard to do on a consistent basis*. In my experience, all practitioners can use practice in skillful reflective listening. As a way to strengthen reflective listening, I encourage students to practice in their everyday conversations by assigning the following exercise adapted from Rosengren (2009). Turn on the TV and watch a typical talk show, such as Dr. Phil or Oprah, or an interview on a news program. After the interviewee makes a statement,

pause or mute the TV and respond with a reflection. Once you have done this, resume the show or unmute the volume and continue. When the interviewee makes another full statement, pause or mute the TV and follow up with another reflection. Consider deepening your reflections as you go along (i.e., reflect on underlying emotions, nuance, body language). Also consider jotting down notes in a journal: Was it easy or difficult to reflect? Were your reflections simple or complex? How do you think the interviewee would respond to your reflections? As an alternative assignment, consider doing this activity by using the radio during your commute to work or school —a fun way to make the time pass by!

Planning

Miller and Rollnick (2013) recognized that once the motivation to make a change is strengthened, practitioners must then move on to negotiating a plan for change. If practitioners fail to address planning, they risk the client backsliding to previous patterns of problematic behavior and possibly relapse. As such, planning is the fourth process of MI.

The first three processes (engaging, focusing, and evoking) are designed to address motivational issues such as increasing importance, enhancing confidence, and building readiness for behavior change. These processes help clients examine their own reasons and motivations, as well as resistances, to behavior change. Clients are guided to contemplate and verbalize their desires, abilities, reasons, and needs (i.e., DARN) for constructing a life free from substance abuse. The process of planning involves guided negotiation while creating goals and action plans and at the same time monitoring client confidence, commitment, and readiness.

Once a change plan has been developed, the practitioner continues to help strengthen commitment and motivation. Session frequency may (or may not) decrease at this point, where counseling sessions focus on providing ongoing support, reinforcement, and adjustments to the change plan. Of course, if motivation wanes at any point in the planning process, more frequent sessions can be scheduled with a focus on rebuilding motivation. In addition, resolving motivational issues does not necessarily mean the client needs less help. It simply means that he or she is ready for the next phase of counseling, whatever that may constitute. As the planning process is carried out, other skills, techniques, and theories can be used as needed. However, in practice, MI practitioners know the importance of keeping MI spirit alive and well no matter what approach is used.

The planning process can be formal or informal. In formal planning, the practitioner might use a “change plan worksheet” (Center for Substance Abuse Treatment, 1999) to help the client think through the change process and anticipate any barriers or challenges in a more structured manner. Typical prompts and questions on a change plan worksheet

might include these:

The changes I want to make are …
The most important reasons I want to make these changes are …
I plan to do these things to reach my goals …
Some things that could interfere with my plan are …
Other people could help me in changing in these ways …

The practitioner is free to use other questions and prompts to help clients map out what change will look like and how they will go about realizing their own behavior change. Informally, the practitioner can simply discuss a change plan with the client without completing a formal worksheet. Regardless of which method is used, the practitioner and client collaborate on a change plan that best fits the client's situation.

Box 11.3 Assessing Your Own Motivation to Change

Think of a food, substance, behavior, activity, or poor habit that you would like to change but feel some ambivalence about. For example, you may notice that you eat too many sugary snacks and want to eat healthier but also like how this food gives you some emotional comfort when you are stressed. Complete an importance/confidence self-assessment using the strategies outlined in this chapter. For example, where do you fall (e.g., the ruler exercise) in terms of the importance of change versus confidence about change related to your behavior or habit? If you were to envision change, what would be the best-case/worst-case scenarios of changing versus not changing? If you feel you are ready to change (i.e., importance and confidence are relatively high [above a 6 on each]), complete a change plan worksheet according to the following prompts:

The changes I want to make are …
The most important reasons I want to make these changes are …
I plan to do these things to reach my goals …
Some things that could interfere with my plan are …
Other people could help me in changing in these ways …

Follow this plan for one week. How did it go for you? What were the barriers, if any, that emerged? How might you tweak your plan? Are you going to continue with the plan? Reassess your importance and confidence, if necessary.

Strengths and Weaknesses of the Theory

A significant strength of MI is its global reach and presence in many parts of the world. The Motivational Interviewing Network of Trainers (MINT), an organization that trains future MI trainers, includes members across Asia, Europe, the United Kingdom, the Middle East, and the Americas (Lewis, 2014). MI's flexibility makes it a good approach to assimilate with other approaches; practitioners can easily integrate MI spirit into

their work to better connect with their clients (Lewis, 2014). MI places emphasis on client strengths and honors their own thoughts, feelings, attitudes, and motivations regarding substance abuse change. It is particularly applicable to substance use problems because a clear target behavior (cutting down or stopping substance use) is relatively straightforward to establish (Lewis, 2014). MI is an effective strategy for clients who are precontemplative; its natural respect for clients tends to ease resistance and open up opportunities for change. The approach has amassed impressive empirical support, making it an evidenced-based practice for substance abuse issues as listed in the national registry for evidence-based practices.

As with any approach, MI does have its limitations. Although clinical research has established the efficacy of MI with a diverse range of problems, not much is known about when and with whom MI should or should not be used (Miller & Rollnick, 2002). In some situations, clients may need a more directive approach in which practitioners educate, offer advice, and direct the treatment process (Miller & Rollnick, 2002). MI will generally not be as effective in crisis situations where the expertise and direction of an experienced clinician is needed. Likewise, the client who has just experienced a significant loss is probably not interested in changing behavior but needing someone to follow and listen. More empirical research is needed to explore MI with diverse clients and populations. Some commentators have pointed out ethical concerns when practitioners and client goals are disparate or when practitioners have a vested interest in a client outcome (Lewis, 2014). For an excellent commentary on ethics and MI, see Miller and Rollnick (2002).

Case Study Responses

The following are responses to the questions in the case of Gabriel. From an MI perspective, Gabriel's motivation level needs assessment. Through the use of OARS and exploring the meaning of what brings Gabriel to counseling, the practitioner begins the engaging process of MI.

The fact that Gabriel has tried to stop using in the past and is currently in counseling suggests a healthy amount of ambivalence about his substance use. This is further evidenced by his avoidance of his niece, despite their strong relationship, when he has been using. Gabriel most likely wants to change, and sees importance in doing so, but may lack the confidence to follow through. His change talk is probably at the preparatory level, suggesting that he is thinking about change but has not yet made a commitment. However, the fact that he has come to counseling at the insistence of others suggests that his intrinsic motivation to change may be on the low side. Gabriel values his relationship with his niece; other values and goals would need to be explored to contrast with his substance use.

Whereas Gabriel is engaging in problematic use, he is struggling with several other issues as well, including questioning his sexual identity, a strong family history of chemical dependency, a poor relationship with his father, and significant anxiety-related

problems. As such, substance abuse may be the main topic of counseling, but it is likely that Gabriel would like to address other topics as well. The second process of MI, focusing, may present a challenge for the MI practitioner. However, through intentional MI strategies, counseling sessions can become focused on topics that are most relevant for Gabriel.

I would first explore Gabriel's substance use, because that appears to be the reason for his visit. Using MI, I would explore past use, family history, current use, and other types of information typical for an intake session. I would assess importance and confidence of changing substance use to see where I need to work in terms of motivation. I always begin MI sessions with the engaging process, using open questions, affirmations, reflections, and summaries to build rapport.

It is likely that other issues will emerge in our initial meetings and discussion. To give the session (and subsequent sessions) focus, I would encourage Gabriel to list the top five or six issues he would like to talk about (including substance use). After writing these issues down, I would then ask Gabriel what would be most pertinent for him to discuss in the current session. For example, Gabriel may wish to explore ways to reduce his anxiety, improve his relationship with his father, or address the shame about his first sexual encounter. I would offer information, with permission, related to my concerns about his substance use and would not hesitate to offer substance abuse as a focus for our session, given its prominence in his life.

With a counseling focus, I would elicit as much as possible from Gabriel his thoughts about the particular topic, what he has tried already, what barriers have prevented him from moving forward, and what he thinks about change. This process would focus heavily on eliciting change talk from Gabriel. When he offers change talk, I would be intentional about reflecting and summarizing this back to him, in his own words. As Gabriel's change talk shifts from preparatory language to commitment language, we would move into the planning process.

In the planning process, I might introduce the change plan worksheet. Using this, we would explore reasons for change, barriers to change, and support systems Gabriel could count on in the process of change. Once a plan is in place, I would consider moving to other theoretical models/approaches to best carry out the behavior plan. However, I would always be ready to move back to MI if motivation waned at any time during the process.

Although MI was not developed as a family counseling approach, I would strongly consider inviting Gabriel's sister and mother into counseling sessions, with Gabriel's permission. I might, for example, meet with Gabriel for three sessions and then hold a family session, continuing this pattern throughout treatment. Using MI with the family, I would be intentional about engaging all members of the family, seeking their perspectives, offering feedback, exploring ambivalence, and eliciting and reinforcing change talk, all within the philosophy of MI spirit. I also would elicit ideas for how

family members could support each other and Gabriel.

I would incorporate all aspects of MI spirit—collaboration, evocation, acceptance, and compassion. MI spirit would be the foundation of my work with Gabriel. Based on this foundation, I would explore the importance and confidence of changing his substance use using the ruler exercises described in this chapter. I would engage with Gabriel using open questions, affirmations, reflections, and summaries. I would use agenda mapping to provide focus in our sessions. I would strive to elicit from Gabriel change talk, specifically using the DARN C+TS acronym, and de-emphasize sustain talk. When change talk is provided, I would explore, remain curious, reflect back, and summarize. In the planning phase, I would use the change plan worksheet as a way to implement some structure in the planning process.

A challenge with using MI with Gabriel is the complexity of presenting concerns he brings to counseling. For example, Gabriel is abusing substances, but he also struggles with numerous other concerns. The MI practitioner would have to use skillful focusing to provide structure and direction for counseling. Formulating a specific concern out of numerous concerns can be quite challenging. The danger is that if a specific focus is not agreed on, the counseling becomes blurred, with the client and practitioner becoming overwhelmed, and nothing gets accomplished.

Other potential challenges are the issues surrounding Gabriel's family background and current family relationships. MI is not an approach designed to explore someone's past, although this may be what Gabriel needs at some point in counseling. Because family dynamics appear to play a role in Gabriel's substance use, MI would not be the best approach to explore these issues. However, the spirit of MI, as well as some of the techniques, such as engaging, focusing, and eliciting concerns, can blend nicely with other clinical and family therapy approaches.

I believe the spirit of MI would be well suited for Gabriel and provide an atmosphere where he would feel accepted and willing to share. The engaging process is the most important, in my opinion, because it sets the tone for counseling. The essential message during this process is

1. Let's work on this together.
2. I'll elicit ideas from you to move forward.
3. I'll affirm your strengths and respect your autonomy.
4. I'll promote your welfare.

The focusing and eliciting processes of MI are also important. Using MI, practitioners are encouraged to get more focus in their sessions. All problems cannot be solved in one session, or even 50 sessions. The focusing process allows clients and practitioners to focus on a couple of concerns per session, while stressing the interrelationships of all concerns (Miller & Forcehimes, 2015). Building on small successes builds confidence as the client continues to improve his life.

Gabriel would benefit from the eliciting process, especially given his past experiences

in treatment. It may be that a practitioner has never asked about Gabriel's own thoughts surrounding substance use, his attitudes toward use, his perspective on change, or how he was able to remain sober for 7 weeks. Eliciting conveys collaboration in which clients take ownership in their own treatment.

Summary

Motivational interviewing is a well-established, empirically supported treatment for clients struggling with substance abuse issues. MI is based on collaboration, evoking ideas from clients, acceptance, and compassion. It is a respectful approach that stresses clients' autonomy in their own recovery. Through the strategies of increasing importance and enhancing confidence, MI practitioners help build intrinsic motivation to change substance abuse behavior. MI is particularly well-suited to address ambivalence about change, a key intrapersonal experience that keeps people stuck in their own destructive patterns. The four processes of MI are designed to build rapport, focus counseling work, evoke change talk from clients, and plan for change.

Resources for Continued Learning

Books

Hester, R. K., & Miller, W. R. (Eds.). (1995). Handbook of alcoholism treatment approaches: Effective alternatives (2nd ed.). Boston: Allyn & Bacon.

Miller, W. R., & Rollnick, S. (2013). Motivational interviewing: Preparing people to change addictive behavior (3rd ed.). New York: Guildford Press.

Prochaska, J. O., Norcross, J. C., & DiClemente, C. C. (1994). Changing for good: A revolutionary six-stage program for overcoming bad habits and moving your life positively forward. New York: Avon Books.

Rollnick, S. (2010). Motivational interviewing for mental health disorders. Eau Claire, WI: PESI Continuing Education Seminars.

Websites

The Change Companies: www.changecompanies.net (includes many MI resources, including the training video based on the 2013 third edition of the classic MI text by Miller and Rollnick).

Motivational Interviewing: www.motivationalinterviewing.org.

National Association of Alcoholism and Drug Abuse Counselors (NAADAC): www.naadac.org.

National Institute on Drug Abuse: www.drugabuse.gov.

Psychotherapy.net: www.psychotherapy.net (training videos in MI).

Video

Hettema, J. (Producer), & Langdon, L. (Director). (2009). Motivational interviewing training video: Instructional information and demonstrative clinical vignettes, a tool for learners. United States: Langdon Productions.

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12 Harm Reduction: *Meeting Clients Where They Are*

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Jana Burson

As the name of the theory implies, the basic notion of harm reduction (HR) is reducing the harm associated with addiction. Although one specific definition of the theory is not available, two of the most widely accepted definitions of HR come from the Harm Reduction Coalition (HRC) and the International Harm Reduction Association (IHRA). The HRC (n.d.) defines HR as a composition of "practical strategies and ideas aimed at reducing negative consequences associated with drug use. HR is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs" (para.1). The IHRA (2015) defines the approach as "policies, programmes and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop. The defining features are the focus on the prevention of harm, rather than on the prevention of drug use itself, and the focus on people who continue to use drugs" (para. 6).

These two definitions offer a glimpse into the theory of HR, and we elaborate on each of the specific components throughout this chapter.

Basic Tenets of the Theory

To some people, HR is shorthand for controversial policies like needle exchange, the teaching of safe injection practices, distribution of naloxone kits to reverse opioid overdose in opioid addicts, and the prescribing of methadone and buprenorphine to treat opioid addiction. Antiharm reductionists often see these policies as contradictions to the classic definition of recovery, defined as abstinence from all drugs (White, 1998). Opponents believe such treatments enable addicted people to stay stuck in a lower quality of life than that achieved by complete abstinence.

However, Denning (2001) describes HR as "a philosophy of inclusion, respect, collaboration, and choice" (p. 24). Not all individuals living with addiction or using substances are able or willing to stop using all substances completely. For some, it is impossible even to imagine living without all substances for one day, let alone forever. Because some individuals seeking help may wish to reduce the harms associated with use but not eliminate their use, complete abstinence from all substances may not be the ultimate goal of people entering addiction treatment. This creates a divergence in treatment goals, even before treatment begins.

Participation in abstinence-based treatment may feel overbearing and even disrespectful for someone who wants to reduce the negative consequences of his or her addiction without completely abstaining. Feeling acutely uncomfortable, such clients may not fully engage throughout the process and may even leave treatment. The prospective client may

feel like a person who tries to buy a gallon of milk only to be told by a salesperson that he should buy a herd of cows to get better, fresher, and more wholesome milk. Whereas it may be true, the person may see cow ownership as too onerous, difficult, and inconvenient. That person may feel as if he is trying to be sold something he does not want or need.

In 1997, the city of San Francisco addressed the growing gap between traditional abstinence-based addiction treatment and rising support for HR practices by hosting the first of three Bridging the Gap conferences (Gleghorn, Rosenbaum, & Garcia, 2001). During the planning stage for this first conference, eight core principles for effective integration of HR into practice were developed and disseminated to conference attendees. The eight core principles as described by Gleghorn et al. (2001) are as follows:

1. Providers of services for those who misuse or abuse alcohol or other drugs shall deliver care in a culturally competent, nonjudgmental manner which demonstrates respect for individual dignity, personal strength, and self-determination.
2. Service providers are responsible to the wider community for delivering interventions that will reduce the economic, social and physical consequences of substance abuse and misuse.
3. Because those engaged in active substance use are often difficult to reach through traditional service venues, in order to reduce risk, the service continuum must seek creative opportunities and develop new strategies to engage, motivate, and intervene with potential clients.
4. The goal of substance abuse treatment services is to decrease the short and long-term adverse consequences of substance abuse, even for those who continue to use drugs.
5. Comprehensive treatments for those who misuse or abuse drugs and/or alcohol must include strategies that reduce harm for those clients who are unable or unwilling to stop using and for their loved ones.
6. Relapse or periods of return to use should not be equated with or conceptualized as "failures of treatment."
7. Medical services are an important component of comprehensive substance abuse treatment; patients prescribed medications for the treatment of medical and psychiatric conditions, including addiction, must have full access to substance abuse treatment services.
8. Each program within a system of comprehensive services will be stronger by working collaboratively with other programs in the system. (p. 2)

Box 12.1 Reflective Exercise

Consider the following quote illustrated in the text: "The prospective client may feel like a person who tries to buy a gallon of milk only to be told by a salesperson that he should buy a herd of cows to get better, fresher, and

more wholesome milk." Now consider you are the person attempting to purchase milk:

- What feelings might you experience during this exchange with the salesperson?
- What thoughts might you have during this experience?
- What actions might you take during this situation with the salesperson?

A key learning in our role as addictions counselors is that of empathy. Being able to consider what your experience (i.e., feelings, thoughts, actions) might be can help give you insight into what the other person's experience is and what he or she may need from you during that time.

Marlatt, Blume, and Parks (2001) summarized the themes of the core principles as embracing a compassionate and realistic approach, offering low-threshold access to services, and creating programs by partnering with the individuals who will be using the services. The elements of collaboration, respect, and inclusion described by Denning (2001) resonate throughout these core principles.

Philosophical Underpinnings and Key Concepts of the Theory

Harm reduction as a theoretical framework primarily began during the mid to late 20th century and gained popularity as a treatment option due to the emerging acquired immune deficiency syndrome (AIDS) epidemic of the time (Cook, Bridge, & Stimson, 2010). The medical test to screen for human immunodeficiency virus (HIV) antibodies was developed in the mid-1980s and led to the discovery of high rates of HIV and AIDS among intravenous (IV) drug users (Cook et al., 2010). Initial harm reduction efforts as we know them today developed to reduce the harm associated with the spread of HIV/AIDS via contaminated needles.

The capital city of the Netherlands, Amsterdam, instituted comprehensive programs aimed at making contact with IV drug users and simultaneously slowing the spread of HIV/AIDS through the community (Buning, van Brussel, & van Santen, 1988). The program involved multifaceted approaches, including but not limited to public education and unique opioid substitution programs. According to Buning et al. (1988), the government refurbished city buses that drove to different locations throughout the city and provided opioid substitution medication to eligible patients. Eligibility was based on a variety of requirements such as doctor referral, receptivity to counseling, and urine screens. Although some critics of harm reduction approaches believe that such programs will reduce treatment admissions, findings of Buning et al. suggest that increasing the availability of these supportive programs actually increased treatment admissions by 200%. This increase in admissions may be attributed to the comprehensive approach offered by the city (meeting clients where they were) and is also likely due to a shift in attitudes resulting in a reduction of the stigma of addiction.

Grassroots programs such as Amsterdam's harm reduction efforts spread worldwide. Although HR is typically associated with substances of abuse, there have been many efforts to use a similar approach to reduce harms in other areas. For example, unwanted teenage pregnancies and transmission of sexually transmitted diseases have benefited from HR condom programs in schools, as opposed to the historical abstinence-only programs (MacCoun, 1998). Although there are many critiques against the HR movement, it appears as though it is increasingly being implemented worldwide.

Key Concepts

Like a beautifully cut gem, HR has many facets. One of the main concepts is that client care should be client focused and client driven. Respecting the autonomy of people to make their own choices is key to the approach. Care providers do not set goals for treatment; instead, they work collaboratively with clients and strongly consider them as the experts on their needs and associated goals. In the end, the client is the only person who can make life changes. When change is forced on a client, it is more likely that the client will drop out of treatment or be only superficially compliant in the short term. One of the biggest barriers to treatment for individuals living with addiction is the notion of denial. Many users do not want to discuss use patterns for fear of being judged and labeled as in denial. HR does not embrace such a notion, instead believing that an individual is in a state of ambivalence about his or her use (Denning, 2001). Clients are given a menu of options, with the focus on improving the person's quality of life. Hopefully they get the message that “we care about you, even if you don't want to stop using drugs completely. Here are the ways you can be safer now.” That kind of unconditional affirmation can be a powerful agent of change. Change often happens as a result of the therapeutic relationship (Assay & Lambert, 1999), and harm reduction messages can build trust and rapport between drug users and the treatment community. Denning (2001) suggests that the most important part of embracing a HR orientation is to develop an ongoing relationship with the client based on a foundation of respect.

In building on the respectful partnership, the HR counselor embodies the role of an educator. Specifically, the client is informed about the effects of drugs on the body through psychoeducation. The client is given as much relevant information as possible in order for him or her to make the best decision. In addition to the counselor embracing an educator role, the client is also encouraged to educate the counselor. Once the counselor gains a clear picture of the client, the integrative treatment incorporates all aspects of the client's life. This means that different forms of treatment can be mixed to provide the support the client desires, and this is not the same for all clients. It is important to be creative and open-minded when individualizing a plan of treatment for each person. Additionally, families and friends are encouraged to be a part of the process (Denning, 2001). In other models, family members and friends may be seen as enabling the individual, and separation may be encouraged. This is not the case in HR in that community involvement is important.

The complexity of change is embraced in this model. Few people are able to change a destructive habit in one day. Clients are supported as they make advances and have setbacks, keeping in mind that change is usually a process that takes place over days to months to years. The focus is on the short term, embracing more easily achievable goals, rather than commitment to lifelong change. This approach acknowledges change usually happens in small increments.

HR looks at substance use, misuse, and addiction as a continuum. People with addiction are not the only ones harmed by drug use. At times, experimental users can experience severe consequences. For example, a young adult may have an opioid overdose the first time he experiments with heroin. If a bystander has a naloxone kit, the ultimate harm (i.e., death) can be prevented. If the user has not developed an addiction, the event may be enough to convince him heroin is not worth the risk of death. Without a naloxone kit, he would not be alive to make that choice. Harm reduction intends to help daily users and occasional users alike. As highlighted in this example, it is not necessary to have the disease of addiction to benefit from harm reduction treatment.

Philosophical Underpinnings

All theories have philosophical roots, and HR is no different. Utilitarian thought appears to be most consistent with HR. Utilitarianism suggests that the morally right action is the one that provides the most good (Driver, 2014). In order to understand this in relation to HR, we must examine the idea of morals.

Morals refer to dichotomous (e.g., right and wrong or good and bad) ways of being, acting, or thinking. In our daily life, moral judgments are unconscious characterizations of actions in a dichotomous way (Richardson, 2013). Many people do not know that what they are doing is making a moral judgment. For example, this can be seen in our criminal justice process. During a criminal trial the judge and/or jurors are charged with convicting an individual as displaying the right or wrong action under investigation (i.e., making a moral judgment about behavior). There are limited options in the decision-making process; most commonly a verdict of either guilty or not guilty is required (see Exhibit 12.1).

Traditionally, drug use has been classified as either right or wrong. Users may classify it on the right side, due to the benefits they experience while using, whereas others may classify use as wrong. The HR approach expands moral judgments from being a dichotomy to a spectrum as seen in Exhibit 12.2. The middle section shows an overlap between the dichotomies, creating an area that may be both right and wrong, which in essence removes the right and wrong nature of what is being classified. As applied to addiction work, if we embrace the notion that some behaviors may be both good and bad, they just become behaviors, without the judgment. This expansion helps us consider more than one viewpoint and helps form a bridge between counselors and clients. For clients it is important to recognize that although there are benefits associated with use, there are also harms, and vice versa for counselors. Acknowledging that there

is more to the spectrum reduces defenses that both parties may bring into the discussion.

Exhibit 12.1 Dichotomous Moral Judgement Beliefs

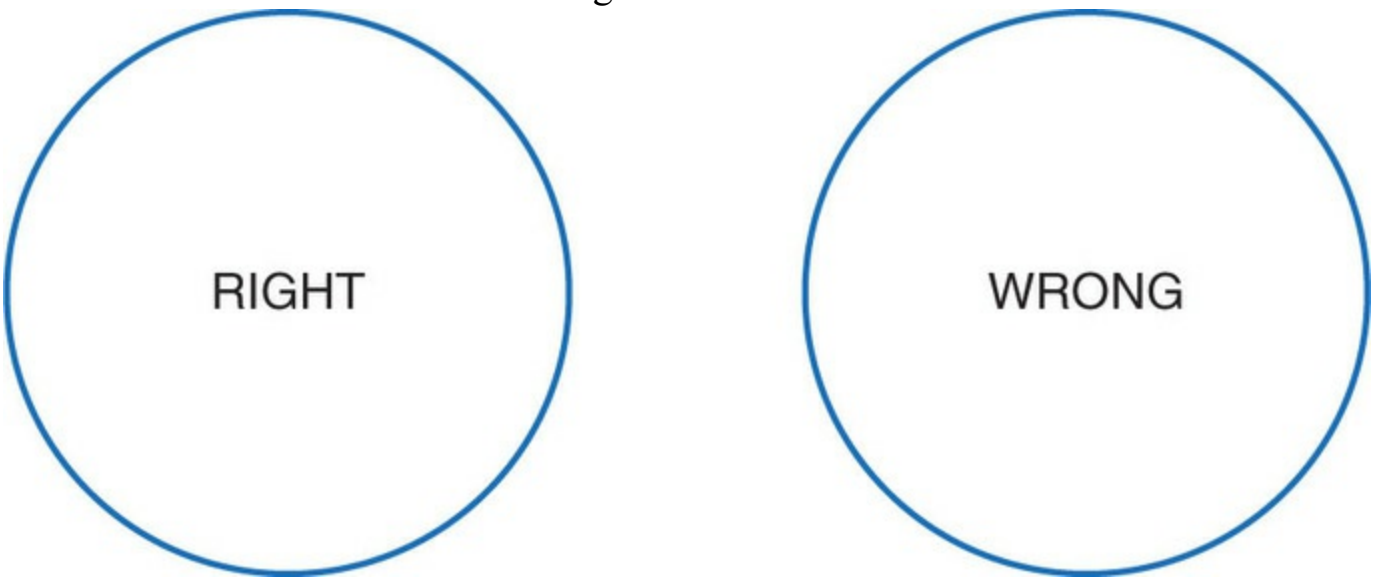
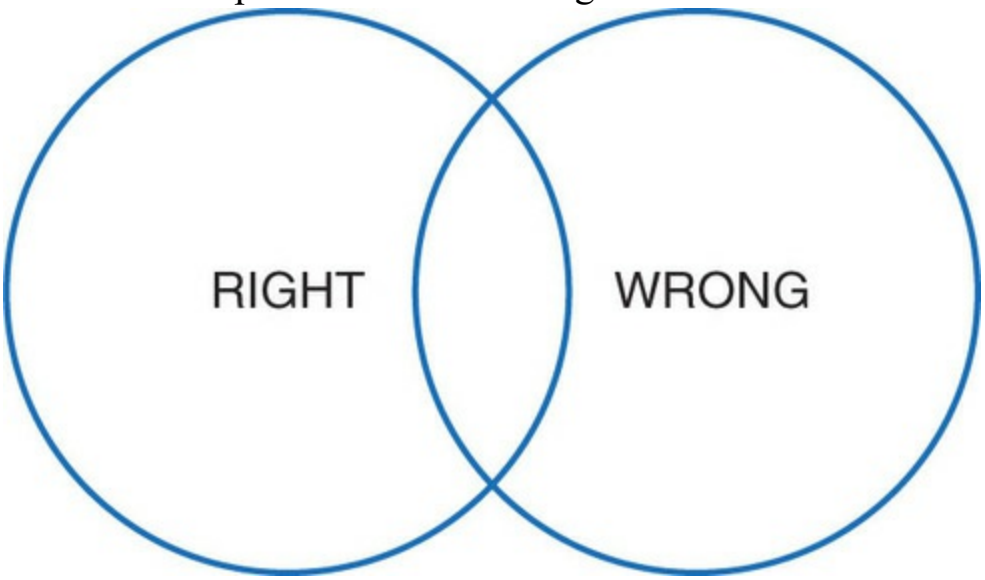


Exhibit 12.2 Spectrum of Moral Judgement Beliefs



The morally right action, as it relates to utilitarianism, results in reduction of harm to one individual or to society on a larger scale. Therefore, all HR practices are the morally right action, because harm is reduced.

Comparison With Other Approaches

In fields of medicine besides addiction treatment, HR concepts are the core of treatment. Medical doctors often embrace harm reduction when managing other chronic diseases. For example, when physicians work with patients living with type 2 diabetes, they often do a thorough assessment and make treatment recommendations according to the individual's circumstances. Although the importance of people with type 2 diabetes limiting their carbohydrate consumption is well known, a physician often does not recommend a no-sugar diet but will be satisfied with the patient limiting his or her sugar content. Most chronic diseases, like addiction, have behavioral components, and

patients often do not follow their physician's advice precisely. Physicians continue to work with these patients, recognizing behavioral change takes time. Physicians know the amount of harm done by the disease can be reduced by smaller changes and accept those changes as better than no changes at all. Physicians usually do not dismiss such patients but rather continue to prescribe medication and attempt to motivate behavioral change. Continued treatment reduces the amount of harm done to patients, even when they are noncompliant.

As discussed, dichotomous thinking in terms of right and wrong categories is easier for most people. Treatment providers may find it easier to condemn the use of any euphoria-producing drug and view recovery solely as abstinence from all drugs. In reality, many shades of gray exist between the two extremes; however, the middle phase of the change process is often ignored, and a false dichotomy is set up between the two extremes. Prochaska and DiClemente (1983) recognized the need for an expansion of this idea and developed the transtheoretical model of change, also known as the stages of change model. This model was examined in detail in Chapter 10, and we encourage you to review it at this time.

Motivational interviewing (MI; Miller & Rollnick, 2013) is the most well-known approach embracing the stages of change model. As discussed in Chapter 11, in this person-centered approach to counseling, a client is fully recognized as being ambivalent about change, not in denial. In this respect, MI is highly consistent with the HR approach. The shared philosophy of person-centered treatment found in both HR and MI is derived from Rogers's (1957) core conditions of counseling. Rogers posited six core conditions for change, three specifically relating to the counselor. The counselor must embrace a stance of unconditional positive regard, strive for empathic connection, and be genuine in his or her interactions with clients. These elements are core to HR practice.

Influences on Social Policy

HR is more closely associated with social policy than any other addiction theory. Expansion and reconceptualization of social policy is crucial for an HR approach to be successful. One social policy of the last century that has needed to be drastically reconsidered for HR to be effective is the “war on drugs.” In 1971, President Richard M. Nixon coined this phrase, which has been responsible for countless policies (Drug Policy Alliance, 2015). In order to successfully implement HR approaches, the “war” would need to be lessened, or at least reconceptualized. Legal regulation of substances, including minimum sentences for drug possession and distribution, has had a significant effect on offenders' lives and society in general. The most common evolving social policy of the past decade is marijuana legislation. Historically, the possession, use, and distribution of marijuana was punishable by jail time, yet there has been a significant change to this policy, mainly in terms of medical marijuana legislation. So far 23 states, as well as the District of Columbia, have legalized medical marijuana (ProCon.org,

2015). In 2012, voters in Washington and Colorado approved recreational marijuana use (Smith, 2012), and many other states are considering similar legislation. Federal law still classifies marijuana as a Schedule I illegal drug, a classification reserved for the most dangerous and most addictive substances.

Social policy, including laws, needs to allow for exceptions to the law for harm reduction purposes. The mayor of Gloucester, Massachusetts, made national headlines with a recent harm reduction approach challenging established social policy. The mayor declared an amnesty program, in which individuals could turn themselves in, with drugs in their possession, and immediately begin treatment (Becker, 2015). This shift in policy away from criminalization appears to be an evolution of the drug court process. A harm reduction approach was used by removing the criminal justice system entirely. Harm reduction approaches allow for individual circumstances to be considered for furthering the good of the individual and ultimately of society.

Outcomes Associated With a Harm Reduction Approach

Numerous studies have examined the outcomes of HR practices. Such studies often examine outcomes relating to the physical body of the client, psychological outcomes, and/or sociological outcomes. Phillips, Stein, Anderson, and Corsi (2012) studied the outcomes of client education, a common HR approach associated with needle exchange programs. The authors enlisted current IV heroin users and randomized the sample to either an intervention group or an assessment-only group. Each group of participants was asked to demonstrate the skin cleaning procedures he or she would use prior to injecting heroin. In addition, they were asked to demonstrate the needle cleaning procedures they commonly used. Researchers rated each participant's demonstration according to approved protocols. Following the baseline assessment, the intervention group participated in brief educational sessions aimed at teaching approved protocols for skin and needle cleaning practices.

The findings of the Phillips et al. (2012) study suggest that education along with a 1-month booster session significantly improved participants' skin and needle cleaning practices at a 6-month follow-up in comparison with the assessment-only group. In addition, the authors report that the intervention group participants reported a larger reduction in IV heroin use and a reduction in use days, although this was not significant between groups. This is encouraging because it highlights the role HR education practices can have on supporting client change, even when not the focus of the practice. The small sample size of the study ($N = 48$) limits the availability to make meaningful insights, but these findings do encourage future research concerning client education on safe use practices and the effects on consumption rates of substances.

There has been large-scale support for methadone maintenance treatment in the scholarly literature. Fullerton et al. (2014) examined the literature base for methadone maintenance programs and found numerous supportive studies for the HR practice. Many of the studies reviewed were meta-analyses, a type of research in which multiple

studies are compiled and results are analyzed on a large scale. The authors report that methadone maintenance programs reduce clients' use of illegal opioids, as well as increase client involvement in treatment. In addition, the programs have been shown to reduce mortality, illegal activity, nonopioid illegal drug use (e.g., cocaine, methamphetamine), and behaviors associated with HIV infection. With such positive outcomes associated with methadone maintenance it is no wonder the programs are widely supported as an HR practice.

Grazioli, Hicks, Kaese, Lenert, and Collins (2015) completed a study with chronically homeless adults who met the diagnostic criteria for an alcohol use disorder. Study participants received counseling based in HR practices. They received personalized feedback about their alcohol use, were encouraged to discuss their own goals for counseling (not necessarily related to alcohol use), were introduced to common safer-drinking practices, and received medication (naltrexone). Study participants were followed over the course of 3 months to see which of the safe-drinking practices they embraced and whether there was change with this over time. The authors report no change over time in endorsement of the practices, but on average the participants endorsed using three safe-drinking practices. The most common practices included limiting the effects of alcohol on the body (e.g., including food when drinking) and changing the manner of drinking (e.g., drinking lower-proof alcohol). In examining the participants' view of alcohol use and abstinence, Grazioli et al. (2015) state that the participants' "abstinence was primarily viewed as a temporary reprieve from ongoing alcohol use instead of long-term lifestyle change" (p. 67). The embracing of safe-drinking practices makes sense given the reported participant attitudes toward abstinence. This study highlights that substance users do embrace and use HR practices when appropriately informed.

The previously referenced studies comprise not even 1% of the available research on HR practices. However, these findings suggest the outcomes one can expect from implementing these strategies. More research examining specific practices and intervention levels would benefit not only clients but also practicing counselors.

How the Theoretical Approach Is Used by Practitioners

The theoretical approach of HR is not only used by individual counselors but also embraced on a larger scale by treatment programs. This section examines current practices of HR, including safe-needle exchanges, client education, and methadone maintenance programs. The section also provides an overview of how HR practices may be implemented by organizations.

Needle Exchange and Injection Education

Perhaps the practice most usually associated with HR is needle exchange programs (NEPs). These programs offer free or low-cost distribution of new, unused needles to intravenous drug users. NEPs have been shown to help prevent transmission of

infectious diseases such as hepatitis and HIV and also reduce the risk of local soft-tissue infections such as cellulitis and skin abscesses. Other serious health issues such as endocarditis (bacterial infection of a heart valve) are reduced when drug users use fresh needles and syringes.

In addition to receiving clean needles, users are taught safe injection practices. For example, drug users are taught to try a small test dose of heroin as a way of assessing how strong the drug is, prior to injecting a full dose, because heroin purity can vary immensely. In addition, users are trained to use cotton filters in the syringes, which can prevent particles and debris from being injected along with their drug. They are taught not to reuse these filters, to reduce the risk of "cotton fever." Cotton fever is a well-known illness among IV drug users and is marked by fever, abdominal pain, and nausea and vomiting, among other medical concerns (Xie, Pope, & Hunter, 2016). Other users are advised against using cigarette filters. It is common for some to use these filters thinking they are safe, but these filters contain glass particles that can be problematic if injected along with the drug. Users are also told not to use lemon juice to help dissolve their drug, as is common practice, because it can contain a type of harmful fungus. Education also includes discussing the importance of not using while alone. The idea is that by using in groups, someone would be available to call for help if an overdose occurs. In addition, injection times are encouraged to be staggered, to allow one person to be alert enough to call for help if needed or to use a naloxone kit to reverse the overdose.

Naloxone Kits

A growing HR practice is increasing the availability of naloxone kits. Naloxone, a prescription medication, reverses the signs of opioid overdose and can be administered in several ways: intravenous (into a vein), subcutaneous (under the skin), intramuscular (into a muscle), and intranasal (sprayed up the nose). Naloxone can be thought of as a kind of anti-opioid, causing the reversal of opioid effects in case of an overdose. Naloxone has been administered in emergency departments for years, but with the recent rise in opioid overdose deaths, many organizations have pushed to have naloxone kits become more available to opioid-using people, opioid addicts, and first responders such as police and emergency medical personnel. These kits are becoming increasingly user-friendly, with some containing automated messages describing the instructions for use.

The quicker an opioid overdose is reversed, the less the chance of death or disability from oxygen deprivation, so time is of the essence when naloxone is needed. Many states now allow third-party prescribing of naloxone. This means doctors can prescribe kits to opioid users and opioid-addicted people and also to their families. At present, laws differ among states.

In addition to the distribution of naloxone kits, opioid-addicted people, friends, and family members are educated on overdose management techniques. Participants are

taught how to position the body of an addict who is unresponsive while waiting for help to arrive. They are also taught what not to do, such as not injecting ice water in the user's veins and not putting the person into a cold shower.

Medication-Assisted Treatment (MAT)

Medications are available to assist with some of the related harms of addiction. Some of the most common medications used for addiction treatment are methadone and buprenorphine. These are medications prescribed to individuals to help manage the withdrawal symptoms associated with discontinuing opioid use. Severe withdrawal is common in opioid addiction and is one major reason users continue to use despite negative consequences. These medications work by activating the same neurotransmitters activated in opioid use, but the feelings of euphoria are not produced. As a result of the medicine blocking the neurotransmitter receptor sites, the user is able to reduce use while not experiencing the physical withdrawal symptoms.

Methadone-assisted treatment has been available since 1964 (Fullerton et al., 2014). The management of opioid addiction with methadone and buprenorphine has traditionally been considered harm reduction, though now many experts feel MAT is a stand-alone treatment in its own right. This position is supported given that addiction is a chronic illness, and as with many other chronic illnesses, the client may need to take medication for an indefinite period of time.

Case Conceptualization

Another major use of an HR approach by counselors is embracing the core principles outlined by Gleghorn et al. (2001) as a framework for case conceptualization. Embracing an HR lens demonstrates a commitment to clients, acknowledging that any reduction in harm is positive for the client and society as a whole. This shift is not an easy one to make, particularly because we are socialized with certain beliefs about addiction (e.g., addiction is a weakness, drug users are bad). It is important for counselors to examine their own biases and reflect on how their beliefs are helping or hindering the population they hope to work with.

Whereas the previous is not a fully exhaustive list of all HR techniques, the measures and strategies have in common the goal of keeping drug users safe. All policies and techniques that have this goal in common can rightly be termed HR and ideally are delivered in a caring, compassionate, and nonjudgmental way by care providers. Indeed, all forms of addiction treatment and counseling should reduce harm to the patient. Even if the provider's goal is abstinence and the client does not achieve abstinence, HR has been accomplished if the client uses less or uses a little more safely. Proponents of an HR approach would say that treatment has not failed because the client is better off than prior to receiving treatment.

Assessment and Prevention Implications

Because HR honors the right of an individual to determine how much and what kind of

treatment is desired, care providers need to assess the client's willingness to change in the context of substance use. Ideally, practitioners can respectfully assess the client's reason for seeking treatment and the desired outcomes. Often this would include determining the patient's stage of change, using Prochaska and DiClemente's (1983) model.

In order to assess a client's readiness to change, an addictions counselor may choose to use a standardized assessment tool. The Readiness for Change Questionnaire (Rollnick, Heather, Gold, & Hall, 1992) is a 12-item tool that assesses the following three stages: precontemplation, contemplation, and action. Each of the 12 items corresponds to one of the three stages and once compiled indicates a score from -8 to +8. The scale with the highest number indicates the current stage of change. The questionnaire was expanded to 15 items for use in treatment settings (i.e., Readiness for Change Questionnaire [Treatment Version]; RCQ-TV) by including items related to abstinence, as opposed to the sole focus on reducing alcohol consumption found in the original version (Heather & Hönekopp, n.d.).

> Box 12.2 Exploring SAMHSA's TIP Series
> The assessments mentioned in this chapter can be found in the Substance Abuse and Mental Health Services Administration, Treatment Improvement Protocol (TIP) Series Number 35, publication titled *Enhancing Motivation for Change in Substance Abuse Treatment*, which can be downloaded for free on the SAMHSA website. The website and further information about ordering printed material is found in the Resources for Continued Learning section at the end of this chapter.

Another assessment tool for assessing a client's readiness to change is the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES; Miller & Tonigan, 1996). There are 19 items on the questionnaire, and a participant's score indicates one of three scales as corresponding to the client's readiness for change: recognition, ambivalence, and taking steps. Two forms of SOCRATES are available, SOCRATES 8A, the Personal Drinking Questionnaire, and SOCRATES 8D, the Personal Drug Use Questionnaire. The two forms allow for separate assessment of change related to drinking and/or drug use, which is a strength over the RCQ questionnaires previously discussed.

In addition to the standardized tools examined earlier, addiction counselors may also use subjective means to assess a client's readiness to change. One counseling skill common to solution-focused brief therapy (De Jong & Berg, 2013) is scaling questions. Clients are asked to rate their readiness for change on a scale from zero to 10, zero meaning no readiness and 10 meaning full readiness. Once clients state a score, they are asked to consider what an incremental change would look like. For example, a counselor may say, “You mentioned that you scored a 6 out of 10 on your readiness to

change. What might a 7 look like for you?" The smaller increment of change helps to not overwhelm the client. A counselor may also ask about motivation on a similar scale, remembering to follow up with what the increment of change would look like.

If treatment professionals do not assess willingness to change, they risk assuming that the patient desires complete abstinence from all drugs. Motivational interviewing (MI) counseling techniques work well in drug addiction treatment, and as identified previously, both MI and HR have the same underlying principles: respect for the individual and recognition that long-lasting change comes only when and if the person decides to change. External pressures may force change in a client, but if there is no desire on the part of the patient to sustain that change, it may not be permanent. Some treatment programs force patients to be superficially compliant in order to make it through whatever treatment program they have entered.

For example, a client in an inpatient residential setting may want to stop using cocaine but may be uninterested in quitting marijuana. The client may detect that voicing her desire and intention to keep using marijuana would lead to unwanted attention from treatment providers. Providers may single out this client in a group setting and pressure other group members to confront the client's attitude toward marijuana. The client, feeling targeted and singled out, may begin to parrot what other clients say rather than being honest about her real plan to continue using marijuana. Treatment providers may mistakenly think they have been successful in changing their client's mind, when in truth, she just decided to avoid conflict.

Throughout the assessment phase, it is crucial that counselors maintain focus on the client and embrace the client's treatment goals according to an HR approach. The HR approach has the ability to reduce clients' defenses if embraced fully by the counselor. Instead of dictating what the treatment goals will be, the client is encouraged to be creative and focus on what he or she would realistically achieve. If a client suggests he or she wants to make a change, the counselor inquires about how that change will benefit the client and helps build up his or her motivation for continuing with the change. This assessment is crucial because it is often the first line of interaction with clients.

Strengths and Weaknesses of the Theory

Proponents of the HR approach identify numerous strengths with the model. The first is the expansion of treatment, both in reaching more clients and in expanding the definition of services considered treatment. More individuals may be encouraged to enter treatment when it is not solely focused on abstinence. In addition, treatment services such as the medication-assisted therapies discussed previously fall under the HR umbrella and therefore expand our definition of treatment.

Another strength of the model is that HR reduces large societal costs of drug use and addiction. A client being prescribed methadone maintenance therapy is at a reduced risk for engaging in criminal behavior to acquire opioids illegally. The reduction in criminal behavior can have a direct result on the reduction of arrests for drug use and trafficking.

Not only would the number of offenders in prisons be reduced overall, but there would also be a reduction of the number of offenders in prisons who would require additional costly medical attention for withdrawal symptoms as well as addiction treatment.
Last, and perhaps the most embraced strength of the HR approach, is the reduction in moral judgment championed by the model. As stated by Denning (2001), the model seeks to include individuals, not exclude them because they are unable or unwilling to follow strict rules. Any sort of change, no matter how small, is embraced and championed. Clients are expected to be the experts on their lives and are encouraged to educate the counselor on what is best for them.
People who object to HR practices usually do so with the best interests of drug users in mind. Many opponents of HR honestly feel that these strategies serve only to enable the person to keep using drugs and in the end cause more harm than if the client were allowed to suffer consequences of active drug use. Some 12-step groups maintain that users must "hit bottom" before being able to find true recovery. They may feel HR keeps users from experiencing a bottom necessary for a complete change of lifestyle.
Opponents of an HR approach also define true recovery as being achieved only with complete abstinence from all euphoria-producing drugs. For example, recovery advocates who feel abstinence is the only recovery may deem clients who are prescribed methadone or buprenorphine as still in active addiction. Although these sentiments are coming from a desire for all to live a drug-free life, clients may hear the message that they will never be able to get clean if they are using supportive medications, which may cause them to lose all hope.

The Great Debate

The strengths and weaknesses of HR have been debated since the model was first conceptualized. The following is an imaginary debate between two addiction treatment professionals. One professional endorses HR measures as worthy activities and feels such measures can keep drug users alive and healthy, even if they never completely stop using. This individual is identified as the advocate. The other professional feels HR does not allow a drug user the opportunity for full and happy recovery, which she believes is seen with complete abstinence from all drugs. This individual is identified as the opponent. They begin by sharing views about needle exchange programs.
Advocate: I fully support needle exchange programs. They have been proven to reduce transmission of infectious diseases, including HIV and hepatitis. Why wouldn't we want to help people avoid getting these potentially devastating diseases?
Opponent: Because giving out needles sends the wrong message. It says we are OK with people injecting drugs and that we are willing to make it easier for them to do so. Appearing to condone drug use in any way sends the wrong message to young adults, who may be considering using drugs for the first time. Stigma toward drug users can be harmful, but maybe it is a good thing to have stigma surrounding dangerous activities like injection drug use.

Advocate: Studies do not show needle exchange increases the likelihood that people will start using drugs intravenously. Do you really think easily available clean needles and syringes would convince a person to start injecting drugs? Besides, even if you have little compassion for the drug user, for every case of HIV we prevent with needle exchange, we save our society countless dollars in medical care. Besides being morally right, needle exchange makes financial sense.
Opponent: No, it doesn't. It sends a message to drug users that we've given up on them. It says we don't think they will ever be able to live without injecting drugs. In a way, it infantilizes them. By making drug use easier, we may cheat them out of trying to become clean and sober.
Advocate: I disagree. Needle exchange tells drug users that we care about their welfare, whether or not they choose to use drugs. They will feel our compassion for them, and these drug users are then more likely to come to us for help if they are ready to stop using drugs, because they trust us.
The advocate and opponent move to the topic of medication-assisted treatment of opioid addiction with methadone and buprenorphine.
Advocate: I fully support medication-assisted treatment. We have 50 years of studies that show people who are addicted to opioids are less likely to die if they enroll in methadone maintenance or buprenorphine maintenance. It is one of the most heavily evidence-based treatments in all of medicine, and it is endorsed by many professional agencies, such as the Institute for Medicine, the Substance Abuse and Mental Health Services Administration, the World Health Organization, and the American Society of Addiction Medicine. We have study after study showing how opioid-addicted people have a better quality of life when on medication-assisted treatment with methadone. We have more information about methadone because it has been used in the United States much longer than buprenorphine, which was approved by the Food and Drug Administration in 2002, after the Drug Addiction Treatment Act of 2000 was passed. Opioid-addicted people enrolled in methadone treatment are more likely to become employed, much less likely to commit crime, and more likely to have improved mental and physical health. They do receive addiction counseling as part of the process of treatment. We think buprenorphine has the same benefits, though there have been fewer studies than with methadone. We do know the risk of opioid overdose death is much lower when an opioid-addicted person is also treated with buprenorphine. Because medication-assisted treatment is so effective, it should be considered a primary treatment of opioid addiction and not only a harm reduction strategy.
Opponent: For that matter, all evidence-based treatments should reduce harm, because they treat the patient. But especially with methadone, opioid-addicted people may be harmed *more* than if they continue in active addiction. It is no different from giving an alcoholic whiskey. It is a heavy opioid that is very difficult to stop using. The opioid treatment programs that administer methadone don't try to help these people to get off of

methadone, because they make more money by keeping them in treatment. These patients are chained to methadone with liquid handcuffs forever.

Advocate: Methadone and buprenorphine treatments are *not* like giving an alcoholic whiskey, because of the unique pharmacology of these medications. Even after an opioid-addicted person stops using opioids and endures the acute withdrawal, he will usually feel postacute withdrawal. This syndrome, often abbreviated PAWS, can cause fatigue, body aches, depression, anxiety, and insomnia. It is very unpleasant. Many people in this situation crave opioids intensely. We think this occurs because that person's body no longer makes the body's own opioids, called endorphins. Endorphins give us a sense of well-being, and without them, we don't feel so good. When humans use opioids in any form, their bodies stop making endorphins. In some people, it takes a very long time for that function to return. In some cases, it may never return. We can't yet measure endorphin levels in humans, so this is just a theory but one borne out by years of observation and experience. Methadone and buprenorphine are both very long-acting opioids. Instead of the cycle of euphoria and withdrawal seen with short-acting opioids, these medications occupy opioid receptors for more than 24 hours. It can be dosed once per day, and at the proper dose, it eliminates craving for opioids and eliminates the postacute withdrawal, which is so difficult to tolerate. We often compare opioid addiction to diabetes, because in both cases, we can prescribe medication to replace what the body should be making. And yes, methadone is difficult to stop using, but most of the time it is in the patient's best interests to stay on this medication, rather than risk a potentially fatal relapse to active opioid addiction. Some patients are able to taper off of the drug, if they can do it slowly. Do you think of a diabetic who needs insulin as being “handcuffed” to it? Do you think the doctor who continues to prescribe insulin is just trying to make money off of that patient? Why is it wrong to make money from treating addiction but not other chronic diseases?

Opponent: What about all of the former opioid-addicted people, now in 12-step recovery, who are healthy and happy off all opioids? Why are these people doing so well, even though they had as severe an addiction to opioids as the patients in opioid treatment programs?

Advocate:I don't know. One form of treatment, even medication-assisted treatment, will not be right for every patient. Maybe the support that a 12-step group can provide got these people through the postacute withdrawal. We don't have much information about these recovering people due to the anonymous nature of that program. But not all opioid-addicted people want to go to 12-step meetings. If they feel well off of all opioids, that's great. They don't need medication. But don't prevent other people who do benefit from medication-assisted treatment from being helped with methadone and buprenorphine.

Opponent: These treatments cheat patients out of full abstinent recovery. Methadone and buprenorphine blunt human emotions and make it impossible to make the spiritual changes necessary for real recovery. Methadone and buprenorphine are intoxicants, and

they prevent people from achieving the spiritual growth needed for full recovery. You keep these people from finding true recovery and condemn them to a life of cloudy thinking from these medications.

Advocate: Various people say that patients on maintenance methadone and buprenorphine have blunted emotions and spirituality, but there's little evidence to support that claim. How can you measure spirituality? If spirituality means becoming reconnected with friends and loved ones and being a working, productive member of society, then studies show that methadone and buprenorphine are more likely to assist patients to make those changes. Physically, studies show patients on maintenance methadone and buprenorphine have normal reflexes and judgment. They are able to think without problems, due to the tolerance that has built up to opioids. They can drive and operate machinery safely, without limits on their activities. Contrary to popular public opinion, clients on stable methadone doses are able to drive without impairment. However, if clients mix drugs like sedatives or alcohol with methadone, they certainly can be impaired. That's why we warn patients not to take other sedating drugs with medication-assisted treatments. My bottom-line argument is this: Dead addicts can't recover. Far too many opioid-addicted people have abstinence-only addiction treatments rammed down their throats. Most of these patients aren't even told about the option of medication-assisted treatment, which is much more likely to keep an opioid drug user alive than other treatment modalities. Too often, people addicted to opioids cycle in and out of detoxification facilities over and over, even though we have 40 years of evidence that shows relapse rates of over 90% after several weeks in a detox facility. We've known this since the 1950s, and yet we keep recommending this treatment that has a low chance of working. And then we blame the addict if he relapses, when in reality he was never given a treatment with a decent chance of working! Medical professionals, the wealthy, and famous people are treated with 3 to 6 months of inpatient residential treatment, and they do have higher success rates, but who will pay for an average opioid user to get this kind of treatment? Many have no insurance or insurance that will pay for only a few weeks of treatment. For those people, medication-assisted treatment can be a life-saving godsend. It isn't right for every opioid-addicted person, but we do know these people are less likely to die when started in medication-assisted treatment. After these people make progress in counseling, there may come a time when it is reasonable to start a slow tapering off of either methadone or buprenorphine, but let us first worry about preventing their death.

Opponent: Given the time, money, expense, and stigma against methadone and buprenorphine, it should be saved as a last-resort treatment. If an opioid-addicted person fails to do well after an inpatient residential treatment episode, then medication-assisted treatment could be considered as a second-line treatment. Let's save such burdensome treatments for the relapse-prone opioid-addicted people.

Advocate: You mean if they live long enough. It seems disingenuous to claim stigma as a

reason to avoid medication-assisted treatment when *you* are the one placing stigma on this treatment.

> Box 12.3 Reflective Exercise
> The text provides a debate between two addiction treatment professionals. One is the advocate and one is the opponent. Based on the conversation,
> 1. What do you think are the advocate's three main points?
> 2. What are the opponent's three main points?
> 3. If you were to get into a discussion with a classmate or future coworker, what side would you take?

Case Study Responses

The case of Gabriel discusses numerous incidents of harm to himself, his family, and society. The immediate harm identified is his alcohol use. He is drinking in a dangerous pattern and is most likely to cause immediate and irreversible harm to himself. Harm reduction tends to focus on the most serious risks first, if the patient agrees. If Gabriel does not see his alcohol use as a problem, the harm reduction approach honors his decision and asks him what he sees as the most critical problem, encouraging discussion of reducing some harm. The aim of HR is to meet Gabriel where he is and encourage him in any change he might be open to as opposed to no change or treatment. The following are some of the identified harms organized in a biopsychosocial framework.

Biological/Medical Concerns

Gabriel's substance use raises serious medical concerns. Gabriel reports alcohol consumption in patterns that result in blackouts, along with steady use of marijuana. These periods of time are a major concern because blackout drinking can cause significant changes to his brain's structure and function, especially the prefrontal cortex. This part of the brain is responsible for decision making and judgment and does not complete development until an average age of 24. Because Gabriel is 26, he is ingesting chemicals during a sensitive time of brain development. Even without drug use, the part of his brain responsible for decision making may not be finished forming.

Another potential medical concern is Gabriel's reported sexual activity—sex with two female patients during his last inpatient admission while in a committed relationship. It is unknown how many other partners these females had and whether they used protection with these other partners as well as with Gabriel. Such activity could put him at risk for sexually transmitted diseases (STDs) such as syphilis, gonorrhea, herpes virus, and HIV, among other ailments.

At present, we don't know if Gabriel sees his sexual activity as behavior worthy of change. Sexual activity does not have to carry risk, yet it is not known whether contraception was used. We may make an assumption that it was not, because sexual activity is typically in violation of the rules at treatment centers and therefore condoms would not be available for patient use.

Psychological Concerns

The case study mentions that there is mental health comorbidity, yet there is no mention if Gabriel is currently getting any care for these two treatable conditions, obsessive-compulsive disorder (OCD) and anxiety disorder. A counselor using this treatment approach would be concerned about the use of substances and the impact on mental health symptoms. There is also a chance that Gabriel is suffering from what he believes to be symptoms related to OCD and anxiety disorder, yet it may be directly linked to his substance use. A thorough assessment would help sort out the cause of his symptoms, but we can assume his drug use is not improving Gabriel's ability to cope with negative mood states.

In addition to the diagnosed mental health comorbidity, Gabriel is questioning his sexual orientation, which can be a confusing time that brings on additional stress. He reports a great deal of shame around an early sexual encounter, which could be fueling some of his drug use and perhaps worsening his mental health and anxiety issues. It would be important for any counselor or treatment provider working with Gabriel to adopt a nonjudgmental stance and be open to exploring issues related to sexuality.

Sociological Concerns

Gabriel has had interactions with the legal system due to his drug use. We need to learn Gabriel's perceptions regarding his legal involvement and also his risk for future issues. Gabriel may be motivated to reduce his risk of being involved with the legal system again, and thus addiction treatment can be framed as a way to reduce the harm done to his personal freedom by drug use.

Gabriel's family dynamics could also be harmed by his drug use. He reports that he has always had a distant relationship with his father. In addition, although his mother and sister are great sources of strength and support currently, his mother is attending Al-Anon and has been setting more firm boundaries. Gabriel may realize further drug use is likely to harm his relationships.

Gabriel could be offered the option to see a physician for a medication evaluation. For example, naltrexone, dosed daily in pill form or by monthly injections, has been shown to help patients with alcohol addiction. It is particularly helpful with reducing the amount of alcohol consumed per occasion, because part of alcohol's euphoric effect is mediated through the brain's opioid receptors. With naltrexone, those receptors are blocked, leading to less euphoria and less enthusiasm for heavy drinking. Acamprosate is another medication approved for use in alcohol addiction. The mechanism of action for this medication is not completely understood, but it appears to modulate the balance of neurotransmitters in the brain. This interaction in the brain eases anxiety and cravings in early alcohol abstinence, thus reducing a client's risk of relapse.

Working With Gabriel

In order to be effective, the counselor must really believe in the HR approach and

accept that reducing harm possibly without reducing drug use is a helpful and worthy goal. After adopting this philosophical approach a counselor is well equipped to do the client-centered harm reduction work with clients. Initially it would be important to ask Gabriel about his perceptions of harm. In addition, it is important to assess Gabriel's readiness for change. This may be done in a variety of ways, but most likely the SOCRATES screening tool (Miller & Tonigan, 1996), both A and D forms, would be used to examine his readiness for change with both his drinking and drug use. After that identification, we could provide Gabriel with a menu of options for this problem, including information about harmful effects of drugs such as alcohol, outpatient counseling, intensive outpatient programs, and possibly even inpatient treatment again. Motivational interviewing may also be a helpful approach to embrace in conjunction with HR to enhance Gabriel's reported readiness and motivation for change.

If working with Gabriel's family, it would be important for each family member to discuss and possibly rank-order the harms they are experiencing due to Gabriel's substance use. They can also consider how they also contribute to the harm and what they are willing to do to reduce harm to Gabriel, themselves, and their family. Although we just discussed how we may work with Gabriel's family, by following a patient-centered approach, it is crucial to ask him how much he wishes to involve his family members.

Key Techniques and Strategies

Consistent with harm reduction principles, Gabriel would be given a menu of possible treatment choices, including medical screening, sexual education, addiction treatment, and any other idea that Gabriel has for himself, to see which appeal to him the most. Harm reduction tends to focus on short-term, immediate goals, so it is important to ask Gabriel what he sees as the most important issue to work on first. Because harm reduction is nonjudgmental, it is crucial that treatment providers deliver care in this manner. In addition, using open-ended questions, affirming Gabriel for his successes, and using reflective listening techniques are foundational skills of motivational interviewing that would greatly benefit our relationship with Gabriel (Miller & Rollnick, 2013).

Medical Screening

Earlier we discussed the importance of assessing for biological harms, which also would include a thorough medical evaluation, specifically screening for prescription medications. If Gabriel has not been prescribed any medications for the management of his OCD and/or anxiety disorder it would be important to provide psychoeducation, particularly because medications can be enormously helpful for both disorders with the addition of counseling. If Gabriel is open to one or both routes of treatment, this can reduce the psychological distress, or harm, he feels in daily life. The provider can offer to connect him with providers for one or both treatments.

Sexual Education

HR strategies such as female or male condom use, human papillomavirus vaccine, or a reduction in number of sexual partners would allow Gabriel to protect himself from STDs and may be an area of interest for Gabriel. Interestingly, some of the medications most effective at treating OCD and anxiety disorders also reduce libido. Usually this is seen as an unpleasant side effect, but in Gabriel's case it may reduce compulsive elements of his sexuality. Treatment providers would have to be very sensitive when informing Gabriel about these medications and their side effects, because he may not believe his sexuality is a problem worth addressing, and his choice must be honored in an HR approach. Also, the case study points out that Gabriel has some shame around his sexuality, so great care must be taken not to add to that shame by suggesting a lowered libido is desirable. Whereas it's possible a decreased libido could help him focus on getting help with his other issues, this must be Gabriel's choice.

Addiction Treatment

Treatment options may be presented to Gabriel. An identified strength of Gabriel's is that he does have familiarity with treatment because he has been in inpatient treatment twice. It is important to note that some treatment providers may see these as treatment failures, but when taking a longer and more optimistic view, Gabriel likely learned something from each of his encounters with addiction treatment professionals. As a result of these encounters he may have a broader base of knowledge on which to build. It would be important to discuss with Gabriel what worked, what did not work, and what may be different if he was open to pursuing that option. It would be important to educate Gabriel further about other treatment options, specifically intensive outpatient (IOP) and also less intensive forms of outpatient counseling. He may not be aware of these options and also may not be aware that different centers may have different philosophical approaches to addiction treatment. Educating Gabriel about his options is crucially important.

Weaknesses or Challenges of the Theoretical Approach

Harm reduction honors the client's choice. Sometimes the client may not choose to work on the issues treatment providers feel are the most important. For example, if Gabriel were drinking heavily and driving drunk daily, but felt he only wanted to work on his anxiety issues, his treatment provider may be fearful about not addressing a behavior that could very well kill Gabriel. The treatment provider may believe that failure to address dangerous drinking is unethical. Such a situation creates tension between what the practitioner sees as most critical for his well-being and what Gabriel sees as a priority for his well-being.

Another challenge of the harm reduction approach is that harm can be defined in many different ways. We chose to use a biopsychosocial framework to conceptualize harm, yet this may also be limiting. It is important to be able to help clients conceptualize

harm and even define it for themselves from this perspective.

Strengths of the Theoretical Approach

As many of us know, permanent change occurs only with the cooperation of the client, and this approach wholeheartedly honors individual client choice. Thus, the practitioner is working with the client's own motivations, on areas the client wants to address. It is believed that this will enable each client to be more enthusiastic about instituting changes seen as most important to well-being. When care is delivered in a nonjudgmental and empathetic fashion and the client's voice is valued and respected, the therapeutic relationship is more likely to be strong and an effective mode of change.

Summary

This chapter examined the HR approach to addictions counseling. This client-centered, compassionate, and optimistic approach has a long history of reducing personal and societal harms related to addiction. Foundational to the practice of HR is the assessment of client readiness and motivation for change, allowing for infusion of motivational interviewing strategies. Common practices of HR include client education, naltrexone kits, and methadone maintenance programs. Strengths and weaknesses of the approach were examined and a debate was presented to encourage further thought.

Resources for Continued Learning

Books

Anderson, K. (2010). How to change your drinking: A harm reduction guide to alcohol. Scotts Valley, CA: CreateSpace.

Denning, P., & Little, J. (2012). Practicing harm reduction psychotherapy: An alternative approach to addictions (2nd ed.). New York: Guilford Press.

Marlatt, G. A. (2012). Harm reduction: Pragmatic strategies for managing high-risk behaviors (2nd ed.). New York: Guilford Press.

Stout, D. (2009). Coming to harm reduction kicking and screaming: Looking for harm reduction in a 12-step world. Bloomington, IN: AuthorHouse.

Scholarly Journals

Harm Reduction Journal: www.harmreductionjournal.com.

International Journal of Drug Policy: www.ijdp.org.

Websites

Harm Reduction Coalition: http://harmreduction.org.

Harm Reduction International: www.ihra.net.

Screening and Assessment Tools for Enhancing Motivation to Change in Substance Abuse Treatment, SAMHSA TIP Series #35: www.ncbi.nlm.nih.gov/books/NBK64976/#A62297.

Substance Abuse and Mental Health Services Administration, *Enhancing Motivation for Change in Substance Abuse Treatment*: http://store.samhsa.gov/shin/content/SMA13-4212/SMA13-4212.pdf.

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13 Cognitive Behavioral Approaches to Addiction Treatment

Edward Wahesh

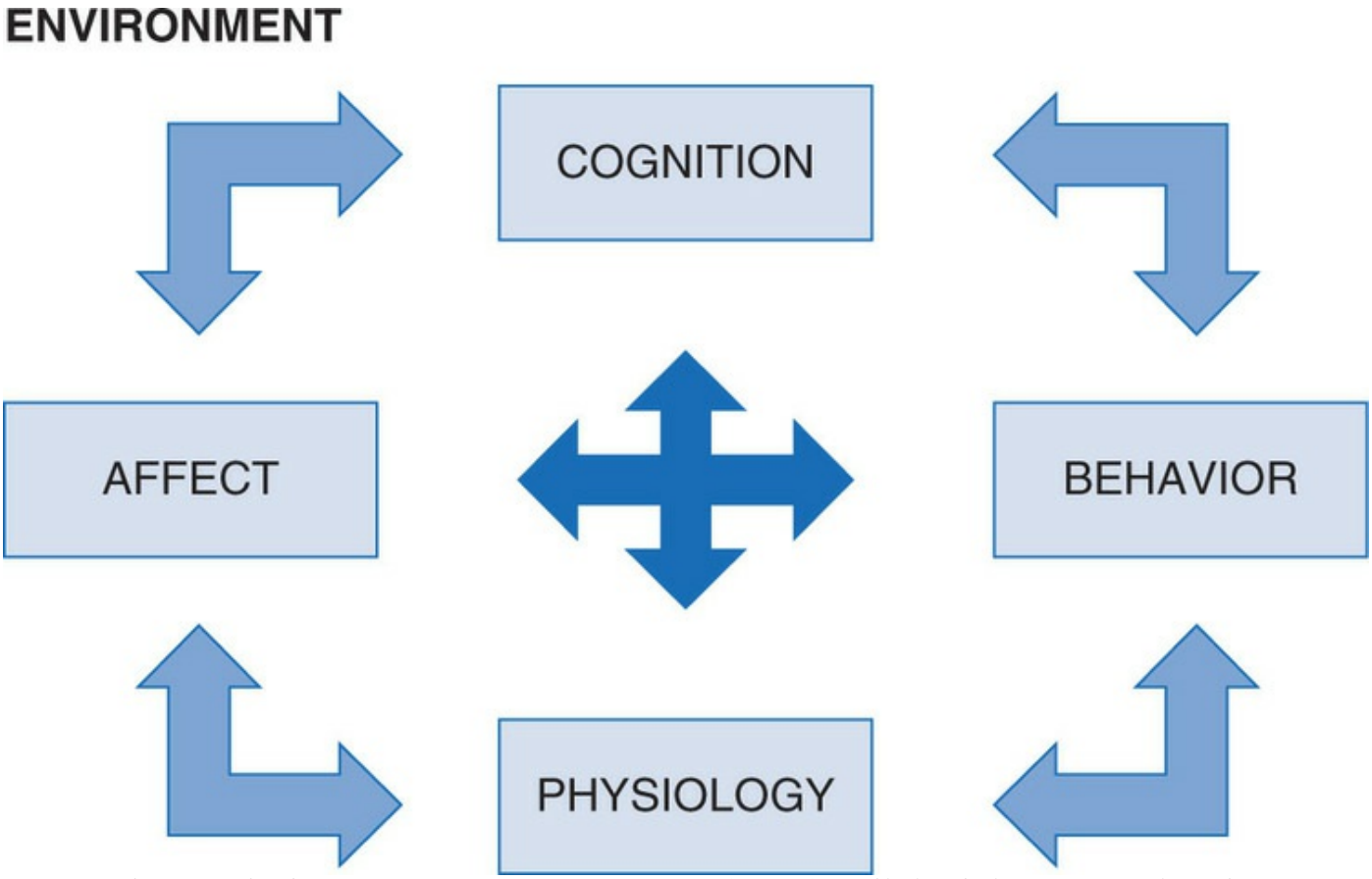
Cognitive behavioral therapy (CBT) is among the most widely used approaches to treat addictive disorders (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). The popularity of this psychosocial treatment is not unfounded; considerable support exists within the literature for the use of CBT to treat a variety of substance use disorders, including alcohol, cannabis, opioid, and stimulant abuse (Magill & Ray, 2009; McHugh, Hearon, & Otto, 2010). Also, there is evidence that CBT is an effective treatment for behavioral addictions, such as gambling disorder (Gooding & Tarrier, 2009) and Internet addiction (Young, 2007). CBT is not a monolithic approach to counseling but is an umbrella term that includes a number of theoretical models. Although variations of CBT are discussed in the literature, each cognitive behavioral approach shares several core assumptions and tenets of treatment. In this chapter, the theoretical principles and techniques used in CBT for addictive behaviors are presented.

Basic Tenets of the Theory

Dobson and Dozois (2010) identified three principles of all major CBT approaches: (a) behavior is influenced by cognitive activity, (b) cognitive activity may be observed and modified, and (c) behavior change can be influenced by cognitive change. The first proposition, also known as the mediation hypothesis (A. T. Beck & Dozois, 2011; Ellis, 1984), represents the assumption that the manner in which individuals interpret events, rather than the events themselves, influence their behavioral and emotional responses. Problems occur when cognitive appraisals of events are biased (A. T. Beck & Haigh, 2014). There is evidence that faulty information processing influences behavioral and emotional responses to events (Dobson & Dozois, 2010) and that different types of psychopathology are associated with specific dysfunctional beliefs (Clark, Beck, & Brown, 1989). Based on this principle, addiction is understood in CBT as a behavior that is initiated and maintained through specific cognitive processes and structures. Related to the mediation hypothesis is the assumption that affect and behavior have a reciprocal influence on cognitions (A. T. Beck & Haigh, 2014; Dobson & Dozois, 2010; Meichenbaum, 1992). Padesky and Mooney (1990) depicted a model that illustrates how multiple systems, including cognitions, affect, behavior, and physiology, interact with each other within the environment (see Exhibit 13.1) and noted that understanding this complex feedback system is essential to modify cognitive activity. In this model, physiology represents biological responses, and the environment refers not only to the physical environment but also to the various microsystems that the individual interacts with and is influenced by. Because of the bidirectional nature of these systems, the

environment as well as emotional and physical responses are conceptualized as playing roles in the introduction and maintenance of addictive behaviors.

Exhibit 13.1 Reciprocal Influences of Cognition, Affect, Behavior, Physiology, and Environment



Based on Padesky, C. A., & Mooney, K. A. (1990). Clinical tip: Presenting the cognitive model to clients. International Cognitive Therapy Newsletter, 6(1), 13–14.

The second and third core principles identified by Dobson and Dozois (2010), that cognitions can be modified and that cognitive changes can influence behavior, hold important implications for treatment. Because cognitions are accessible, a defining goal of CBT is for clients to learn how to identify beliefs and styles of thinking that reinforce their addictive behaviors. Possessing this awareness enables clients to use strategies to alter these cognitive processes, which in turn influences their behavioral and emotional responses. Given the reciprocal influences of other systems on cognitions and behavior, it is essential to assist clients in modifying both the internal and environmental processes that support addictive behaviors (J. S. Beck, Liese, & Najavits, 2005). As a result, CBT often includes some combination of cognitive and behavioral skills training. Clients learn how to recognize the cognitive, behavioral, affective, physiological, and environmental variables that contribute to their addictive behaviors so that they can use skills to monitor, avoid, modify, or cope effectively with these risk factors.

Philosophical Underpinnings and Key Concepts of the Theory

As mentioned earlier, CBT is an amalgam of both behavioral and cognitive models. Therefore, in order to understand how this approach is used to treat addictive behaviors, it is necessary to review the salient principles of each underlying theory. In the section that follows, the principles of behavior therapy, including classical conditioning and operant reinforcement and how they relate to addictive behaviors, are presented. This is followed by a discussion of relevant concepts drawn from cognitive therapy and rational emotive behavior therapy (REBT).

Behavior Therapy

Behavior therapy is based on two theories of learning, classical conditioning and operant conditioning. Each model has been used to clarify the learning processes associated with the development, maintenance, and extinction of addictive behaviors (Kouimtsidis, Reynolds, Drummond, Davis, & Tarrier, 2007). Further, both learning models have had a major impact on CBT approaches to addiction treatment.

Classical Conditioning

Classical conditioning is a learning process initially studied by Ivan Pavlov (1927). According to this model, learning occurs when a neutral stimulus is paired repeatedly with a salient stimulus. Take for example a person who uses cocaine. Use of cocaine (unconditioned stimulus) produces intense physiological cravings in the person to continue use (unconditioned response). Over time, the cocaine use is paired with particular people, emotional states, and paraphernalia. Eventually these initially neutral stimuli become conditioned stimuli, meaning that exposure to these cues is sufficient alone to produce cravings for cocaine (conditioned response). The intensity of the conditioned response and the frequency with which the unconditioned and conditioned stimuli are paired influence whether a conditioned stimulus produces a conditioned response (Rotgers, 2012). When the conditioned stimulus is repeatedly not paired with the unconditioned stimulus the association gradually disappears through a process known as extinction.

A number of researchers have found evidence in support of classical conditioning in understanding the development and maintenance of additive behaviors (Carter & Tiffany, 1999). Stormark, Laberg, Bjerland, Nordby, and Hugdahl (1995) examined the differences in autonomic responses to the odor of alcohol in a laboratory setting between social drinkers and individuals with alcohol dependence disorder and found that the participants with alcohol dependence showed greater increases in heart rate and skin conductance compared with the social drinkers. They also found that participants with alcohol dependence were more likely to report difficulty resisting an offer to consume alcohol after being exposed to the odor of alcohol. An implication of classical

conditioning is that as individuals engage in addictive behaviors, various stimuli become conditioned to produce cravings that reinforce the behaviors; therefore, it is critical for individuals to learn skills to respond effectively when exposed to these cues.

Operant Conditioning

A key principle of operant conditioning, which was originally studied by B. F. Skinner (1938), is that behavior is influenced by its consequences within the environment. Moreover, individuals learn to engage in a behavior based on the positive and negative consequences associated with the behavior. When a meaningful reward is provided (positive reinforcement) or negative consequences are removed (negative reinforcement) a behavior can be increased. On the other hand, a behavior can be decreased using negative consequences, such as removal of the associated rewards (extinction) or through punishment. Operant conditioning is helpful in understanding the initiation and maintenance of addictive behaviors; for example, substance use is initiated by the positive effects of the substance (positive reinforcement) and maintained over time through relief seeking and avoidance of withdrawal symptoms (negative reinforcement). Operant principles hold implications for conceptualizing and treating addiction; indeed, researchers have found that substances such as stimulants, alcohol, and barbiturates possess reinforcing properties that have a powerful influence on human behavior (Hughes, Higgins, & Bickel, 1990).

Cognitive Therapy

The central notion of cognitive therapy, originally developed by Aaron T. Beck, is that it is not the experience itself but the meaning ascribed to the experience that is important to psychological health. What differentiates this model from behavioral theories described earlier in this chapter is that rather than reflexively responding to stimuli, humans interpret and react to these events based on their beliefs about themselves, their world, and their future (Newman, 2013). Errors in the way events are interpreted help shape and reinforce beliefs that contribute to psychological disturbances (A. T. Beck & Haigh, 2014). These biased or negatively skewed interpretations of events influence emotional reactions, behavior, and beliefs. Biased information processing has been associated with addictive behaviors (Rohsenow et al., 1989) and is an important area for treatment intervention (Center for Substance Abuse Treatment, 1999). Examples of common information processing errors are presented in Exhibit 13.2.

Cognition Distortion	Description
Dichotomous thinking	Interpreting information in extreme or all-or-nothing terms (e.g., "If I slip up once, I am a failure")
Overgeneralization	Making sweeping conclusions based on a single incident (e.g., "Because it felt weird being sober at the party, I am incapable of functioning in social settings without a drink")
Arbitrary inference	Reaching a conclusion based on incomplete evidence (e.g., saying "If I try to quit smoking, I will fail" before actually attempting to stop smoking)
Catastrophizing	Automatically expecting the worst-case scenario to occur (e.g., "These cravings are never going to end")
Mindreading	Believing that one can know what others think and feel without actual evidence (e.g., thinking *This person thinks I'm a loser because I'm not drinking* without speaking to the person)
Disqualifying the positive	Placing less value on positive experiences than on negative experiences (e.g., "I made it through the day without using, but that was because of luck")

Cognitive Therapy of Addictive Disorders

According to A. T. Beck, Wright, Newman, and Liese (1993), addictive behaviors are driven by a combination of situational-specific cognitions and deeply ingrained beliefs. Wenzel, Liese, Beck, and Friedman-Wheeler (2012) organized these cognitions, along with associated biological and environmental processes, into two tiers, distal background factors and proximal situational factors. How each of these dynamic processes contributes to addictive behaviors is described in the following section.

Tier 1: Distal Background Factors

Two types of long-standing beliefs that influence addictive behaviors are basic beliefs about oneself, the world, and the future and addiction-related beliefs. Basic beliefs, a term often used interchangeably with core beliefs and schemas, represent fundamental and global beliefs that are accepted as truths (Newman, 2013). J. S. Beck (2011) hypothesized that maladaptive core beliefs, which increase vulnerability to psychological problems, fall into three broad categories, those associated with adequacy (e.g., "I am helpless"), lovability (e.g., "I am undesirable"), and worthlessness (e.g., "I am a bad person"). Basic beliefs are shaped by a number of background factors, including early life experiences, and influence how individuals interpret and act within their environment. These beliefs guide cognitive appraisals of situations through intermediate beliefs, which are assumptions or rules based on the individual's basic beliefs. For example, a person with a basic belief that he or she is

helpless may interact within the environment based on the rule *If I try at something, I will fail*.

In addition to basic beliefs, addiction-related beliefs also influence one's vulnerability to engaging in addictive behaviors. These beliefs reflect an individual's positive expectations for engaging in the addictive behavior. Two common types of addiction-related beliefs are anticipatory beliefs and relief-oriented beliefs. Anticipatory beliefs reflect expectations of receiving positive reinforcement by engaging in the behavior, whereas relief-oriented beliefs represent beliefs that addictive behaviors will result in negative reinforcement (Wenzel et al., 2012). The formation of addiction-related beliefs is influenced by one's basic beliefs, in that these dogmatic views help shape the types of early exposure and interactions with addictive behaviors. Basic beliefs also have an impact on the perceived value assigned to addiction-related beliefs. For instance, a belief that substance use is necessary to function will likely be more salient to a person with the basic belief that he or she is powerless. Wenzel et al. (2012) described a number of background factors that shape basic and addiction-related beliefs, including early life experiences, exposure and experimentation with addictive behaviors, personality traits, comorbid psychiatric disorders, social support, and participation in activities viewed as being meaningful.

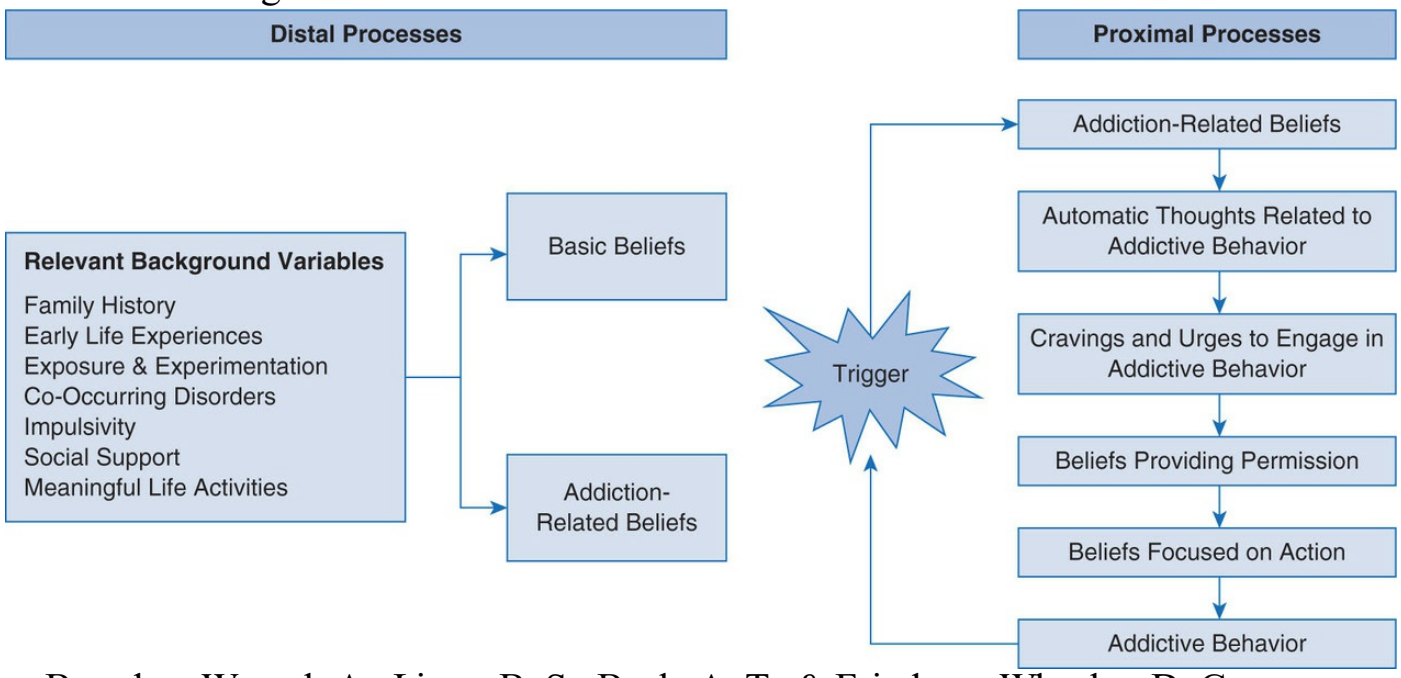
According to Wenzel et al. (2012), basic beliefs and addiction-related beliefs are activated by triggers that cue the addictive behavior. Triggers can be intrapersonal, interpersonal, or environmental stimuli, unique to the individual, that increase the likelihood of engaging in the addictive behavior. Marlatt (1996) described several types of triggers that can result in alcohol use: (a) unpleasant emotion states, such as anxiety, boredom, or frustration; (b) conflicts with others; (c) pressure to conform with perceived group norms or direct persuasion to use; and (d) positive emotional states that promote celebration using alcohol. Although this list was originally developed for relapse prevention of alcohol dependence, these high-risk situations have been implicated in addiction in general (Wenzel et al., 2012). Following exposure to a triggering stimulus, a number of cognitive, behavioral, physiological, and emotional processes spring into action. These proximal factors, referred to as the cognitive model of addiction (A. T. Beck et al., 1993), mediate the relationship between distal background factors and addictive behaviors (see Exhibit 13.3).

Tier 2: Proximal Situational Factors

Exposure to an internal or external stimulus results in the activation of an individual's addiction-related beliefs. Following the activation of these anticipatory or relief-oriented expectancies, automatic thoughts are generated that direct the individual to engage in the addictive behavior (Wenzel et al., 2012). Examples of automatic thoughts that command an individual to act on her or his addiction-related beliefs include *Drink!*, *Have fun!*, and *Seek relief!* Automatic thoughts are brief, surface-level cognitions that often go unnoticed by the individual. These beliefs sometimes are represented by mental

images (e.g., image of drinking or drug use) in addition to short verbal statements (J. S. Beck, 2011). Despite their abbreviated and spontaneous nature, automatic thoughts play a powerful role in shaping emotions, behaviors, and physiological responses. Automatic thoughts are followed by intense physical sensations to engage in the addictive behavior (Wenzel et al., 2012). Cravings occur simultaneously with urges, which are cognitions that represent internal pressure to relieve the craving through use. Cravings are immediately followed by cognitions that mobilize the individual toward action. Facilitative beliefs are cognitions that provide permission (e.g., *only this one time*, *I deserve it*). Once the behavior has been rationalized, the focus shifts toward action. Beliefs related to planning or instrumental strategies that facilitate the addictive behavior are activated. Examples of action-oriented thoughts include *go to the ATM* and *roll that joint*. After planning, the individual then engages in the addictive behavior. Engaging in the addictive behavior produces new stimuli that trigger cognitive, physiological, and behavioral responses that maintain addiction.

Exhibit 13.3 Cognitive Behavioral Formulation of Addictive Behaviors



Based on Wenzel, A., Liese, B. S., Beck, A. T., & Friedman-Wheeler, D. G. (2012). Group cognitive therapy for addictions. New York, NY: Guilford.

According to Kouimtsidis et al. (2007), a primary goal of CBT is to help clients understand this sequence between activating stimuli to engaging in the addictive behavior so they are able to disrupt the cycle. Therefore, important tasks of counseling include helping clients restructure their cognitions and teaching coping skills to improve their ability to respond to addiction-related stimuli and cravings. Teaching clients how to identify the links in the chain can be challenging because over time addictive behaviors become governed by automatic cognitive processes (Rotgers, 2012), which makes these separate cognitive, physiological, and behavioral processes less noticeable.

Rational Emotive Behavioral Therapy

A precursor to cognitive therapy, rational emotive behavior therapy (REBT) was developed by Albert Ellis. REBT and cognitive therapy have many similarities, such as the mediation hypothesis, which states that the influence of internal and environmental stimuli on behavioral, affective, and physiological responses is mediated by information processing (Ellis, 1984). Another similarity is that both therapies recognize the central role of dysfunctional beliefs on psychological disturbances (Padesky & Beck, 2003). A unique feature of REBT is that, according to Ellis (1984), a central quality of all dysfunctional thinking is demandingness. More specifically, inflexible insistence that one's preferences should be reality leads to illogical conclusions and distress. This maladaptive style of thinking is often reflected in words such as *should*, *ought*, and *must*. Holding rigid evaluative beliefs about oneself, others, or conditions in life is the opposite of having an adaptive or flexible style of thinking, which is the ultimate treatment goal of REBT (Dryden, David, & Ellis, 2010).

Low Frustration Tolerance (LFT)

DiGiuseppe and McInerney (1990) argued that LFT, which stems from demandingness, plays an important role in the maintenance of addictive behaviors. LFT represents the demand that life must be comfortable and that any deviation from this expectation is intolerable. The implication of this belief is that frustration or discomfort perceived as unacceptable must be immediately relieved. When activated, frustration intolerance produces an intense emotional response, known as discomfort anxiety. According to DiGiuseppe and McInerney (1990), LFT beliefs, coupled with relief-oriented outcome expectancies, increase the likelihood that an individual will engage in addictive behaviors following exposure to an activating stimulus. These individuals are more likely to use because they believe they must immediately satisfy their cravings (e.g., “I cannot stand not getting high”) to relieve their discomfort.

A. T. Beck et al. (1993) concurred that LFT was associated with addiction and argued that this dysfunctional cognitive appraisal mechanism is rooted in basic beliefs of helplessness and inadequacy. Moreover, according to A. T. Beck et al. (1993), LFT results in engaging in addictive behaviors in order to provide instant relief from unpleasant emotional or physical experiences. Treatment approaches, therefore, focus on teaching clients how to identify, evaluate, and modify this problematic style of thinking and helping clients develop coping skills that improve their response to discomfort anxiety.

How the Theoretical Approach Is Used by Practitioners

CBT is a short-term, goal-directed approach to treating addictive disorders (Carroll, 2011; Liese, 2014; Wenzel et al., 2012). Because of the brief and focused nature of CBT, education and structure to treatment also are emphasized as key qualities of this approach (Ellis, 2003). During treatment, clients learn how to identify, monitor, and

modify maladaptive cognitions and behaviors. A strong therapeutic alliance is needed to facilitate this learning process. Relatedly, clients also need to be introduced to the principles of CBT so that they can actively participate in their treatment. To assist clients in changing their addiction-related cognitions and behaviors, counselors use a number of behavioral and cognitive techniques drawn from the theoretical principles described earlier. These interventions are intentionally selected based on the counselor's case conceptualization. An overview of these core components of CBT application, (a) collaborative therapeutic relationship, (b) case conceptualization, and (c) cognitive and behavioral skills training, follows.

Collaborative Therapeutic Relationship

Effective CBT requires a robust therapeutic relationship (Newman, 2013). Counselors should convey empathy, genuineness, and respect to the client. Although these relational qualities, defined by Rogers (1957) as core conditions of successful counseling, are not considered in CBT to be sufficient alone to facilitate change, they are regarded as essential (J. S. Beck, 2011). One reason why the bond between the counselor and client is important is because a goal of CBT is for clients to learn new, more adaptive behaviors that are often outside of the client's comfort zone. If a therapeutic environment defined by trust and acceptance is not established, the client will be less likely to risk new behaviors (Liese, 2014).

The therapeutic relationship also is important because CBT is a collaborative endeavor. Counselors and clients collaborate in selecting treatment goals and interventions. Counselors also practice flexibility in how they manage the structure and tasks of treatment by pacing counseling on the client's level of engagement and motivation to change (Liese, 2014). Early in counseling, informed consent for treatment, including the client's rights and responsibilities, is discussed so that appropriate boundaries are established (e.g., confidentiality) and miscommunications that can potentially rupture the therapeutic relationship later in treatment are prevented (A. T. Beck et al., 1993). It is also critical that the counselor and client explore together any cultural values and beliefs that can potentially influence the client's engagement in treatment (Pantalone, Iwamasa, & Martell, 2010). In cases where there is discord within the relationship, counselors are expected to seek feedback from clients and explore how clients' own basic beliefs are influencing treatment (A. T. Beck et al., 1993).

This spirit of partnership is reflected in the CBT concept of collaborative empiricism (A. T. Beck & Dozois, 2011). Collaborative empiricism reflects a style of engagement in which the counselor and client work together as coinvestigators in exploring the client's cognitions. The counselor engages in an open and collaborative process of assessing and testing hypotheses about the client's subjective evaluations and how these cognitions influence client functioning. In addition to examining their formulations of the client's thinking style and beliefs, counselors also affirm the client's strengths and efforts made in treatment (A. T. Beck et al., 1993). Given the high rates of attrition in addiction

treatment, the emphasis placed on increasing client engagement seems warranted (Brorson, Ajo Arnevik, Rand-Hendriksen, & Duckert, 2013).

Case Conceptualization

According to J. S. Beck et al. (2005), the first principle of CBT for addiction is that treatment is based on a unique and evolving case conceptualization of the client. Wenzel et al. (2012) identified several variables that should be included in the comprehensive client case conceptualization. Background factors such as the client's environment, development history, basic beliefs, and addiction-related beliefs are assessed to provide proper context to the client's current functioning. The case conceptualization should also represent a thorough understanding of the various situational factors, including activating stimuli and automatic thoughts, which contribute to the client's addictive behaviors (J. S. Beck et al., 2005; Carroll, 1998).

Box 13.1 Identifying Situational Factors

It is important that counselors who use CBT understand how proximal factors interact and contribute to addictive behaviors. Follow these steps to practice conceptualizing a behavior using CBT principles.

1. Select a personal behavior or habit, which may not be especially healthy or productive, that you have considered changing (e.g., eating unhealthy foods, watching too much TV).
2. Create a diagram of the situational processes, including (a) triggers, (b) anticipatory or relief-oriented beliefs about the behavior, (c) automatic thoughts, (d) urges and cravings, (e) facilitative beliefs, and (f) instrumental actions, that illustrate the various cognitive, behavioral, physiological, and environmental factors associated with your habit and how they interact with each other
3. Develop a list of strategies you can use to change your behavior for the proximal processes listed in Step 2. How can you "break the chain" keeping you from changing?

As distal and proximal factors are identified, the counselor and client explore how these processes interact and ultimately contribute to addiction. Wenzel et al. (2012) remarked that this process not only helps socialize clients to treatment but can also strengthen motivation to change by increasing their awareness of the problems associated with the addictive behavior. Collecting and organizing these data in a systematic way allows the counselor and client to map out treatment. Treatment goals and techniques are strategically chosen to address the most salient determinants of the client's addictive behaviors. Both J. S. Beck et al. (2005) and Carroll (1998, 2011) agreed that the initial focus of treatment should be on changing situational cognitions and behaviors associated with addictive behaviors, instead of the client's deeply embedded basic beliefs. The case conceptualization naturally evolves and is refined over time based on the outcomes

of the various therapeutic interventions used during treatment.

Cognitive and Behavioral Skills Training

A core tenet of CBT is that the learning processes associated with the development and maintenance of addiction can also be used to change these behaviors (Rotgers, 2012). Therefore, the process of change in CBT involves enhancing the client's repertoire of cognitive and behavioral skills. The significance of clients developing new skills in counseling was best expressed by J. S. Beck (2011), who argued that CBT "aims to teach the patient to be her own therapist" (p. 9). Because of the focus placed on skill development in CBT, clients are given assignments to complete outside of sessions to practice skills discussed with the counselor (J. S. Beck et al., 2005; Liese, 2014). Homework allows clients to generalize skills learned in counseling and apply them to real-life challenges (Kouimtsidis et al., 2007). According to Carroll (1998) and Liese (2014), the structure of individual CBT sessions generally centers on reviewing and planning for homework. During each session, previous homework is reviewed and new homework is assigned to follow up on new skills introduced by the counselor. Examples of cognitive and behavioral skills training used in CBT follow.

Cognitive Skills Training

In a nutshell, cognitive skills training is meant to teach clients how to identify, evaluate, and modify unhelpful beliefs and styles of thinking. An initial step in this process is to teach clients the core tenets of CBT, including the mediation hypothesis, that cognitions can be accessed and altered, and that changing cognitive processes can facilitate behavior change (A. T. Beck & Dozois, 2011). Clients are also oriented to the various distal and proximal processes associated with addiction. This includes providing examples of biased information processing strategies or cognitive distortions. Once clients have learned to apply this information to their addictive behaviors, through observing these processes between sessions and exploring their implications with the counselor, the focus of training transitions to education on how to modify unhelpful cognitions (Carroll, 1998). Guided discovery, thought monitoring, distraction, imagery, and the downward arrow exercise are examples of cognitive techniques used during this process.

Guided Discovery

Through guided discovery, clients deepen their awareness of how their beliefs influence their behaviors and emotions. Clients also learn how to evaluate the validity and utility of their cognitions. During this process, the counselor balances the use of evocative questioning and reflections with education and feedback from the client. J. S. Beck (2011) developed a six-step process of guided discovery for counselors to help clients challenge maladaptive beliefs: (a) assess the evidence of the belief's accuracy; (b) examine possible alternative explanations that dispute the belief's validity; (c) identify the range of consequences associated with the belief (i.e., worst outcome, best outcome,

and most realistic outcome); (d) determine the consequences or usefulness of holding the belief; (e) teach clients to distance themselves from the belief by having them imagine what they would tell a friend in the same situation; and (f) ask clients what they will do now that they have discussed these questions. Outcomes of the guided discovery process naturally feed into the counselor's case conceptualization of the client and help determine client homework between sessions.

Triggering Event Description, Date/ Time	Activated Beliefs: Outcome Expectancies, Automatic Thoughts, Permissive Thoughts	Consequences: Physical, Emotional, Behavioral	Adaptive Response
Returned home feeling stress from work because my boss told me that if I show up for work late again he will fire me (Monday night, 8 p.m.)	Playing online card games will help take my mind off work stress. I need some relief! I will only play for a little while, and I have been on a roll recently.	Increased agitation, unable to settle down Frustrated Sign into gaming website, confirm my credit card information	Say to myself, *Gambling is not going to help me*, and *If I start playing, I won't be able to stop later* Think of all of the reasons why playing cards right now will make things worse

Thought Monitoring

Thought monitoring helps clients identify and challenge the cognitive processes associated with their addictive behaviors (A. T. Beck et al., 1993). It also increases the client's awareness of specific internal and environmental addiction-related stimuli. Thought monitoring begins with the client recording addiction-related triggers along with the sequence of cognitive, behavioral, physiological, and emotional responses associated with these stimuli. Once they learn to recognize these responses, clients also monitor their use of thought challenging techniques. An example of a thought monitoring worksheet is found in Exhibit 13.4. As clients add new skills to their repertoire, thought monitoring allows them to document their efforts to more adaptively respond to addiction-related cues. This technique, which can be used in session and as homework between sessions, can help reinforce client learning and increase the counselor's awareness of client progress. Evidence of successful use of skills can lead to increased self-confidence, whereas ineffective responses to high-risk situations provide grist for the mill in counseling that can be used to modify treatment goals and tasks.

Distraction

Clients can use distraction techniques to refocus their attention away from stimuli and cognitions associated with their addictive behavior (Carroll, 1998; Ellis, McInerney,

DiGiuseppe, & Yeager, 1988). Distraction techniques useful when faced with an addiction-related trigger include imagining a relaxing setting (Kouimtsidis et al., 2007) and recalling the negative consequences associated with the addictive behavior (Carroll, 1998). Another distraction strategy, drawn from mindfulness-based relapse prevention, is the SOBER breathing space. SOBER stands for (a) stop, (b) observe, (c) breathe, (d) expand your awareness by placing things into perspective, and (e) respond intentionally keeping in mind that you have a choice (Bowen, Chawla, & Marlatt, 2011). In their SOBER breathing space, clients delay the sequence of cognitive and behavioral processes and observe the high-risk situation in a nonjudgmental way, making it more likely that they will be able to muster the internal resources needed to effectively respond to cravings and urges to engage in addictive behaviors.

Imagery

Imagery involves the counselor assisting the client in bringing to mind a recent experience involving addiction-related stimuli. During this process, clients are instructed to use as many of their senses (i.e., sight, sound, smell, taste, and touch) as possible when mentally re-creating the situation (J. S. Beck, 2011). By mentally reliving past experiences, clients increase their awareness of the factors that influence their addictive behaviors. This technique is particularly useful in helping clients identify automatic thoughts, in that these brief cognitions generally go unnoticed (J. S. Beck, 2011). Imagery also allows clients to envision how they could use new skills to more effectively respond to high-risk situations. For example, a client can practice using distraction techniques or challenging unhelpful cognitions (Ellis et al., 1988). Kouimtsidis et al. (2007) endorsed the use of imagery in CBT treatment of addictive behaviors; however, they cautioned that having clients vividly recall mental images of problem events can be very powerful and trigger a strong affective response. As a result, it is essential that the counselor inform the client of the potential emotional impact of imagery and wait to use this technique until a strong therapeutic relationship has been established.

Downward Arrow Exercise

The downward arrow exercise can be used to assist clients in accessing and understanding the implications of their basic beliefs. Mitcheson et al. (2010) described this strategy as a form of guided discovery that involves the repeated use of open-ended questioning to gradually uncover the meaning of the client's maladaptive cognitions. For example, to help a client “decatastrophize,” the counselor can start with the question “What is the worst that could happen to you?” and use follow-up questions such as “Why is that so bad for you?” and “If the worst does happen, what does it say about you, other people, and your future?” (Mitcheson et al., 2010). Each question moves the client and counselor closer to identifying the client's basic beliefs. This sequence of open questions also promotes client self-reflection on the faultiness and rigidity of maladaptive cognitive processes and helps illustrate how proximal factors associated

with addictive behaviors are connected to basic beliefs. An example of the downward arrow exercise is provided in Exhibit 13.5.

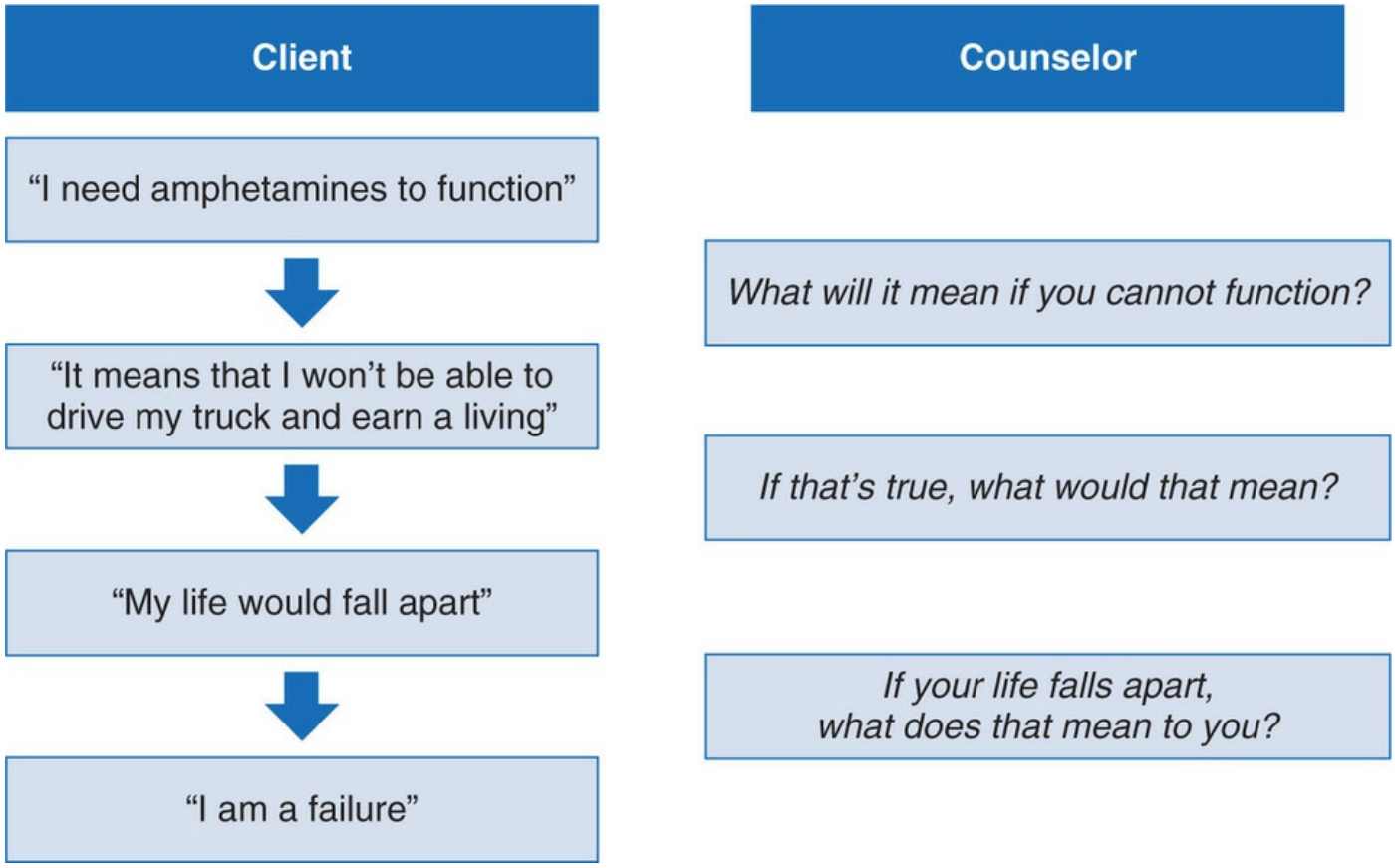
Behavioral Skills Training

The goal of behavioral skills training in CBT is for clients to learn new behaviors that reduce the likelihood that they will engage in addiction-related activities. This includes helping clients make changes to their environment that reduce exposure to the addictive behaviors (A. T. Beck et al., 1993). Also important is teaching clients how to incentivize positive behaviors and reduce the reinforcing properties of their addictive behaviors. Behavioral skills training goals and techniques are based on models of classical conditioning and operant reinforcement. Five examples of behavioral skills training are described: (a) high-risk situation planning, (b) contingency management, (c) relaxation training, (d) behavioral rehearsal, and (e) the community reinforcement approach.

High-Risk Situation Planning

A basic behavioral technique used during CBT is to teach clients how to identify and avoid stimuli associated with their addictive behavior (J. S. Beck et al., 2005). This process typically involves the counselor and client developing an extensive list of high-risk situations that precipitate addictive behaviors. Clients are encouraged to self-monitor their behavior between sessions so they can add to the list of triggers. Another strategy to help identify high-risk situations is the timeline followback (Sobell & Sobell, 1992). During this process, the client thinks back on and documents any engagement in addictive behaviors during the previous 30 days using a form that looks similar to a calendar. In addition to the specific circumstances, the quantity and frequency of the addictive behaviors are also recorded. These data can also help identify the types of reinforcement associated with use during each situation. Knowledge of this information can then inform the development of plans to avoid these situations in the future. Avoidance of external or environmental stimuli can be as simple as driving a new route from work to home to avoid a liquor store. Responding to interpersonal and intrapersonal stimuli can require additional training in communication skills and relaxation techniques.

Exhibit 13.5 Downward Arrow Exercise



Contingency Management

Contingency management involves the dissemination of rewards as positive reinforcement for client engagement in therapeutic activities (Ellis et al., 1988). Behaviors that can be incentivized include submitting negative urine screenings and compliance with antagonist or agonist medications (Dallery, Meredith, & Budney, 2012). Reinforcement for treatment-oriented behaviors often takes the form of vouchers or prizes with monetary value. The schedule of reinforcement can be fixed (i.e., reward of similar value provided each time desired behavior occurs), escalating (i.e., value of reward increases for each consecutive demonstration of the behavior), or unpredictable (i.e., random selection of prizes with different monetary values). Dallery et al. (2012) recommended that rewards be applied as close as possible to the desired behavior because the greater the delay, the less likely the behavior will be sustained. These authors also stressed the importance of the magnitude of the incentive reflecting the challenges associated with the desired behavior, in that incentives with little value do not provide enough reinforcement to encourage the behavior (Dallery et al., 2012). Using contingency management increases engagement in counseling and also teaches clients how to incentivize positive behaviors associated with changing their addictive habits.

Relaxation Training

Teaching clients how to cope with negative emotional states using relaxation techniques is an important task of treatment (Carroll, 1998). Negative emotional states can be the

result of interpersonal and intrapersonal addiction-related stimuli. Skills clients can use to reduce tension and increase relaxation in high-risk situations include slow breathing and progressive muscle relaxation (Dobson & Dozois, 2010). When clients slow down the length of exhalation and inhalation they reduce the unpleasant physiological and emotional responses associated with addiction-related stimuli. They also create more space to disrupt the cycle between activating event and engagement in addictive behavior, allowing them to use other cognitive and behavioral strategies. During progressive muscle relaxation, clients slowly tense and relax muscle groups in various parts of their body. By learning how to purposefully tense and release muscles, clients are able to neutralize the physiological effects of stressful situations, making them more likely to resist the urge to engage in their addictive behavior.

Behavioral Rehearsal

It is advantageous to provide opportunities in session for clients to practice new skills. Behavioral rehearsal allows clients to practice, in a safe environment, communication skills they plan on using to respond to high-risk situations. For example, a client may want to practice using refusal skills to turn down offers of alcohol in specific settings. This process can include role-play and reverse role-play, which involves the counselor acting as the client. Reverse role-playing allows the counselor to model new skills for the client, potentially increasing the client's self-efficacy. One benefit of behavioral rehearsal is that it helps clients identify unexpected challenges that were previously unknown to them (Kouimtsidis et al., 2007). For example, a client may decide to use the excuse “I have to drive home tonight” to avoid drinking at a party. While role-playing, the client realizes that this excuse may not be effective because the counselor (playing the role of the client's friend) offers to call a cab so the client doesn't have to drink and drive. Practice doesn't necessarily “make perfect,” but it can enhance the client's ability to respond to addiction-related stimuli within the environment.

Community Reinforcement

During treatment it is critical to assist clients in making changes to their environment that eliminate reinforcement to engage in addictive behaviors and increase positive reinforcement to change. This can include helping clients address issues related to employment or housing (J. S. Beck et al., 2005) as well as assisting them in scheduling activities that provide meaning and purpose to their life. Community reinforcement and family training (CRAFT) uses a number of systemic strategies that reduce incentives to continue engagement in the addictive behavior and enhance motivation to change (Miller, Forcehimes, & Zweben, 2011). In addition to helping clients learn how to address addiction-related triggers within their environment, CRAFT also includes training for family members on how to provide positive reinforcement for abstinence and participation in treatment. Relatedly, family members also learn how not to reinforce or enable their loved ones' addictive behaviors. By training family members and making changes to the environment, potential obstacles for maintaining therapeutic

change are eliminated.

Assessment and Prevention Implications

CBT holds important implications for the assessment and prevention of addictive behaviors. A key assumption of CBT is that addiction is a learned behavior that must be understood within an environmental context (Mitcheson et al., 2010). Therefore, when planning interventions, it is necessary to identify the cognitive, behavioral, affective, physiological, and environmental conditions associated with the initiation and maintenance of addictive behaviors. In addition, special attention is paid to understanding the cognitive processes that influence functioning. Cognitive and behavioral techniques can then be used based on how these internal and external processes interact to promote addictive behaviors.

Assessment

In CBT, the client's early life experiences, initial exposure to the addictive behavior, and family history of addiction are assessed to understand how the client's beliefs were developed (Wenzel et al., 2012). The client's cultural background also is an important consideration because cultural traditions communicate messages about the permissiveness and prevalence of the addictive behavior. Personality traits, such as impulsivity and co-occurring psychiatric disorders, are assessed to help explain the client's global level of functioning. Further, the client's social support and participation in meaningful life activities are evaluated. Gathering this information helps determine the client's basic and addiction-related beliefs and offers insight into how these beliefs influence the client's behavior in both the past and present.

Situational factors that should be examined during the assessment process include (a) characteristics of typical addiction-related stimuli, (b) outcome expectancies, (c) automatic thoughts, (d) permissive beliefs, (e) action-oriented beliefs, (f) self-confidence to change, and (g) urges and cravings to use (Wenzel et al., 2012). The degree to which the client's behavior has become automatic or unconscious also needs to be considered. Relatedly, J. S. Beck et al. (2005) suggested the client's current life problems and emotional responses to those problems be evaluated. This information provides context for the types of addiction-related stimuli and reinforcement (positive or negative) associated with the client's addictive behaviors.

It is important that the process of assessment reflect the educative and collaborative nature of CBT. Clients should be oriented to the CBT formulation of addictive behaviors early in counseling so they can take an active role in testing hypotheses related to their beliefs and subjective evaluations of events. Further, assessment is not confined to early treatment but should continue throughout counseling. As clients learn new cognitive skills and behaviors, they become increasingly aware of how their beliefs influence their behaviors. These new insights should be reflected in the case conceptualization.

Prevention

A number of concepts drawn from CBT with addictive behaviors can be applied to prevention practices. Considering the hypothesized role that environmental influences have on addiction-related beliefs, it seems logical to design prevention efforts that seek to reduce the availability and exposure to addictive behaviors. For example, a community may wish to restrict the marketing of alcohol or nicotine products near schools and playgrounds. This kind of ecological intervention can prevent children from developing addiction-related beliefs. Addressing the formation of addiction-related beliefs among children is warranted. Zamboanga, Ham, Van Tyne, and Pole (2011) surveyed 157 adolescent nondrinkers and found that many of these individuals held positive beliefs about alcohol use. These authors also found that greater positive beliefs were associated with greater intentions to drink in the future. Reducing early life exposure can potentially prevent the formation of these permissive and positive beliefs. Prevention efforts can also be designed to provide individuals with positive coping skills that make engaging in addictive behaviors unnecessary. This can include training on how to effectively cope with unpleasant moods using healthier and more adaptive strategies. Skills training programs also can focus on enhancing an individual's refusal and assertiveness skills to prevent the initiation of use or keep moderate use from developing into a full-fledged problem. Brief alcohol screening and intervention for college students (BASICS; Dimeff, Baer, Kivlahan, & Marlatt, 1999) is an example of a prevention program, based partly on CBT principles, that has demonstrated efficacy in reducing alcohol use and alcohol-related negative consequences among college student drinkers by addressing outcome expectancies, perceived norms, and skills deficits (Borsari & Carey, 2000).

Strengths and Weaknesses of the Theory

CBT possesses a number of strengths as a method of treating addictive behaviors. Substantial evidence exists supporting the use of CBT with addictions (Magill & Ray, 2009). Gossop, Steward, Browne, and Marsden (2002), for example, found that patients in a residential treatment program who used more cognitive coping skills had lower rates of relapse to heroin use. Strategies based on behavior therapy, such as the community reinforcement approach, also have demonstrated efficacy in reducing substance use (Miller et al., 2011). One reason this approach has shown promise is that CBT has also been found effective for conditions that often co-occur with addiction, such as depression and anxiety (Epp & Dobson, 2010). Because CBT theory and techniques are applicable to other mental health issues, treatment for co-occurring disorders and addictive behaviors can occur simultaneously. An additional strength of CBT is that it can be effectively combined with a variety of other therapeutic approaches, including motivational interviewing (MI; Moyers & Houck, 2011). Combining CBT with MI is advantageous because limited guidance is provided in CBT

on how to treat clients who are ambivalent to change. The overall flexibility and utility of CBT enables the counselor to tailor treatment to the specific needs of the client. Although evidence supports the use of CBT for a wide variety of psychological disorders, limited research exists testing CBT principles and techniques with diverse populations. Pantalone et al. (2010) suggested that because of the core qualities of CBT (e.g., focus on collaboration and empowerment, emphasis on personalizing treatment based on the unique needs of the client), this approach can be effective across cultural groups; however, these authors also stressed the need for CBT research to assess how cultural differences influence treatment engagement and efficacy. Another weakness of CBT is the general lack of treatment fidelity among practitioners. Rotgers (2012), for example, lamented that many providers of CBT do not have the necessary training or expertise to competently use CBT techniques with their clients. Finally, because of the cognitive demands associated with learning new cognitive and behavioral skills, CBT may not be appropriate for clients with cognitive impairment (Carroll, 2011). Carroll (2011) recommended that CBT with clients who present with attention or memory problems be conducted at a slower pace to assess client understanding of key concepts and skills.

Case Study Responses

Gabriel grew up in a chaotic household having to protect his mother and sister from his abusive father, who suffered from chemical dependency. As a result of these experiences, Gabriel never developed a strong emotional bond with his father. Gabriel also felt shame related to an early sexual encounter with a male friend. These experiences shaped Gabriel's basic beliefs that he is unlovable and vulnerable. Gabriel's basic beliefs are consistent with his current unstable pattern of romantic relationships and conflicted sexual identity. More specifically, Gabriel likely interacts with the environment based on conditional assumptions such as *If I reveal my true self, I will be rejected* and *If I feel bad, I will fall apart*.

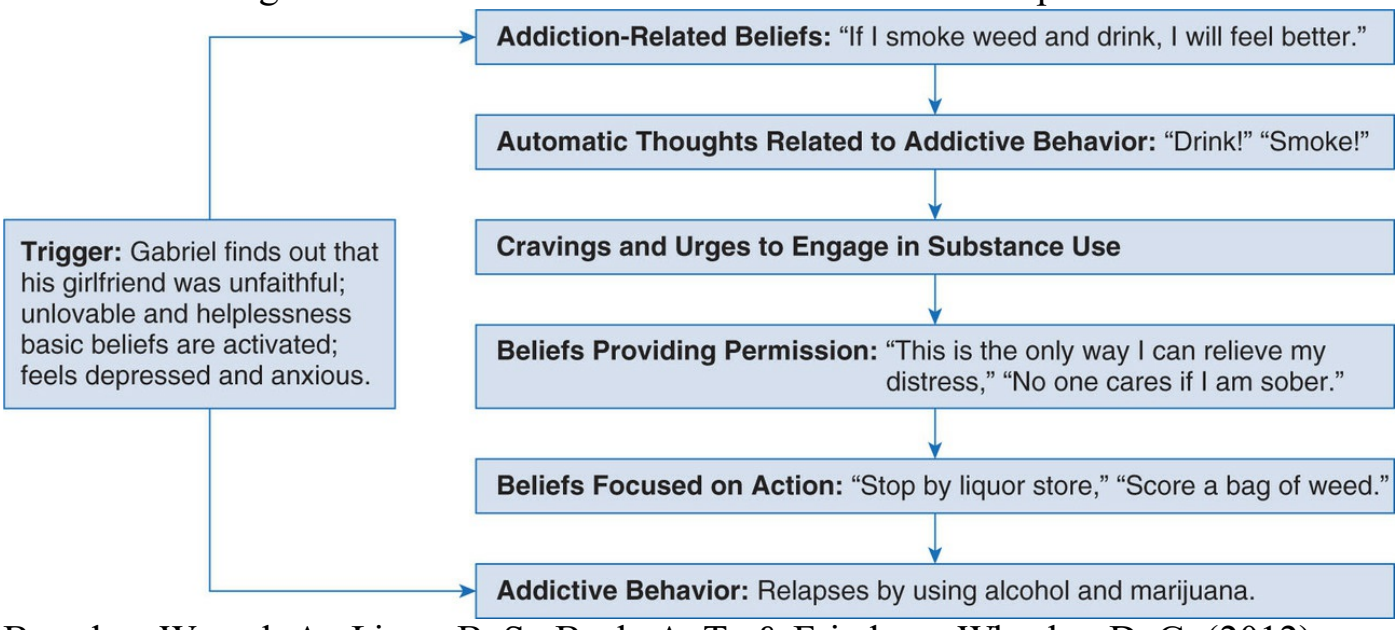
Through early experimentation with substances and observation of his chemically dependent family members, Gabriel developed the addiction-related belief that substance abuse can provide relief. It is likely that negative emotional states associated with his basic beliefs act as triggers for substance use. A hypothesized illustration of how Gabriel's beliefs influenced his most recent relapse is presented in Exhibit 13.6. Gabriel's helplessness and unlovable basic beliefs were activated after learning that his partner was unfaithful, creating an unpleasant emotional state. This internal cue activated his relief-oriented addictive beliefs and initiated a sequence that ultimately led to Gabriel's use. Continued use reinforces his basic beliefs and creates new activating events (e.g., feeling guilty about use, increased anxiety due to a negative consequence associated with use).

Gabriel's Native American lineage (Chartier & Caetano, 2010) and his symptoms of anxiety and obsessive-compulsive disorder (A. T. Beck et al., 1993) also increase his

risk of substance abuse. Gabriel possibly engages in substance use to cope with obtrusive thoughts and fears activated by his basic beliefs that he is unlovable and vulnerable. On the other hand, a strength that Gabriel brings to treatment is his previous success abstaining from use. Remaining abstinent for 7 weeks can be used as evidence to counter Gabriel's helplessness beliefs. Further, Gabriel appears to have a strong social support network; his mother and sister can help him address the environmental triggers and reinforcement contingencies related to his substance abuse. They can also help by providing opportunities for Gabriel to participate in meaningful activities that promote change and recovery, such as playing sports with his niece.

My first task would be to establish a strong therapeutic alliance with Gabriel. During this process, I would pay particular attention to possible treatment-interfering beliefs that Gabriel might have based on his cultural background and his previous experiences in counseling. For example, Gabriel may have a collectivist worldview consistent with his Native American heritage that may prevent him from focusing on his individual needs if he perceives that changes he makes in treatment will negatively impact other people in his life (Pantalone et al., 2010). Attending counseling also may activate negative beliefs that Gabriel developed about treatment during his earlier hospitalizations. Exploring beliefs that can interfere with the process of counseling can help strengthen the relationship and develop appropriate goals for treatment.

Exhibit 13.6 Cognitive Behavioral Formulation of Gabriel's Relapse



Based on Wenzel, A., Liese, B. S., Beck, A. T., & Friedman-Wheeler, D. G. (2012). *Group cognitive therapy for addictions*. New York, NY: Guilford.

I would also introduce Gabriel to the principles and goals of CBT so that he is able to play an active role in treatment. This includes educating Gabriel on how his anxiety and obsessive-compulsive symptoms are related to his substance abuse. The primary task of the initial phase of treatment would be to help Gabriel understand the various situational processes that maintain his substance abuse so that he can learn how to respond to these

risk factors more effectively. Learning new strategies to cope with triggers would help Gabriel reduce his dependence on substances. In addition to skills training, we would discuss changes that he can make to his environment that limit exposure to triggers and increase positive reinforcement of treatment-oriented behaviors. As Gabriel takes control of his life and his behavior stabilizes, we can delve into Gabriel's basic beliefs and how they have shaped his life experiences. It may be fruitful to explore how Gabriel's beliefs about being unlovable and vulnerable have influenced how he views his sexual orientation and history of romantic relationships. Increasing Gabriel's awareness of these issues can potentially help reduce his anxiety.

A number of cognitive and behavioral interventions are applicable to this case. We can explore the use of problem-solving and coping skills to respond to internal and external cues identified by Gabriel. Teaching relaxation and distraction techniques can also help Gabriel cope more effectively with cravings. Altering Gabriel's environment can support his skills training; this includes teaching Gabriel's sister and mother how to reinforce treatment-oriented behavior. As we investigate the unhelpful types of thinking that contribute to Gabriel's pattern of addiction, I would use guided discovery so that Gabriel can learn how to evaluate the validity and utility of his cognitions. To help generalize these skills to problems outside of counseling, Gabriel should engage in thought monitoring between sessions. These strategies will help Gabriel learn how to identify and challenge faulty styles of thinking. In the later stages of counseling, we can use the downward arrow technique to explore Gabriel's basic beliefs.

This case highlights a weakness of CBT in addressing Gabriel's motivation to change. Gabriel entered treatment at the request of his mother and sister; therefore, it is likely that he feels some ambivalence about changing his addictive behaviors. If Gabriel has reservations about participating in treatment, it is unlikely that he will complete homework and openly engage in the guided discovery process. Although readiness to change has been recognized as a critical treatment variable in CBT (A. T. Beck et al., 1993; Wenzel et al., 2012), limited guidance exists on how to use CBT techniques with ambivalent clients. Carroll (2011), Liese (2014), and J. S. Beck et al. (2005) suggested that clients analyze the advantages and disadvantages of change versus continued use. This technique may unintentionally amplify the client's ambivalence. Miller and Rose (2015) examined the clinical outcomes of the cost-benefit analysis with clients and found that CBT actually decreased commitment to change.

One strength of CBT is that the techniques used to reduce Gabriel's substance dependence can also be used to address other problems in his life. As Gabriel explores the cognitions and activating stimuli associated with his substance use, it is very likely that other issues in his life, such as his sexual identity, will surface. The same can be said about his anxiety and obsessive-compulsive symptoms. A benefit of this integrated approach is that it can increase Gabriel's awareness of how all of these issues are interconnected. Further, because CBT techniques target the same processes relevant to

all psychological distress (A. T. Beck et al., 1993), Gabriel may see improvements in other aspects of his life during treatment. Once he has acquired these new skills, Gabriel will be able to cope more effectively with life problems well after treatment has ended. On a related note, another strength of CBT is its comprehensiveness. Gabriel is not being taught to "think away" his problems. More accurately, during treatment Gabriel is empowered to make changes to his thinking, behavior, and environment that support improvements in his overall functioning and reduce his dependence on substances.

Summary

During CBT, clients develop skills that empower them to change their addictive behaviors. They also make modifications to their environment to address reinforcement contingencies and addiction-related stimuli that can potentially derail the change process. Elements of successful CBT include establishing a strong therapeutic alliance, formulating an individualized and evolving case conceptualization, and engaging the client in a collaborative learning process to identify and change unhelpful cognitions and behaviors. It is essential that these qualities of CBT be practiced by the treatment provider throughout counseling.

Resources for Continued Learning

Websites

The Albert Ellis Institute: http://albertellis.org.
Association for Behavioral and Cognitive Therapies: www.abct.org.
Beck Institute for Cognitive Behavior Therapy: www.beckinstitute.org.
National Institute of Mental Health: www.nimh.nih.gov.
National Institute on Drug Abuse: www.drugabuse.gov.
Substance Abuse and Mental Health Services Administration (SAMHSA): www.samhsa.gov.
SAMHSA's National Registry of Evidence-Based Programs and Practices: www.nrepp.samhsa.gov.

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14 Twelve-Step Facilitation

Jeremy M. Linton

The 12-step approach is among the oldest and most widely practiced models of addictions intervention and treatment (Fisher & Harrison, 2013). As practiced today, the 12-step approach has its roots in the early models of mutual-help groups such as Alcoholics Anonymous, Narcotics Anonymous, and other 12 step–based fellowships. Several unique aspects of 12-step theory distinguish it from the other approaches to addictions counseling reviewed in this book. These include a focus on spirituality as an essential component of treatment, adherence to the disease model of addiction, necessary acceptance of and surrender to alcoholism and drug addiction as a prerequisite to recovery, and a focus on altruism and helping others as part of the treatment process.

In this chapter the 12-step approach to addictions treatment is explored. The history of the 12-step movement is examined and its impact on 12 step–based treatment approaches is discussed. Etiology of addiction, recovery, and methods for practice based on the 12-step model are also reviewed. The chapter ends with a discussion of Gabriel's case and the application of the 12-step principles to Gabriel's current situation. In recent years, as several research-focused approaches have been developed, it has become popular to discount the effectiveness of 12 step–based treatment (Dodes & Dodes, 2014; Fisher & Harrison, 2013; Glaser, 2015; Miller, 2008; Peele & Bufe, 2000; Sack, 2012). As a result, the reader is encouraged to look at this approach with openness, objectivity, and a keen eye for the intricacies of the model.

Basic Tenets of the Theory

In order to effectively practice 12 step–based treatment, clinicians must have a solid understanding of the model's historical roots and basic tenets. Because Alcoholics Anonymous (AA) is the oldest and most widely recognized 12-step fellowship, the discussion here focuses mainly on the history and impact of the AA fellowship. As we begin this review, it is important to note that the 12-step movement was developed as a theoretical foundation for mutual-help groups and fellowships and not as an approach to treatment (Alcoholics Anonymous, 2001; Borkman, 2008a; Slaymaker & Sheehan, 2008). As the addictions counseling field developed, however, the 12-step philosophy was integrated into addictions treatment approaches. Accordingly, the history and impact of AA and the 12-step movement as they pertain to 12 step–based treatment are outlined briefly next.

Box 14.1 The Twelve Traditions of Alcoholics Anonymous (Short Form)

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 nonprofessional, 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.

The origins of the 12-step movement can be traced back to the establishment of Alcoholics Anonymous, popularly known as AA (Alcoholics Anonymous, 2001). Alcoholics Anonymous was created by Bill Wilson and Dr. Robert Smith (more commonly known as Bill W. and Dr. Bob), with the first documented AA meeting occurring on June 10, 1935. As stated in their literature, AA is a worldwide fellowship of persons working together to confront their addiction (Alcoholics Anonymous, 1981). Similarly, Nace (2011) stated that the fellowship of AA is structured to introduce and assist with the maintenance of abstinence and recovery among members. According to the AA literature, the only criterion for acceptance into the AA fellowship is a desire to stop drinking (Alcoholics Anonymous, 1981). Similar to AA, the only criteria for acceptance into Narcotics Anonymous (NA) is a desire to stop using mood-altering substances (Narcotics Anonymous, 2008). The governing principles of the AA fellowship are outlined in the 12 Traditions of Alcoholics Anonymous (Alcoholics Anonymous, 1981) and presented in Box 14.1. Narcotics Anonymous and other 12-step fellowships have similar governing principles based on the AA doctrine.

Recovery through AA is facilitated by working through the 12 steps, which were established soon after the first edition of *Alcoholics Anonymous* (the Big Book) was published by AA in 1939. The 12 steps of AA are listed in Box 14.2. Alcoholics

Anonymous was the first of many 12-step fellowships and has served as the model for other mutual-help groups operating from a 12-step philosophy such as Narcotics Anonymous, Overeaters Anonymous, and Gamblers Anonymous (Kingree, 2013; Laudet, 2008). As Kingree (2013) stated, the 12 steps are sequenced in a way that reflects the recovery process; Steps 1 through 3 prompt preparation, Steps 4 through 9 encourage action, and Steps 10 through 12 are concerned with recovery maintenance.
Later in this chapter several important aspects of 12-step theory are outlined as they pertain to treatment and recovery. Whereas this discussion centers on 12-step theory related to treatment, the concepts reviewed also hold true for 12-step mutual-help group participation. Concepts reviewed later in the chapter include the disease model of alcoholism and addiction, spirituality, acceptance and surrender, working the steps, making amends, forgiveness, and altruism.

Research on 12-Step Mutual-Help Group Attendance

Research on the effects of 12-step fellowship participation on recovery is difficult to accomplish. By their nature, 12-step fellowships are anonymous, making it difficult to identify research participants (Kaskutas, Ye, Greenfield, Witbrodt, & Bond, 2008). Despite this difficulty, several researchers have indicated that attendance at 12-step mutual-help groups such as AA or NA can be positively correlated to success in recovery (Kingree, 2013; Morgenstern, Labouvie, McCrady, Kahler, & Prey, 1997; Worley, Tate, & Brown, 2012). Moos and Moos (2004), for example, found that persons who took part in AA for at least 4 of the first 12 months after entering treatment had better success than did those who did not participate in AA at this frequency. McKellar, Stewart, and Humphreys (2003) found similar benefits of 12-step attendance on alcohol use and related problems. One issue with research methodology pertinent to both the Morgenstern et al. and McKellar et al. studies was that all participants in the studies were also enrolled in treatment at some point. Accordingly, little is known about the effectiveness of 12-step fellowship participation as a singular intervention without participation in some other form of treatment or intervention.

Issues With Diversity

Whereas AA and other 12-step fellowships exist worldwide, there appears to be a lack of diversity within 12-step fellowships (Fisher & Harrison, 2013; Laudet, 2008). Proponents of 12-step fellowships indicate that anyone is welcome at 12-step mutual-help group meetings so long as he or she is ready to quit drinking and/or using drugs. Despite this, 12-step fellowships in Western cultures tend to attract a large number of persons from similar backgrounds. Laudet reported on separate surveys of AA and NA members indicating that 89.1% of AA members and 70% of NA members identified as Caucasian. In the same surveys, 65% of AA members and 55% of NA members identified as male. Average age of AA members was reported to be 48 years old and average age of NA members was reported at 38 years old.

Based on these statistics it appears that the average 12-step fellowship member is generally a middle-aged Caucasian male. This, in turn, may lead persons from other racial/ethnic groups, ages, and genders to feel less accepted at 12-step fellowship meetings. Kaskutas et al. (2008) reported that the demographics of AA membership show increasing diversity. Data reported by these authors, however, also indicated that the overwhelming majority of AA members were still Caucasian middle-aged men. At the same time, anecdotal data suggest that some individual 12-step meetings may be more diverse than others, which could depend on geographic location or other such factors. As such, practitioners working from the 12-step perspective should discuss issues of diversity with their clients in order to ensure client comfort and success in 12-step mutual-help groups.

Box 14.2 The Twelve Steps of 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.

Philosophical Underpinnings and Key Concepts of the Theory

All 12-step models of addiction treatment describe addiction through the lens of the disease model (Alcoholics Anonymous, 2001; Narcotics Anonymous, 2008). The

disease model of addiction was first introduced by Jellinek in the 1950s and 1960s (Fisher & Harrison, 2013). Prior to the introduction of the disease model, addiction was viewed as a moral problem with alcoholics and addicts lacking the willpower to control their drinking and drug use. Jellinek's work challenged this notion and offered a medical framework for understanding the disease of addiction.

Proponents of the disease model view addiction as a primary, enduring, and progressive disease that may include genetic susceptibility to addiction (Fisher & Harrison, 2013). As a primary disease, addiction is understood to be a disease in and of itself and not the result of some other condition. In the disease model, addiction is also considered to be a physical disease much like heart disease or diabetes. And, like heart disease and diabetes, if left unchecked the disease of addiction will most likely lead to disability or death. Consistent with the disease model, Narcotics Anonymous (2008) defines addicts as persons who experience life problems as a result of drug use. Within this definition, NA also endorses the idea that addicts may be predisposed to addiction and therefore powerless over drugs even prior to their first use.

From the perspective of the disease model and 12-step approaches, the symptoms of addiction are many (Alcoholics Anonymous, 2001; Narcotics Anonymous, 2008). These include the presence of life problems due to the use of alcohol and drugs, loss of ability to control alcohol and drug use, unsuccessful attempts at cutting down on drinking and drug use, persistent use to the point of intoxication, lack of insight into the effects of alcohol and drug use (i.e., denial), and general disinterest and nonparticipation in life activities that do not involve alcohol or drugs. These and other behavioral and emotional indicators endorsed by AA and NA are the primary mechanism for recognizing alcoholism and addiction.

Within the disease model it is purported that there is no cure for the disease of addiction (Kingree, 2013). Rather, the alcoholic or addict must learn to live with and manage his or her disease in an effort to prevent the worsening of symptoms. This process is similar to the way a person with diabetes might control his or her disease with lifestyle changes and medication. Because the disease of addiction is thought to be incurable, addicts and alcoholics are never cured or recovered from their addiction problem. Instead, within the disease model and 12-step framework, addicts and alcoholics are viewed as being *in recovery* from the disease of addiction. In this sense, the disease of addiction is still present even when the outward signs and symptoms of the disease are not observable or descriptive of the alcoholic or addict's current behavior.

From the 12-step perspective, because there is no cure for the disease of addiction, abstinence from alcohol and drugs is viewed as the only viable option for recovery. Moderate use of alcohol and drugs is not an option for the true alcoholic or addict. Living with alcoholism and addiction is seen as a two-solution proposition. Either the alcoholic or addict (a) quits using alcohol and drugs and enters into recovery or (b) remains entrenched in alcohol and drug use thereby running the risk of death, disability,

or some other undesirable outcome (Alcoholics Anonymous, 2001; Narcotics Anonymous, 2008).

Recovery and the 12 Steps

Sobriety through the 12-step model is achieved through several mechanisms. Descriptions of the change-inducing mechanisms within the 12 steps are outlined in individual chapters within the AA and NA basic texts (Alcoholics Anonymous, 2001; Narcotics Anonymous, 2008). In reviewing the influence of 12-step fellowships on recovery, Donovan and Floyd (2008) suggested that, for successful recovery, simply attending 12-step meetings is not enough. Rather, the person entering recovery must be fully engaged with the fellowship program in order to increase the likelihood of success. The concepts, goals, and activities described next are important areas of engagement for those seeking recovery through a 12-step model.

Spirituality

One aspect of 12-step models that differs from other mutual-help (e.g., rational recovery) and treatment approaches is a focus on spirituality (Nowinski, 2013). A common misconception about AA and other 12-step fellowships is that they are religious organizations (Alcoholics Anonymous, 2001, 2014). This mistaken belief can be reinforced by the fact that many AA groups begin or end with a prayer and may be held in church basements or similar settings (Alcoholics Anonymous, 2014). The use of the term *God*, commonly associated with Christianity, within several of the 12 steps and other AA literature may further this misconception. For example, God is referenced in the Serenity Prayer that is regularly recited at 12-step fellowship meetings (Narcotics Anonymous, 1986, 2008). The Serenity Prayer is presented in Box 14.3.

> Box 14.3
> God grant me the serenity To accept the things I cannot change, The courage to change the things I can, And the wisdom to know the difference.

Spirituality within the 12-step philosophy is seen as both the foundation for and driving force behind successful recovery. According to Nowinski (2013), spirituality provides guidance and direction to those in recovery and can lead to positive changes in personal goals and objectives. A focus on spirituality is the cornerstone of 12-step approaches to recovery with the goal of membership in the fellowship being a spiritual awakening (Alcoholics Anonymous, 2001). A spiritual awakening equates to learning a new way of living and functioning without alcohol and drugs. During a spiritual awakening, beliefs and values consistent with the prerecovery lifestyle are devalued and replaced with a new ideology more consistent with abstinence and recovery.

The 12 traditions and 12 steps reference aspects of spirituality often, and a reliance on a higher power is deemed necessary in order to successfully enter recovery. For example, Tradition 2 in the 12 Traditions states, “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" (see Box 14.1). Spirituality is also referenced in several of the 12 steps (see Box 14.2). For example, Step 2 directs persons entering recovery to discover and accept a higher power to lead them into recovery. Likewise, in Step 3 fellowship members are directed to turn their lives over to that higher power as an avenue to successful recovery. A reliance on spirituality is also referenced in Steps 5, 6, 7, 11, and 12 (Alcoholics Anonymous, 1981).

The focus on spirituality and the use of the term *God* has led many away from 12-step fellowships such as AA. To combat this, AA makes a point in many of its publications (e.g., Alcoholics Anonymous, 2014) to communicate that all are welcome to become fellowship members so long as they desire to stop drinking. Additionally, in the early history of the 12 steps AA members decided to add the phrase "as we understood Him" to qualify the use of the term *God*. The addition of this phrase was intended to portray AA as more open and accessible to persons from all backgrounds, not just those affiliated with organized religion or other groups with an already conceived notion of God (Alcoholics Anonymous, 2001). Tolerance and acceptance are highly regarded values in AA, and persons from all faiths and denominations are encouraged to take part (Alcoholics Anonymous, 2014). This message is further delineated in Chapter 4 of the Big Book (Alcoholics Anonymous, 2001) titled "We Agnostics" wherein the differences between organized religion and a nonaffiliated higher power are outlined.

Acceptance and Surrender

With all 12-step fellowships, the first step toward entering recovery is to complete Step 1, admitting powerlessness over alcohol and drugs (Alcoholics Anonymous, 2001; Narcotics Anonymous, 2008). Until Step 1 is completed individuals will be unable to effectively work the remaining steps in a beneficial manner. In essence, this involves confronting and overcoming any denial the individual has about his or her addiction. The concepts of acceptance and surrender are key here (Connors, Walitzer, & Tonigan, 2008; Pearce, Rivinoja, & Koenig, 2008). With Step 1, the individual entering recovery must accept that willpower alone cannot create sustained sobriety in recovery. After accepting the presence of addiction in Step 1, fellowship members must then surrender to a higher power, be willing to take action, and use the 12 steps to guide them in recovery (Nowinski, 2006). In Steps 2 and 3 individuals must accept the existence of a higher power, surrender to that higher power, and give control of their lives to the higher power of their choosing. Taken as a whole, Steps 1 through 3 are known as the surrender steps (Connors et al., 2008).

Following Step 3, and the acceptance and surrender implied therein, fellowship members are able to engage their recovery in a more active manner by moving through the remaining steps. Without acceptance and surrender, though, working the remaining steps will be fruitless. By the end of Step 3 individuals should have a firm understanding of their higher power and the ways in which they will rely on that higher power for support. As well, individuals completing Step 3 should also be actively and

consistently engaging in activities such as attending 12-step meetings, engaging with 12-step literature, creating new relationships both within and outside 12-step communities, and giving up old habits associated with addiction (Nowinski, 2006).

Group Attendance

To be successful in recovery, regular attendance at 12-step meetings is essential (Alcoholics Anonymous, 2001; Narcotics Anonymous, 2008). Attendance at these meetings is vital for a variety of reasons. First, research has demonstrated that regular attendance at 12-step mutual-help group meetings can lead to protective and positive influences in the life of the addict or alcoholic (Kelly, Hoeppner, Stout, & Pagano, 2012). Attendance at meetings can also be correlated to increased psychological health, reductions in impulsivity, and decreases in drinking and drug use (Kelly, Stout, Magill, Tonigan, & Pagano, 2010).

In addition to these overall positive effects of group membership, attendance at 12-step meetings is also crucial to the work associated with recovery. Through attendance, group members come to recognize that they are not alone in their struggles with addiction and that others have experienced similar problems as a result of their addiction (Alcoholics Anonymous, 2001). This outcome of group attendance, also known as universality in the group counseling literature (Yalom, 2005), is one of the main catalysts for recovery in the 12-step model.

Finally, attendance at group meetings provides members with an open and accepting forum in which to discuss addiction-related issues (Alcoholics Anonymous, 2001). Meetings are seen as a mechanism for encountering recovery-minded individuals with whom the trials of addiction can be shared. Additionally, by attending different meeting formats (e.g., step meetings, speaker meetings), members are encouraged to examine their recovery from different perspectives and through different lenses. Meetings can also provide an ever-present system of support to be called on in times of need. Finally, attendance at group meetings can fill the gaps in daily schedules that were once occupied with drinking and drug use.

Working the Steps

Engaging and following through with activities specified in the 12 steps is commonly known as “working the steps” or “step work” and is essential to the recovery process. As mentioned previously, dividing the 12 steps into sequential categories can be helpful to persons working through recovery. As stated previously, Steps 1 through 3 focus on preparation for recovery (including acceptance and surrender), Steps 4 through 9 highlight specific recovery activities, and Steps 10 through 12 center on maintaining gains in recovery (Kingree, 2013). This conceptualization of the 12 steps mirrors the stages of change model developed by Prochaska and DiClemente (1984), which is reviewed in Chapter 10. These similarities are illustrated in Box 14.4.

Box 14.4 Stages of Change and the 12 Steps

Stages of Change	12-Step Perspective
Precontemplation	Pre-Step 1 (Denial)
Contemplation	Steps 1 and 2
Preparation	Step 3
Action	Steps 4 through 9
Maintenance	Steps 10 through 12

The purpose of step work is to help the addict or alcoholic become less self-centered and more focused on surrendering control to his or her higher power (Borkman, 2008b). In general, the steps must be worked sequentially. For example, one cannot turn his or her life over to a higher power (Step 3) before accepting the existence of said higher power (Step 2). Likewise, one cannot make amends to those he or she has wronged (Step 9) prior to taking an inventory of those persons harmed during active addiction (Step 8). It is common for those in recovery to want to skip steps or work through them too quickly. Alcoholics Anonymous warns about this and offers numerous perspectives on how to avoid this potential pitfall (Alcoholics Anonymous, 1981, 2001, 2014). For example, addicts and alcoholics can rely on their sponsor or a group they attend to stay on track in their sequential step work.

Making Amends and Forgiveness

After working Steps 1 through 7 persons in 12-step recovery programs are prompted to make amends with those whom they negatively impacted during active addiction (Alcoholics Anonymous, 1981, 2001, 2014; Narcotics Anonymous, 2008). In Step 8, the person in recovery is directed to make a list of persons whom they harmed during their active addiction. Following this, in Step 9, recovering persons are tasked with making direct amends to those persons identified in Step 8 except in situations when to do so may cause more harm to the wronged party. Finally, with Step 10, recovering persons are expected to continue with their personal inventory and promptly make amends when necessary (Alcoholics Anonymous, 1981).

The process of making amends is aimed at creating inter- and intrapersonal peace (Alcoholics Anonymous, 1981). When creating a list of those who have been wronged, the recovering person is engaging in personal and relational introspection. The intent is for the recovering person to gain more insight into past actions, take responsibility for

harmful behaviors, and seek forgiveness from those who have been harmed in the past. Within this process, it is also expected that the recovering person engage in self-forgiveness. The practice of making amends and seeking forgiveness can assist recovering persons in forming healthy, new, and lasting relationships free from drugs or alcohol (Connors et al., 2008).

Altruism

The final area of 12-step engagement to be discussed in this chapter is that of altruism. For 12-step fellowship purposes, altruism is defined as an intentional action that is of benefit to others and where no reward or reciprocation is expected (Zemore & Pagano, 2008). Alcoholics Anonymous (1981, 2001) suggests that recovering persons engage in altruistic acts later in their recovery when lifestyle changes are more consistent and entrenched. This is evidenced by the placement of altruism in the 12th step. The two main altruistic activities recommended in 12-step fellowships are service and sponsorship.

Service in 12-step fellowships most commonly refers to activities aimed at helping other addicts, whether those addicts are in recovery or not (Zemore & Pagano, 2008). This can include such activities as offering contact information to others in recovery, helping with meeting setup and cleanup, providing transportation to and from meetings, and numerous other activities that can benefit other fellowship members or persons not yet in recovery. Research on altruistic service supports the theory that one can gain personal benefit from helping others who either suffer or are in recovery from addiction (Zemore & Pagano, 2008). As such, completing altruistic acts may serve the secondary function of benefiting the addict or alcoholic involved in 12-step service activities.

A second and more specific form of altruism is sponsorship (Borkman, 2008a; White & Kurtz, 2008). In 12-step fellowships, sponsors are persons who are well-established in their recovery and, as a result, can serve as mentors, models, and guides to those whom they sponsor (Kelly & McCrady, 2008). Newcomers to 12-step fellowships are encouraged to seek out established fellowship members (i.e., sponsors) who can assist them in acclimating to fellowship activities and the world of recovery. Once fellowship members are firm in their recovery, providing sponsorship to newer members can further ensconce the sponsor in his or her recovery and provide personal feelings of satisfaction and pride when helping others.

How the Theoretical Approach Is Used by Practitioners

Over the past two decades the addictions treatment field has experienced a movement toward professionalization (Fisher & Harrison, 2013). During this time, several states have adopted licensure standards for addictions practitioners. With this professionalization, addictions treatment has become more science based and theory driven (e.g., cognitive behavioral therapy, motivational interviewing) (Borkman, 2008b). At the same time, Alcoholics Anonymous and other 12-step approaches to

recovery, which were designed for use in voluntary self-help fellowships rather than methods of formalized treatment, continue to flourish (Borkman, 2008b; Fisher & Harrison, 2013). Despite differences between mutual-help groups and treatment, addictions practitioners frequently adopt the 12-step philosophy in their treatment settings and use the related principles in their work with clients (Slaymaker & Sheehan, 2008). As a result, the literature on 12 step–based treatment approaches continues to expand (Galanter & Kaskutas, 2008). One of the most widely practiced models of 12 step–based treatment is the structured approach of Twelve-Step Facilitation (TSF), which is explored next.

Twelve-Step Facilitation

Twelve-Step Facilitation was developed as a model of treatment designed to support 12-step fellowship involvement and was one of the treatment modalities examined in Project Match (Kingree, 2013; Longabaugh & Wirtz, 2001; Nowinski, 2006, 2013; Nowinski, Baker, & Carroll, 2007). As Ries, Galanter, Tonigan, and Zielger (2010) noted, TSF is not a 12-step fellowship nor has it been formally endorsed by any 12-step groups (in accordance with Tradition 6 of the 12 Traditions of AA). Instead, TSF is a professionally developed approach to addictions treatment that relies on the skills of competent and trained clinicians for delivery of treatment interventions. Nowinski (2006) stated that TSF is completely compatible with the 12-step philosophy and is based on the same values and principles. As such, the TSF practitioner should be well versed in the 12 steps and related concepts. Likewise, the TSF practitioner should also work through any negative reactions or beliefs he or she has about the guiding principles of the 12-step approach. In other words, to be successful with this approach, addictions practitioners must be fully versed in the 12-step model of addiction and recovery and be open to all philosophies, concepts, interventions, and activities suggested therein.

The TSF model is generally categorized as a manualized and structured approach designed to be used to complement 12-step mutual-help group attendance. Whereas generally thought of as a model for group counseling, TSF can also be applied in individual, couples, and family formats of treatment. The overarching goals of TSF are (a) increasing abstinence from alcohol and other drugs and (b) increasing participation with 12-step fellowships and mutual-help groups such as AA and NA. Similar to AA and other 12-step groups, TSF practitioners adhere to the disease model of addiction (Kingree, 2013). Accordingly, the goal of therapy for those participating in TSF therapy is abstinence from alcohol and other drugs.

TSF Practitioner Characteristics

Nowinski et al. (2007) suggest that practitioners using the TSF approach should possess several important professional characteristics. First and foremost, the successful TSF practitioner should have formal training in addictions treatment and a comprehensive understanding of the 12 steps and related principles. This includes comfort in

facilitating client reliance on 12-step fellowships and use of 12-step slogans (e.g., “one day at a time,” “fake it 'till you make it.”). Additionally, TSF practitioners should be comfortable operating from an active, supportive, collaborative, and confrontational approach to treatment.

Nowinski et al. (2007) also stated that it is not essential for TSF practitioners to be in recovery. Provided they have extensive knowledge of the 12-step recovery process, nonrecovering practitioners can be just as successful with the approach as practitioners who are in recovery. When using TSF, nonrecovering practitioners should be prepared to answer questions about recovery status. Nonrecovering practitioners should also be ready to discuss how they can assist clients in being successful despite not having personal experience with addiction and recovery. In a qualitative study, Crabb and Linton (2007) found that nonrecovering practitioners are more likely to operate strictly from a 12-step perspective when compared with their recovering counterparts. Whereas the authors did not link this finding to treatment outcomes, their results suggest that nonrecovering practitioners can indeed be comfortable in using the TSF model.

TSF Practitioner Roles and Responsibilities

To successfully implement the TSF approach, and to help clients achieve the overarching goals, Nowinski et al. (2007) outline several important roles for practitioners. The primary roles are that of educator and facilitator. As TSF educators, practitioners serve as a 12-step resource and guide. This includes (a) explaining the 12 steps and related concepts, (b) teaching clients to identify personal examples consistent with the 12-step orientation to addiction, (c) emphasizing the differences between recovery (desired outcome) versus cure, (d) encouraging reliance on the 12 steps and fellowship meetings as the path to recovery, (e) discussing sponsorship, and (f) answering questions about 12-step readings such as passages from the Big Book or other resources published by 12-step organizations.

In taking on the role of facilitator, TSF practitioners emphasize clients' between-session behavior and 12-step involvement participation (Nowinski et al., 2007). From the facilitator standpoint, practitioners (a) place the responsibility for change directly on clients, (b) encourage more personal involvement and participation in different types of 12-step fellowship groups (e.g., step meetings, discussion meetings), (c) explain and maintain the role of practitioner and avoid taking on roles such as sponsor or fellow group member, (d) highlight instances of denial particularly as it pertains to slips with alcohol or drug use, (e) provide suggestions for recovery tasks, and (f) enhance clients' integration into the 12-step community, including active participation in 12-step fellowship meetings. As a facilitator, practitioners should strive to create change-inducing discussions aimed at meeting TSF treatment goals.

TSF Implementation

Nowinski (2013) offered several strategies for the implementation of TSF in group settings. Recommendations include the use of (a) small groups (6–8 clients); (b) an open

format with newcomers welcome at all group meetings; (c) topic-focused sessions; (d) structured session formats; (e) handouts and other didactic materials; (f) discussions of urges, cravings, slips, and relapses; and (g) client commitment to recovery tasks at the end of each TSF meeting. Nowinski indicated that TSF practitioners should choose session topics ahead of time and cover only one topic per session. Assigned recovery tasks can include activities such as making a commitment to attend a certain number of 12-step mutual-help group meetings, conducting relevant readings on the topic of addiction and recovery, or engaging in other tasks that solidify recovery. Several TSF manuals and publications are available to assist practitioners in implementing this approach with clients (Nowinski, 2006; Nowinski & Baker, 2003; Nowinski et al., 2007; Ries et al., 2010).

Effectiveness of 12-Step Counseling

Numerous research studies have demonstrated the effectiveness of 12-step approaches to addictions treatment. One notable finding on the effectiveness of 12-step approaches to addictions treatment emerged during Project MATCH (Longabaugh & Wirtz, 2001). Participation in Project MATCH included 952 outpatient and 774 aftercare clients from multiple treatment sites. Among other variables examined in Project MATCH, treatment outcomes were compared for clients receiving either cognitive behavioral therapy (CBT), motivational enhancement therapy (MET), or 12-step facilitation (TSF). Participants in each of these groups showed reductions in alcohol and drug usage at a 1-year posttreatment follow-up with no significant differences noted between the three groups. At a 3-year follow-up, however, participants in the TSF condition demonstrated significantly higher rates of abstinence (36%) when compared with the CBT (24%) and MET (27%) conditions (Butler Center for Research, 2010; Longabaugh & Wirtz, 2001; Slaymaker & Sheehan, 2008). Other studies have also demonstrated the effectiveness of 12 step–focused addictions treatment (Campbell, Guydish, Le, Wells, & McCarty, 2015; Galanter & Kaskutas, 2008; Kingree, 2013; Martino, 2013; Pearce et al., 2008). As such, TSF continues to be an effective option for the treatment of addiction.

Assessment and Prevention Implications

Just as with any treatment approach, assessment is an important part of the 12-step model of addictions treatment (Nowinski, 2006). In general, assessment from a 12-step perspective includes many of the same information-gathering activities used in other approaches. This involves obtaining background on clients' substance use history, consequences of substance use, mental and physical health, education and employment history, legal history, and many other standard areas of inquiry. At the end of the assessment process, 12-step model practitioners should have a thorough understanding of the client's relationship with alcohol and drugs and determine whether the client is an alcoholic or addict.

Contrary to popular belief, within the 12-step model not all persons who drink or use

drugs in problematic ways are described as addicts and alcoholics (Alcoholics Anonymous, 2001; Narcotics Anonymous, 2008). Whereas the behavior of some alcohol and drug users may mimic that of the alcoholic or addict (e.g., role failure, substance-related legal problems), not all persons who use alcohol and other drugs to excess have the disease of addiction. Rather, proponents of the 12-step model offer a typology, or continuum of sorts, to describe the progression of the disease of addiction.

In the Big Book, AA (2001) acknowledges that some people who drink heavily are able to return to moderate drinking and are therefore not alcoholics. The first of these is the moderate drinker. Moderate drinkers enjoy drinking alcohol and may even drink to excess at times. However, the moderate drinker can "take it or leave it" when it comes to alcohol and drug use. By AA standards, moderate drinkers can control their use even though they may, at times, seem to be out of control with their substance use or behaving in ways similar to the true alcoholic or addict.

Second, in comparison with the true alcoholic, AA (2001) acknowledges the hard drinker. The hard drinker is seen as a person who

> may have the habit badly enough to gradually impair him physically and mentally. It may cause him to die a few years before his time. If a sufficiently strong reason—ill health, falling in love, change of environment, or the warning of a doctor—becomes operative, this man can also stop or moderate, although he may find it difficult or troublesome and may even need medical attention. (p. 20)

Whereas both moderate and hard drinkers do not fall into the category of alcoholic, they may, in the future, become alcoholics if their drinking increases and leads to bodily damage. In these situations, heavier drinking over time can lead to the onset of the disease of alcoholism to which the drinker was genetically predisposed.

Typologies of use also exist within the NA description of the disease of addiction. Narcotics Anonymous acknowledges that, whereas many persons may use drugs to intoxication and engage in risky behavior as a result of this use, not all persons who do so are addicts. Rather, addicts are those who experience an allergic reaction to drugs thereby limiting their ability to control their usage (Narcotics Anonymous, 2008). This allergic reaction, which results in symptoms of addiction, is understood to be the product of genetics and not some other psychological or environmental factor. Those who are not genetically predisposed to an allergic reaction to drug use could theoretically use drugs in a recreational manner, even after problematic use has occurred.

Case Study Responses

Having now summarized the 12-step approach to addictions treatment, the case of Gabriel is examined through the 12-step lens. This discussion includes a case conceptualization, suggestions for therapeutic approaches and techniques, and strengths and weakness of the approach as applied to Gabriel. Within this discussion, several unique aspects of Gabriel's case are used to highlight the application of 12-step theory

to his treatment and eventual recovery.

The first step in offering 12 step–based treatment to Gabriel would be assessment. During the assessment process the practitioner's primary responsibility would be to determine Gabriel's relationship with drugs and alcohol. Through discussions about Gabriel's patterns of use and related behaviors, the practitioner would try to determine if Gabriel has the disease of addiction.

Whereas Gabriel clearly does not fit into the category of the moderating user, it may be helpful to find out if he is a hard drinker versus an alcoholic or addict. Although the outcome of this assessment (i.e., hard drinker versus alcoholic) does not appear to impact the effectiveness of 12-step fellowship involvement (Longabaugh & Wirtz, 2001; Slaymaker & Sheehan, 2008), finding a common language for use in Gabriel's treatment will likely be advantageous to the therapeutic process. Because Gabriel has unsuccessfully tried on multiple occasions to reduce his alcohol and drug use, and because he has multiple substance-related legal offenses (i.e., DWI and possession), it may be more likely than not that he is suffering from the disease of addiction. Accordingly, abstinence would be his only feasible option for recovery.

In addition, during the assessment process the practitioner would take inventory of Gabriel's behaviors toward self and others while he is or was actively engaging in heavy alcohol and drug use. From the case study it is evident that Gabriel's patterns of drug and alcohol use have led to negative consequences for him and his family. For instance, Gabriel's alcohol and drug use has impacted his relationship with his niece, who we have been told looks up to Gabriel as a role model and mentor. Gabriel's niece knows of his struggles with addiction and has begged him on numerous occasions to stop using alcohol and drugs. Because Gabriel attempts to stay away from his niece while using, the time he is able to spend with her is greatly reduced because of his alcohol and drug use. In addition, Gabriel's mother has started attending Al-Anon meetings, a 12 step–based fellowship for family members of alcoholics, demonstrating that she has had difficulty coping with Gabriel's addiction issues. These factors, too, point to the presence of the disease of addiction.

One key issue to assess with Gabriel would be his views on spirituality. As delineated throughout the chapter, spirituality is the foundation for 12-step approaches to mutual-help groups and treatment. As a result, it would be imperative for the practitioner to discuss Gabriel's spiritual life and determine his beliefs concerning the presence of a higher power. Because a reliance on a higher power is necessary to complete Steps 1 through 3, having a discussion on spirituality would be key as the treatment process begins.

Finally, regarding assessment, the practitioner should pay close attention to Gabriel's strengths and determine how those strengths can be used to enhance the treatment process. From the case study we know that Gabriel has had some limited success (7 weeks of abstinence) while attending AA. In addition, Gabriel appears to have support

within his family. His aforementioned niece could be a motivator for recovery, and his mother's attendance at Al-Anon may indicate a desire to help Gabriel with his recovery. Whereas being around some family members (e.g., Gabriel's father) might actually put Gabriel's recovery at risk, he appears to have some support as he attempts to change his relationship with alcohol and drugs.

Toward the end of the assessment process, treatment for Gabriel would begin. For the practitioner working from the 12-step theory, 12-step facilitation (TSF) could be considered the go-to model. At the start of treatment the practitioner should determine whether Gabriel would benefit more from individual or group treatment or some combination of both. Small groups are recommended for use in TSF practice, but allowing for some client input into the selected treatment modality could be beneficial to the treatment process.

The first task in TSF would be to educate Gabriel on the 12-step model. This would include discussions of the Big Book and other AA/NA literature, the 12 steps and 12 traditions, the disease model of addiction, and the necessity of attending 12-step fellowship meetings. With the help of the TSF practitioner, Gabriel would use both treatment and fellowship meetings to work through Steps 1 through 3 (the surrender steps). The time needed to successfully fulfill Steps 1 through 3 would depend on his spiritual beliefs. As such, patience on the part of the practitioner would be imperative as Gabriel begins his 12-step journey.

Following completion of the surrender steps, Gabriel would work Steps 4 through 12. His step work would be the primary topic of TSF, and treatment discussions would center on his attempts to navigate the 12 steps. In this sense, TSF as an intervention could be considered an adjunct to 12-step fellowship attendance. As such, one main goal for TSF could be to enhance Gabriel's participation in 12-step fellowships.

In comparing Gabriel's current situation to the 12 steps, several goals for Gabriel's treatment emerge. After surrendering to the higher power of his choosing, Gabriel would begin the process of self-examination. For example, in Step 4 Gabriel would take a personal inventory and admit to himself and his higher power the exact nature of his wrongs. The TSF practitioner would be actively involved in this process and could help Gabriel to realize the impact of his past behavior. Later, in Step 9, Gabriel would begin the process of making amends. From the case study we know that Gabriel's behavior has harmed his family members and has perhaps been related to his lack of success in romantic relationships. Again, the TSF practitioner could assist with this process and provide support to Gabriel as he takes on this challenging task. At some point during his treatment the practitioner would work with Gabriel to identify a good sponsor and support him as he sought guidance from other 12-step fellowship members. Later in treatment, Gabriel would begin providing service and support to other addicts and alcoholics and may find solace in such altruistic activities. Again, the TSF practitioner could provide much support with this task.

There are several inherent strengths and weaknesses of the TSF approach as applied to Gabriel. Whereas Gabriel does have some supportive family members, it is unknown whether he has social support beyond that of his mother, sister, and niece. Twelve-step fellowship meetings would provide an opportunity for Gabriel to gain social support from persons with similar goals. In addition, we know from the case study that Gabriel has much shame related to previous romantic relationships, especially his first sexual encounter. In 12-step and TSF meetings, Gabriel would meet other persons experiencing similar shame about past actions. This experience of universality regarding his shame may propel him toward self-forgiveness and acceptance.

In addition to these strengths, two important weaknesses of the 12-step approach as applied to Gabriel should also be discussed. First, the TSF practitioner would need to obtain information about Gabriel's spiritual beliefs. Whereas we don't have any information about this, the fact that spirituality is not mentioned in Gabriel's case study may indicate a lack of belief or commitment in this area. Were this true, helping Gabriel identify and surrender to a higher power may prove to be an arduous task. Practitioners' commitment to the TSF approach would be crucial here.

A second potential weakness of the TSF approach with Gabriel pertains to the diversity issues discussed earlier in the chapter. As a biracial 26-year-old male, Gabriel may feel less accepted or even out of place at 12-step fellowship meetings. The TSF practitioner could explore this reality with Gabriel and discuss ways in which Gabriel could find common ground with other fellowship members. Pursuant to this, it would also behoove the TSF practitioner to have information on multiple support groups present in Gabriel's geographic location, especially as it pertains to the diversity of membership at individual meetings. With this in mind, it is likely that the practitioner could assist Gabriel in identifying a group or groups where he feels welcomed, accepted, and comfortable, thereby increasing his fellowship participation.

Despite these potential weaknesses, Gabriel is likely to have success in TSF treatment. Should he commit to working the steps, TSF could help Gabriel establish new and healthy relationships. Twelve-step facilitation could also assist Gabriel in reconnecting with his family and working toward forgiveness of his past trespasses. Finally, Gabriel could use treatment and fellowship meeting attendance to address and eradicate feelings of shame over past behaviors. This would help Gabriel engage in more self-acceptance and could lead to a spiritual awakening that fellowship members aspire to obtain. With these factors in mind, Gabriel could find his way into successful recovery using 12-step principles and practices.

Summary

The 12-step approach is one of the earliest models of addictions treatment. Based on the principles of 12-step fellowships such as AA or NA, persons receiving treatment in 12 step–based programs are viewed as having a physical disease leading them to drink or use drugs in problematic ways. Central to treatment is the idea that rather than

experiencing a cure for alcoholism or addiction, the client must enter and stay in recovery. Recovery is described as an active and lifelong process with abstinence being the only acceptable goal of treatment. Entering recovery involves the acceptance of a spiritual higher power and a reliance on that higher power to achieve sobriety. Twelve-step facilitation is one approach practitioners can use in their work with clients. Ultimately, practitioners offering treatment from a 12-step perspective must have advanced knowledge of 12-step principles. Additionally, these practitioners must be willing and able to use those principles to encourage client attendance at fellowship meetings and process the experiences clients have therein. Without these commitments from practitioners, 12 step–based treatment approaches may be less effective in helping clients to enter recovery from alcoholism and addiction.

Resources for Continued Learning

Websites

AA Big Book: www.aa.org/pages/en_US/alcoholics-anonymous.
Al-Anon: www.al-anon.org.
Alcoholics Anonymous: www.aa.org.
American Society of Addiction Medicine: www.asam.org.
Cocaine Anonymous: www.ca.org.
Erickson Research: http://sites.utexas.edu/erickson.
Gamblers Anonymous: www.gamblersanonymous.org.
Narcotics Anonymous: www.na.org.
Narcotics Anonymous Basic Text: www.na.org/?ID=NAWay_October_2008.pdf.
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15 Constructivist Approaches to Addiction Counseling: *Feminist, Womanist, and Narrative Theories*

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The field of addiction counseling began embedded within a white, Western, and mostly male framework. For instance, the founder and attendees of the original meetings of Alcoholics Anonymous were mostly white men. Although the field of addiction counseling has evolved in many ways since that time in terms of attention to women's concerns and people of color, important components of this evolution can be attributed to feminist critiques of the addiction field and the call for attention to women's issues in general. In addition, there is a need for a constructivist approach to addiction counseling that acknowledges the multicultural and social justice issues influencing addiction, and narrative approaches to addiction give context to the multiple truths and stories of clients' lived experiences of addiction.

In this chapter, we review three constructivist approaches to addiction counseling. In doing so, womanist theory and its application to addiction counseling is proposed for the first time. Womanist theorists grew out of feminist networks, asserting the need for the lives of African American women (and later women of color) and their everyday lived experiences of empowerment and power to be recognized (Phillips, 2006). In this chapter, narrative approaches to addiction counseling are reviewed in addition to feminist and womanist approaches due to the constructivist approach narrative traditions in counseling bring to the client-counselor relationships. We give attention to the philosophical underpinnings and key concepts, practitioner strategies, strengths and weaknesses, case study, and policy change across feminist, womanist, and narrative approaches to addiction counseling.

Philosophical Underpinnings and Key Concepts of Feminist and Womanist Theories

Postmodern approaches such as feminist, womanist, and narrative therapy share a common philosophical stance around issues of power, justice, and advocacy. They may, however, look different in clinical application. Feminist and womanist approaches to addiction counseling emphasize concepts such as the intersections of personal experience and political realities, the importance of egalitarian relationships, and explorations of voice and resilience. We now explore these philosophical stances and key concepts.

The philosophical underpinnings and key concepts of feminist and womanist theories

share many similarities, but there are also numerous distinct differences. The following sections distinguish a range of feminist and womanist theories and the related key concepts contained within them as they relate to addiction counseling.

Feminist Theory

Feminist approaches to addiction counseling arose out of the feminist movement within counseling and psychology in the 1960s and 1970s (Enns & Byars-Winston, 2010). Before this movement, approaches to counseling in general tended to neglect women's concerns, with a focus on individuality, assertiveness, and independence (Brown, 2008). The feminist critique of general counseling approaches focused on androcentric frameworks that did not necessarily respond to the daily lived experiences of women. Feminists, such as Jean Baker Miller (1976), author of *Toward a New Psychology of Women*, advocated for the counseling and psychological fields to shift to a paradigm that centered on the concerns of women. For instance, in Miller's groundbreaking text, she asserted that individuality should not be the goal of counseling, but rather, the focus in counseling should be on relationships and the extent to which clients were able to develop growth-fostering relationships that enhanced their lives. This shift in perspective was a large one in the counseling field and faced much resistance; however, feminist counseling scholars continued to write about feminist approaches into the 1990s and beyond, developing more than four decades of feminist counseling frameworks (Enns, 1993; Popadiuk, 2015).

Also important to note are the contributions of Charlotte Kasl (1989) in her landmark book *Women, Sex, and Addiction*, in which she described 16 steps to healing addiction that integrated increased attention to community support, as well as affirmation of women's identities and empowerment. Kasl's 16 steps to empowerment are based on the idea that the 12 steps of Alcoholics Anonymous were focused on mediating the hubris of male alcoholics and that women with addiction issues needed to feel empowered and have their self-esteem lifted, not humbled.

Within the original feminist movement, many types of feminism developed (Worell & Remer, 2003). Liberal feminists focused on women's experiences of sexism with regard to gender and neglected to address other types of oppression such as racism and ableism. Radical feminists asserted that the structural inequities within patriarchy were so embedded within institutional power structures that the only way to transform these structures was to develop new approaches to power, which sometimes were believed to necessarily include women-only spaces. Social feminists, on the other hand, not only focused on gender but also critiqued economic class structures within society, therefore asserting the need for noncapitalist approaches to societal structures. Womanists (discussed later in this chapter) began to address issues of race, ethnicity, and gender, among other intersections, whereas cultural feminists advocated for the valuation of women's experiences and lives and a transformation of patriarchal structures through this valuation. Worell and Remer (2003) note that across these feminist frameworks are

two shared foci for feminist counselors: valuing women's experiences and social justice change.

The basic tenets of feminist therapy are that the personal is political and that the therapist-client relationship is egalitarian. The “personal is political” stance takes into account the meanings of gender and power in the client's social and cultural reality. The female experience is validated through therapy, and clients learn to distinguish between internal (internalized stereotyping and gendered socialization) and external (institutionalized sexism, racism, heterosexism) realities. Therapy is about exploring attitudes and values, and the goal is change rather than adjustment. That which oppresses and limits the client is a part of the “system” and thus must be changed.

The egalitarian relationship between the therapist and client is the foundation of the feminist approach. The therapist becomes a real person with the client, a fellow traveler looking for answers to life's struggles. By being genuine and authentic, the therapist serves as a potential model for self-awareness, with clear psychological boundaries and an ability to express both gentleness and definitiveness. In feminist therapy, clients are in the room with a person who wants them to discover the power within and to learn to express that power without worrying about the established order. The process of assuming power in one's life may bring up feelings of anger, and dealing with anger is essential in feminist therapy. The goals of therapy are determined collaboratively, within a relationship, in which each person brings equally valued expertise to the process. Ultimately, feminist therapy is concerned with the client's empowerment, personally, politically, economically, and socially. Feminist therapy addresses issues from the real world, including employment disparities, sexual assault, sexual orientation, eating disorders, body image, interpersonal violence, and the stress associated with being a person of color. It is perhaps one of the only areas of counseling and psychology that highlights issues related to physical appearance and women's control over their own bodies. Feminist therapy is also one of the few approaches that recognizes and addresses the unique struggles confronting lesbian and bisexual women.

Womanist Theory

Women of color share common struggles that impact their life experiences, particularly as they relate to sexism and racism. Contextually appropriate counseling and intervention strategies that acknowledge the intersection of multiple marginalized identities are still emerging for this population. This is particularly true when providing addiction counseling that incorporates a culturally sensitive approach that meets the unique needs of women of color. In this section, womanism is described as a contextually appropriate counseling approach to help women of color struggling with addiction from a culturally sensitive framework that acknowledges the intersection of race and gender. The philosophical framework of the womanist approach to counseling derives from Alice Walker's womanism (1983) and the five tenets of womanism constructed by Phillips (2006) and Maparyan (2012). This philosophy includes

intersectionality, which defines how intersecting identities, such as race, class, and gender, contribute to life experiences, particularly experiences of privilege and oppression (Crenshaw, 1996).

> Box 15.1 Reflection Activity: Understanding Your Gender Socialization
> Take a moment to answer the following questions:
> - What were your earliest memories of your gender socialization?
> - What messages did you receive about your gender growing up within your family, school, friend group, and community?
> - How did these gendered messages influence your well-being, hopes, and dreams?

Womanism is believed to fill the gap within traditional feminist approaches by not only acknowledging male privilege and power differentials related to gender but recognizing other forms of marginalization that intersect to impact women's lives. Womanism speaks particularly to the lived experiences of women of color because this framework is founded in the understanding of women's experiences as not shaped by sexism alone but the systemic ways sexism is embedded within racism, classism, and other marginalized social identities women inherit. This does not mean that womanism excludes white women or men. On the contrary, womanism provides a more holistic and shared viewpoint when exploring the lived experiences of all women in a patriarchal society. In essence, womanism prevents exclusion by acknowledging that all voices are needed to participate in the conversation about power and gender effectively.

Intersectionality, as defined by Crenshaw (1996), is considered the key component of womanism because this theoretical lens examines how multiple sources of oppression intersect to form a shared lived experience. A number of research studies and journals explore the experiences of marginalized populations from separate constructs of identity, such as the experiences of Asian Americans, the experiences of LGBTQ people, or the experiences of persons with disabilities. These examples reflect an attempt to understand a person's worldview from the framework of essentialism. Essentialism is the idea that all people who share a singular characteristic also share the same experiences (Coleman, Norton, Miranda, & McCubbin, 2003). As a result, other aspects of an individual's identity become minimized due to a perceived level of importance of one identity over another, the visibility of the individual's identity, or the belief that an individual's identity can be packaged, like produce, into separate and distinct boxes. Intersectionality promotes recognition of the entire person and that every individual is not a reflection of one lived experience but many shared experiences (Crenshaw, 1996). This, again, is why intersectionality is considered to be at the core of womanism when exploring the shared experiences of all women.

Layli Phillips (2006) published *The Womanist Reader* based on Alice Walker's definition of the term and constructed five tenets of womanism. She has since published

a second text, under a different last name, that elaborates on the first in *The Womanist Idea* (Maparyan, 2012). Each tenet, as described across both texts, is explored for practitioners who want to incorporate womanism as a framework to support people struggling with addictions.

The five tenets of womanism are anti-oppression, vernacular, nonideological, communitarian, and spirituality/luxocracy (Maparyan, 2012; Phillips, 2006). Anti-oppression, the first tenet, focuses on empowering individuals beyond socially constructed identities used to oppress and dominate marginalized groups. The second tenet, vernacular, is essentially described as "the everyday" where people are simply members of humankind with similar goals and desires, and the core of humanity is not a divergence of those with and without privilege. The third tenet of womanism, nonideological, promotes inclusiveness and positive interrelationships by deconstructing "lines of demarcation" and recognizing the value of removing areas of demarcation and replacing these spaces with positive structures. Communitarian is the fourth tenet of womanism that acknowledges "commonweal as the goal of social change" (Phillips, 2006, p. 25). Commonweal is defined as an intellectual understanding of how each individual contributes to the whole system through choices, actions, thoughts, and words and how each decision impacts other people and the environment, which inevitably impacts the individual again. The final tenet, spirituality/luxocracy, asserts the interconnection of all natural creations that include people, animals, plants, and other forms of life on earth. Luxocracy means to rule by the light of the higher self. Spirituality is considered separate from religion in such a way that permits religious, nonreligious, the spiritual but not religious, and even atheists and agnostics to be connected and engaged in common dialogue (Maparyan, 2012).

Box 15.2 Think, Share, and Pair Activity

Many counselors are trained from a multicultural framework geared toward helping clients from various cultural backgrounds. However, counselor preparation programs may be training future counselors from an essentialist framework that overlooks the unique experiences of clients with multiple marginalized identities. Consider these questions as they relate to you as a counselor and then share with a partner:

- What identities do you acknowledge (e.g., race, gender, class, sexual orientation)?
- How have these identities shaped or contributed to your life experiences?
- How has the intersection of these identities shaped or contributed to your life experiences?
- In what ways are your identities similar to or different from your clients'?

How the Theoretical Approach Is Used by Practitioners

Feminist and womanist approaches to addiction counseling highlight issues of power, privilege, and oppression within clients' presenting issues and within the counselor-client relationship. For people living with addiction, the attention that these theories bring to these power differentials can be powerful methods of healing, in that systemic injustices and their influence on addiction are named, while authenticity and valuing of self are emphasized.

Feminist Counseling Practices

Counselors using a feminist perspective use the overarching idea that the personal is political in order to identify how clients' presenting concerns are connected to larger systems of privilege and oppression (Worell & Remer, 2003). For instance, when working with a transgender woman of color who presents with anxiety, a feminist counselor would explore how her anxiety may be connected to larger experiences of racism and transphobia. As mentioned previously, feminists value the experiences of women, so in feminist counseling an emphasis on validating women's experiences and supporting client authenticity in expressing oneself is paramount (Jordan, 2010).

Feminist counseling also recognizes that gender socialization is culturally embedded. For example, a South Asian cisgender woman who is an immigrant to the United States may have significantly different gender socialization experiences within her South Asian country of origin, whereas a South Asian woman who is fourth-generation in the United States may have experienced gender socialization grounded in a Western context (Singh & Hays, 2008).

Empowerment is another component of feminist counseling, with counselors exploring the areas of women's lives where clients may feel emotionally, physically, and/or spiritually blocked in some way (M. Walker, 2008). In this manner, feminist counselors work with clients not as experts but rather as collaborators and consultants on their healing journey. Overall, specific attention is paid to sexism and the influence sexism has on overall well-being, self-expression, job and career pursuits, family roles and family building, sexual health, and other domains of women's lives.

Therefore, when working with clients living with addiction, feminist counselors are interested in simultaneously identifying not only the specific addiction concerns but also how societal oppression and gender socialization experiences influenced the development of addiction in clients' lives. In addition, rather than have addiction as the focus of treatment, feminist counselors often center their work on empowerment interventions with clients that increase their coping resources and self-esteem and challenge beliefs, thoughts, and behaviors related to internalized sexism (Jordan, 2010). Feminist counselors also are careful to continuously self-reflect on their own gender and cultural socialization training to ensure they do not impose their values on clients living with addiction, and they often use their own experiences with this socialization

within the counseling relationship to explore ways in which clients may feel a lack of power in their lives. Because feminist counselors view power from a multicultural and social justice lens, they also view the presence of distress (e.g., alcohol addiction) or client resistance (e.g., relapse) as ways in which clients are holding power as a result of experiencing disempowerment (M. Walker, 2008).

Womanist Counseling Practices

A counselor who uses a womanist approach with clients who are women of color, white women, men of color, or white men engages in a holistic way of thinking rather than a specified theoretical approach. The womanist counselor, then, sees every client as a sum of interconnected parts and the expert of his or her life experiences throughout the counseling relationship. The five tenets of womanism (Phillips, 2006; A. Walker, 1983), as described earlier, collectively embody the view of human nature from a womanist perspective. Therefore, the aim of therapy from a womanist approach is to help clients feel fully understood, empowered to confront life's obstacles, and encouraged to develop new patterns of thinking and behaving based on their personal goals of growth. Women of color struggling with addiction may benefit from a womanist approach in counseling because of the intersectional framework that focuses on the client and not the addiction in isolation from the client. In addition, the womanist counseling process can be uniquely different from other addiction counseling approaches because of its emphasis on acknowledging the impact of systemic injustice on the lives of marginalized groups of people, rather than "curing" people from addiction. Rather than operating from a medical model geared toward diagnosing or "fixing" a client suffering from addiction, a womanist counseling approach can be designed to help women of color acknowledge how their addiction is uniquely tied to other aspects of their identity and to increase their self-awareness of the contributing factors that led to the addiction and continued use. Personal growth and change will look different for every client as a result of varying needs and life experiences but can be accomplished through education, empowerment, and self-awareness, all of which are based on the five tenets of womanism.

Techniques and interventions employed during the womanist therapeutic process are directly aligned with the tenets of womanism (Phillips, 2006; A. Walker, 1983) and should be mutually agreed on between the client and counselor. Each tenet can be used as a guide to assist counselors in their work with clients and remain in line with a womanist framework. For example, the first tenet, anti-oppression, involves empowering individuals beyond socially constructed identities used to oppress and dominate marginalized groups. For a woman of color struggling with addiction, incorporating this tenet into the therapeutic process may involve the counselor helping the client to identify anxiety or fears related to her identity and deconstruct oppressive identities (e.g., alcoholic, narcotic, "meth-head") while redefining herself by her own perceptions. Once the client is able to deconstruct oppressive identities or socially

constructed identities that might have contributed to the addiction (e.g., sexism, racism, classism), the counselor empowers the client to make positive affirmation statements that validate her worth and personhood.

The previously mentioned therapeutic intervention should be considered as just one example of how the womanist counselor can embed the tenets of womanism into the therapeutic process to assist clients struggling with addiction. The counselor, once again, is guided by the tenets of womanism as well as the collaboration and mutual respect with the client. Including all five tenets into the therapeutic process is recommended to fulfill a womanist counseling approach and should be fluid throughout the counseling process. Therefore, practitioners interested in using a womanist approach to assist clients in overcoming addiction, especially women of color, should become knowledgeable in current literature related to womanism (Phillips, 2006; A. Walker, 1983).

Assessment and Prevention Implications

Feminist

When assessing addiction concerns from a feminist perspective, there should be specific attention on understanding the following areas as they relate to the development and maintenance of a client's addiction:

- Gender socialization and intersection with other social identities and cultural experiences
- Internalized sexism and related negative beliefs
- Client empowerment
- Trauma and other abuse experiences
- Client strengths and resilience

The first three bullet points have been discussed earlier, but the latter two are also important to assess. Because the system of sexism is extensively embedded in society, clients who live with addiction may often have trauma and abuse experiences. For instance, a white cisgender lesbian may have been rejected by her family when she came out at 18 years old; therefore, when she experienced intimate partner violence in her first lesbian relationship, she may have been so isolated that she began to abuse substances as a way to cope with both the societal oppression (e.g., family rejection) and physical abuse. Trauma occurs on both an individual and a systemic level for a client such as this. Whereas trauma is important to assess on the multiple levels at which it can occur, clients also can develop resilience in response to trauma that feminist counselors can address. For example, the client in this example may have learned to build a family of choice in the LGBTQ community that the counselor may explore in terms of providing social support for leaving the abusive relationship. Therefore, a simultaneous exploration of trauma and resilience when working with clients with addiction from a feminist perspective is needed.

Box 15.3 Activity: Feminist Assessment

In pairs, think of a recent client with an addiction with whom you have worked. How might you integrate the following areas into your intake session with this client?

- Gender socialization and intersection with other social identities and cultural experiences
- Internalized sexism and related negative beliefs
- Client empowerment
- Trauma and other abuse experiences
- Client strengths and resilience

Box 15.4 Think, Share, and Pair Activity

Beginning a common dialogue with clients involves the counselor communicating with the client in ways that extend beyond active listening or "getting-to-know-you" introductory questions. Beginning a common dialogue also incorporates what is *not* said within the therapeutic process, which can include, but is not limited to, nonverbal communication, style of office space, and other counselors or staff. "Dialoguing and sharing stories, regardless of format, provide opportunities for women to share their experience, knowledge, or wisdom" (Banks-Wallace, 2006, p. 320).

- In pairs or groups of four, develop a platform that would help clients feel valued and free to share their experiences in the counseling session. Use the following questions as a guide:
  - How is the counseling space organized?
  - Where is the counseling space located?
  - What items or décor are visible?
  - Who is represented or not represented in the counseling office?
  - What materials or resources would you provide to facilitate a common dialogue?

Womanist

Acknowledging questions important to women of color struggling with addiction should be one of the first steps in assessing their problems within the counseling session. As mentioned earlier, womanism embodies a collaborative approach that also emphasizes a common dialogue. This common dialogue takes place when the counselor views the client holistically, not primarily as a client battling addiction but as a client with addiction and contributing factors that may have led to addiction (e.g., systemic oppression, social barriers, environmental influences) from the client's unique worldview. Once the counselor establishes a common dialogue with the client while assessing his or her patterns of existence, the counselor can begin to approach helping

the client from a womanist framework (Phillips, 2006).
Promoting a counseling relationship grounded in commonweal, the fourth tenet of womanism, can support emotional well-being and drug prevention for every client struggling with addiction by understanding how each person, client and counselor, contributes to the whole system (Phillips, 2006). Counselors can help clients prevent relapse by providing them with knowledge and resources that inform the client of internal and external factors that contribute to the addiction. This does not suggest clients should not feel responsible for their behavior, but education is viewed as a key component toward understanding oneself and one's relationship with others. In addition, the counseling relationship provides a system of support, particularly from a counselor who is also willing to be educated about clients' experiences as they relate to living in the United States with multiple marginalized identities.

Strengths and Weaknesses of the Feminist and Womanist Theories

For addiction counselors using feminist theory, there are many strengths they may draw on in their work with clients. For instance, feminist counselors are able to use a perspective that works with issues of addiction through empowerment and naming of oppression. In doing so, it can be transformative for clients to not focus on the problem of addiction but rather work on ways to build their sense of self-worth, esteem, and overall well-being. Other strengths include the attention to self-disclosure on the counselor's part and the emphasis on authenticity and development of mutual empathy within the counseling relationship (Miller, 1976). Feminist approaches to addiction can be used in tandem with other counseling theories as well in an integrative manner. Because traditional addiction treatment programs were developed and researched based on the needs of men, the needs of women with addictions have been less of a focus. Women struggling with addiction may seek counseling for different reasons than men and usually under very different circumstances. For example, women seeking treatment for addiction have higher rates of physical and sexual trauma followed by post-traumatic stress disorder (PTSD) than their nonaddicted female counterparts (Hien, Cohen, & Campbell, 2005). Women with a history of exploitation, trauma, internalized shame and stigma, and resulting lower self-esteem will likely benefit from feminist counseling approaches that focus on empowerment.
However, in terms of weaknesses, feminist counseling has so many branches (Enns, 1993) that it becomes important to specifically note the type of feminist theory that drives feminist addiction counseling interventions. Other weaknesses include the lack of attention in feminist counseling to the needs of transgender women and other diverse groups of women. Although scholars such as bell hooks and Angela Davis have challenged feminist theorists to account for the lives of diverse and marginalized communities in their approaches, there is still the tendency at times to solely focus on

gender without the intersectionality necessary to fully understand the contextual factors influencing clients' presenting concerns.

There are also strengths and weaknesses of using a womanist approach in addiction counseling. Building authentic relationships with clients and acknowledging how intersecting identities play a unique role in shaping one's lived experiences is a strength of using a womanist theoretical lens. The goal of the counselor using womanism as a theoretical approach is not to suggest or make assumptions or claims about clients' identity but to listen respectfully to their concerns and maintain a supportive relationship. Womanism emphasizes change and support through positive relationships (Maparyan, 2012). The focus on social well-being is also a strength of using womanism as a theoretical approach when working with clients struggling with addiction by assisting the client in taking personal responsibility and acknowledging how certain decisions can impact one's ability to overcome addiction. In addition to acknowledging how decisions can promote or prevent positive growth, using a womanist framework can also help a client identify visible and invisible barriers that influence those decisions overall. These barriers can include environmental factors such as sexism, racism, heterosexism, and other forms of systemic oppression that privilege some and disempower others. Womanism tenets acknowledge how all of these factors come together to influence the client's lived experiences and outside factors that can contribute to addiction (A. Walker, 1983).

There is currently an absence of research on the effectiveness of using a womanist approach with clients struggling with addiction. Womanism can be considered as still in the growing phase of awareness in its use within the counseling profession. Another point of weakness related to the use of womanism with clients struggling with addiction is that current literature reflects multiple perceptions and definitions of womanism, particularly in relation to black feminist theory. There are still misunderstandings or misconceptions around the use of the term *womanism*.

Philosophical Underpinnings and Key Concepts of Narrative Theory

Problem-saturated stories are common among people struggling with addictions. From a narrative lens, addiction is viewed as a relationship with a substance or behavior that separates the individual from one's sense of self. Narrative therapists perceive people as separate from their problems and assume people have many competencies, beliefs, values, and skills that will help them reduce the amount of influence problems have over their lives. In this section, narrative concepts such as deconstructive listening, externalizing conversations, unique outcomes, thickening the plot, spreading the news, and mining for hope guide our exploration toward creating alternative stories and preferred realities in therapeutic work.

Box 15.5 Think, Share, and Pair Activity

Counselors bring their own narratives into the therapeutic relationship. Consider these questions about yourself as a counselor and then share them with a partner:

- How does your own family or cultural narrative affect your work?
- What themes from your own family or culture are carried into your work?
- How do you separate yourself and your family/cultural narrative from your clients' narratives?

Narrative therapy is an approach to helping people that evolved out of social constructionist thought. It assumes that perceptions of reality are socially constructed, created through language, and organized and maintained through personal narratives. Personal narratives are the stories we create to give meaning to our experiences and are arrived at through our interactions with others. They are situated in cultural and historical contexts (White & Epston, 1990). Construction of meaning occurs most often in social contexts, and the process of "living our story" reflects the communal values and meanings embedded in our small social systems (families, communities) as well as the larger society and culture (White, 1995). The narrative metaphor suggests that people live their lives by these stories and that they have real and not imagined effects, providing the structure of life and identity. Because narrative therapy is informed by social constructionism and a postmodern worldview, it is primarily concerned with the following:

1. How people construct meaning
2. The social, cultural, and historical influences on this process
3. How narratives or belief systems shape experience
4. How people become stuck in problem-saturated stories
5. Alternative stories that may suit people better

The major assumptions of narrative approaches about how change occurs are that (a) people create meaning in their lives by organizing (selected) key events into stories and incorporating these into larger life narratives; (b) life narratives are constructed over time by people in interaction with other people; (c) although narratives are created within social contexts, people have the capacity to author their own lives; (d) human dilemmas are created in social contexts versus being embedded in human beings themselves (O'Hanlon, 1994); (e) people are separate from their problems (White & Epston, 1990); (f) blocks to healing and growth can occur when people perceive their problems as being a large part of who they are; and (g) a major goal of therapy is to create a space between the person and the problem, giving the client room to see alternative views of himself or herself.

The therapeutic attitude of a narrative therapist is one of optimism. This optimism sets the tone for therapeutic discourse that facilitates change. This approach requires a positive view of human nature and a belief that ultimately people are the unique

resourceful creators of their own realities.

Box 15.6 Questions for Reflection: Implications for 12-Step Approaches

- The disease model is a cornerstone of 12-step programs. How do these narrative assumptions fit with the disease model of addiction?
- What about the notion that one must admit identity as an addict or alcoholic in order to comply with 12-step programs?
- Is it possible that both are true (that a person could identify as an alcoholic and work with a therapist who helps him or her separate the problem from the person)? Claiming an identity as an addict serves to create space between the person and the problem. How?

Dominant Narratives

Dominant narratives (first described by French philosopher Michel Foucault) are societal stories that specify preferred and customary ways of believing and behaving within the particular culture, which are often internalized and regarded as truths (Foucault, 1975). Examples of dominant narratives include stories our cultures tell us about achievement and success, attractiveness and youth, gender and career roles, or age and quality of life. Whereas dominant narratives can be adaptive and helpful, they can also be maladaptive when they obscure positive views of self. Dominant stories can minimize or eliminate alternative knowledge positions, or narratives (Foucault, 1980). Individuals and families may tend to accept dominant narratives regardless of how well they fit. For example, dominant Western narratives that define success in terms of monetary gain may interfere with the self-esteem of an artist who has not yet sold his or her work. Likewise, an elder may not feel valued by a culture that puts a premium on youth.

Goal of Narrative Counseling

According to Freedman and Combs (1996), people seek therapy when the stories they are living restrict their choices, and the perceived available options are painful or unfulfilling. Michael White (1990) believed that people come to counseling when their dominant narratives keep them from living out preferred narratives or when the narratives they are living through contradict a large portion of their own personal lived experiences. The major goals of therapy then are to help people shift from narratives of failure to preferred narratives of hope and meaning. When clients see themselves as living more meaningful stories, the ongoing perceptions, choices, and behaviors they have will change more or less automatically (Freedman & Combs, 1996). To state it another way, counseling is a process of "piecing together fragments of healthy life experiences into new healing narratives, in which clients experience themselves as competent protagonists in their own stories of strength" (Semmler & Williams, 2000, p. 61).

Box 15.7 Dominant Narratives
Discussion: Describe some examples of dominant narratives about the following:

- Achievement and success
- Attractiveness and youth
- Gender and career roles
- Addicted people

How the Theoretical Approach Is Used by Practitioners

Narrative approaches are less about technique and more about strategies of discourse. In other words, they involve a strategic focus of conversation or discourse by the counselor. The primary approaches are externalizing conversations, deconstructive listening, unique outcomes, thickening the plot and spreading the news, and reflective practices.

Externalizing Conversations

Problem-saturated narratives keep people stuck and help them to overidentify with their struggles. Externalizing conversations help separate the problem from the person. In this strategy, the problem is discussed as an object. Instead of "I am a depressed person," the client would be encouraged to speak of his or her "struggle with depression" or to describe how long depression has been in his or her life. Overidentification with problem narratives keeps people stuck in their problems. These types of conversations allow the invisible to become visible. They invite a person to explore his or her relationship with the problem and open spaces for new stories to emerge. Externalizing conversations about the problem also create new possibilities for action.

Box 15.8 Externalizing Questions With Addictive Thinking
Examples of externalizing questions with addictive thinking:

- How does addictive thinking get you to use more than you intended to?
- How does addictive thinking get you to believe that you are not in danger when in fact you are?
- How does addictive thinking cause you to be dishonest with yourself?
- How does addictive thinking separate you from people you really care about?
- How has addictive thinking convinced you that no one understands, in an attempt to isolate you from others?

Deconstructive Listening

The person is not the problem, "the problem is the problem" is the underlying assumption held by a narrative therapist (White & Epston, 1990, p. 39). The purpose of deconstructive listening is to unravel the history of the problem. It is a way of listening that points out the differences between reality and internalized stories of self. For

example, a very successful person may carry a personal narrative that helps him or her believe he or she is an imposter who will be found out just around the corner. Deconstructive listening has the potential to loosen the grip of dominant stories and can allow unconscious dominant stories to be named and externalized. It is a way of listening and engaging in dialogue with a client that exposes the history of the problem, the context of the problem, the effects of the problem on the client's life, the interrelationships between problems in the person's life, and the strategies the person has used to try to solve the problem. Examples of these focused discussions follow.

- History: When and where did you first encounter the problem?
- Context: When is it most likely to be present?
- Effects: What effects has this had on you and your relationships?
- Interrelationships: Are there other problems that feed this problem?
- Strategies: How does it go about influencing you?

Box 15.9 Conventional Counseling Questions Versus Externalizing Questions

Conventional	Externalizing
When did you first become addicted?	What made you vulnerable to addiction so that it was able to dominate your life?
What kinds of things typically lead to you being addicted?	What kinds of things happen in your life that lead to addiction taking over?
When you are in active addiction, what do you do that you wouldn't do if you were not addicted?	What has addiction gotten you to do that is against your better judgment?

Adapted from Gehart, 2010

Unique Outcomes

Once the therapist has sought to understand the history, context, effects,

interrelationships, and strategies of the problem with the client, he or she can begin using strategies that lead toward change, but not before (Freedman & Combs, 1996). This competency-based approach assumes that there are times in clients' lives when they were successful at working to defeat the problem. Identifying *unique outcomes* or exceptions to the problem is an important change strategy (White, 2007). The therapist listens for and asks about times when the problem could have been a problem but was not. Here are some questions a counselor might ask to elicit a dialogue about unique outcomes to a problem with addiction:

- When was the last time you were able to turn addiction away?
- How did you get to that point?
- What did you tell yourself that was different?
- What does it say about you that you could do this?

It is important to ensure that the unique outcome is preferred by the client. Rather than assume, the therapist asks clients about whether the unique outcome is a preferred outcome: "Is this something you want to do or have happen more often?" Next, the therapist begins working with the unique outcome by *mapping it in the landscape of action* (White, 2007), in other words, by identifying what actions were taken by whom and in which order. For example, the counselor might ask specific details about the exception to the problem: "What did you do first? How did the other person respond? What did you do next?" In thickening the story of competence, it is important to gather details about critical events, the circumstances surrounding events, the sequence of events, the timing of events, and the overall plot.

Finally, it is important in promoting change to map the unique outcomes in the landscape of identity or consciousness. *Thickening the plot* is crucial to expanding the story of competence (White, 1995). A thicker, more voluminous story of competence in the face of struggle leaves less room for stories of incompetence and failure. After obtaining a clear picture of the unique outcome, the therapist begins to thicken the plot associated with the successful outcome, strengthening the connection with the client's identity. Here are some sample questions to help connect unique outcomes to a client's identity:

- What do you believe this says about you as a person?
- What were your intentions behind these actions?
- What do you value most about your actions here?
- How does this change how you see life, your higher power, your purpose, or your life goals?

Unique outcomes may seem similar to "the miracle question" in solution-focused therapy (De Jong & Berg, 2002). There are, however, some differences in the situation of the question. For example, in the conventional approach a client might be asked, "If by some miracle you woke up some morning and were not addicted anymore, how, specifically, would your life be different?" By comparison, a counselor using a narrative approach would seek unique outcomes using this question: "Have there been

times when you have been able to get the best of the addiction? Can you talk about times when addiction could have taken over but you kept it out of the picture?" One approach is seeking a new vision or possibilities for the person's life, and the other is mining for internal competencies and examples of past successes. One important thing a counselor should expect when exploring unique outcomes with a client is to be prepared to hear "I don't know" a lot. Much of what we are asking for is an exploration of the not yet said and the never considered (White, 2007). The power is in the question. Even if the client draws a blank, the questions will have a life of their own, and the client may search for the answers more or less automatically beyond the boundaries of the counseling session.

Thickening the Plot and Spreading the News

Thickening the plot or the competency narrative involves telling, retelling, and retelling of the retelling. The goal is to expand the influence of stories that do not support or sustain problems. Narrative strategies for thickening the unique outcome narrative include but are not limited to note taking, lists, tapes, declarations, certificates, symbols, and coalitions. The words in a letter or a document do not disappear the way a conversation does. They endure, bearing witness to the work of therapy (Epston, 1990). Narrative letters might be used to develop and solidify preferred narratives and identities. For example, counselors may write letters detailing a client's emerging story after a session in lieu of doing case notes. They may even send those letters to the client. Letters can be used to highlight clients' agency in their lives, including small steps in becoming proactive. Advice to counselors using these strategies for thickening the plot include to (a) clearly take an observer role in the changes the client is making; (b) cite specific, concrete examples if possible; (c) highlight temporality by using a time dimension to plot the emerging story: where clients began, where they are now, and where they are likely to go; and (d) encourage polysemy rather than propose singular interpretations—multiple meanings are entertained and encouraged (Freedman & Combs, 1996). Letters can be used early in therapy to engage clients, during therapy to reinforce new preferred behaviors, or at the end to consolidate gains by narrating the change process.

Other examples of plot thickening include the use of leagues such as the Fear Basher's Club of America or the Anti-Anorexia/Anti-Bulimia League (Maisel, Epston, & Borden, 2004). These leagues can help unite people in community and competency against common problems, while reducing a sense of isolation. In fact, the Anti-Anorexia League is an example of how narrative strategies can challenge the dominant social narrative to stop defining acceptable body image (e.g., in popular media, the diet and food industry). Leagues of clients can be formed to fight against externalized problems just as 12-step groups unite to fight against addictions. Twelve-step groups and other leagues can help clients form a new competency-based identity of recovery.

Box 15.10 Sample Letter

Dear Robert,
Sometimes the best ideas have the habit of presenting themselves after the event. So it will come as no surprise to you that I often think of the most important questions after the end of an interview. Anyway, I thought I would share some important questions that came to me after our meeting:
How were you able to decline alcohol's invitation to drink after you found out about your job loss? What did you do? What did you do next? What did you tell yourself that helped you decline alcohol's invitation? Where did you learn to talk to yourself in this different way? How has this changed your relationship to alcohol? Is this something you want to have happen more often?
By the way, what ideas occurred to you after our last meeting?
Adapted from White and Epston, 1990

Reflective Practices

From a narrative viewpoint, ethical counselors develop a reflective stance. They invite people to see themselves as experts on themselves. They offer people a sense of community and collaboration. The counselor is required to enter the world of the client, instead of the client entering the world of counseling. The idea of professionalism has to do with the counselor's presentation of self to the people seeking assistance. In other words, counselors do not hide their personhood behind a clinical white coat in an "expert" role. Instead, the counselor and client are real people forming a collaborative community engaged in seeking hope.

Assessment and Prevention Implications of Narrative Theory

Assessing addiction problems in counseling involves using deconstructive listening and externalizing conversations in helping clients understand the impact addiction has had on their lives and helping them explore their relationship to addiction. Assessment is a collaborative process that unravels the impact of addiction in a person's life and unveils the process of separation from self. Through the use of externalizing conversations and deconstructive listening (described earlier), the counselor exposes the history of the problem, the context of the problem, the effects of the problem on the client's life, the interrelationships between problems in the person's life, and strategies the person has used to address the problem. The assessment process starts the cognitive shift from problem-saturated stories to those of competency. Narrative approaches do not ignore the role of genetics and biology in the addictive process but may focus more on the rediscovery of self (e.g., uncovering competencies, developing more helpful and hopeful narratives, regaining authorship of one's own life).
Prevention from a narrative perspective involves a shift from didactic, logical

arguments that present empirical “truths” about the dangers of drug use and how to avoid its consequences to a model that highlights description; explanation; personal experience; and representing a sequence of connected events, characters, and consequences. An example of a prevention strategy focused on youth substance abuse is the narrative engagement framework (NEF; Miller-Day & Hecht, 2013). This framework asserts that narratives are central to prevention efforts because they enhance narrative knowledge, promote engagement, and provide mental and behavioral models. The approaches to prevention are more culturally grounded, locally located, and personally meaningful to the target audience. An example of NEF is demonstrated in the keepin' it REAL adolescent drug prevention curriculum. For more information on prevention strategies in a narrative framework please see Miller-Day and Hecht (2013).

Strengths and Weaknesses of Narrative Theory

Studies have shown narrative approaches to be helpful in the treatment of addiction (Garte-Wolf, 2011; Hagedorn, 2011; Poole, Gardner, Flower, & Cooper, 2009). Strengths of the approach are that it empowers the client, values the insight and competencies of the client, and positions the client as the protagonist in his or her own life story. It is a hopeful search for meaning among the struggles of life. The counselor is an active collaborator who uses creativity and curiosity to connect the client to shifts in perspective and preferred outcomes. This approach acknowledges the meaning of addiction in a person's life and helps the person explore its value. It connects people to communities in the development of preferred realities in an effort to expand the narrative of hope. Within the approach is a commitment to social justice and social change especially around oppressive dominant narratives.

Weaknesses of narrative approaches include its opaque nature in terms of techniques. It is rather a set of positions. Also, clinicians may ignore the usefulness of combining other approaches with narrative therapy in working with addictive problems, and its emphasis on cognitive change may negate the emotional and behavioral dimensions of a person's life. Further, narrative therapy has been accused of trying to impose its own language on clients (Flaskas et al., 2000). For example, externalizing language used in therapeutic dialogue can be very awkward and odd at first, but it implicitly challenges cultural assumptions about the location of problems. The use of metaphor in externalizing conversations may imply meaning that may not be available in all language contexts. Twelve-step groups encourage clients to identify as alcoholics or addicts, which seems contradictory to narrative approaches that encourage the separation of the problem from the person. Narrative approaches may seem to take away responsibility for the problem from the client and may upset family members who have experienced minimization of addiction and denial for many years.

Feminist Theory Case Study Response

Gabriel is a 26-year-old, straight, biracial man of African American and Native

American heritage living in a rural context. Each of these identities is important to a feminist counselor in understanding his addiction concerns, and although it is not stated in the case study, being a cisgender man and understanding his immigration history and citizenship status in the United States is also important. When meeting with Gabriel, the counselor might not only ask Gabriel questions about substance abuse but also carefully assess when this concern began, including his experiences of gender, race/ethnicity, class, religion, and other social identities and cultural experiences. In this assessment, the feminist counselor should explore the experiences of internalized dominance (male privilege) and internalized racism with regard to this incident, focusing on the impact of this event on his self-worth, self-esteem, and self-expression. The feminist counselor should also explore the past disconnections and relationship patterns that Gabriel learned from his family of origin, with his father, mother, sister, and other relationships. The counselor would explore and challenge beliefs that reflect hegemonic masculinity, emotional repression, and internalization of stress. In discussing these experiences further, in addition to other experiences of gender socialization, the counselor may ask what support Gabriel needs from his family and community to heal. There should be an additional focus on Gabriel's ideas about his past dreams, jobs, career, relationships, and other concerns that may reflect internalized oppression or stereotyped gender roles. The counselor would validate Gabriel's gender socialization experiences and the related influences on these areas of his life and also explore how his other salient identities intersect with this gender training.

The counselor may ask Gabriel to imagine what he would like his life to look like if he were pursuing his dreams with the energy and attention that is now going into his substance abuse. The counselor would then work with Gabriel to make connections between the power or lack of power he experienced at various times in his life and the origination of his addiction experiences. Further exploring how Gabriel may have learned disempowerment, the feminist counselor is careful to collaboratively explore the power issues in the 12-step programs he and his family attend. For instance, the step of acknowledging one's powerlessness may trigger feelings of internalized racism or internalized male dominance. The feminist counselor would work closely with Gabriel to identify reframed models of power that can lead to his own empowerment and healthy model of masculinity and healing.

Womanist Theory Case Study Response

From a womanist perspective, Gabriel's issues with alcohol, drugs, and familial relationships are considered integral to other aspects of his identity, specifically how his worldview shapes his behaviors and decisions, and as a result are not the primary focus of therapy. Considering the holistic and intersectional foundation of womanism, a counselor operating from a womanist framework may begin to conceptualize Gabriel's problems by first understanding how he defines those problems based on his lived experiences. There is not a presumed method or approach to helping a client's

problems, needs, or issues because womanism acknowledges that every individual's experience is unique. Men and women struggling to combat alcoholism and drug usage may carry out behaviors associated with addiction differently due to gendered expectations of seeking help or acknowledging the need for assistance. In addition, people of color, people with disabilities, people who identify as LGBTQ, and other marginalized populations impacted by addiction may face these issues in ways directly tied to systemic oppression. Therefore, a counselor operating from a womanist framework may focus on a client's strengths because recognizing strengths, though different for every client, is considered an important factor in helping the client overcome life's challenges (Phillips, 2006).

The holistic component of womanism makes the use of this approach with clients struggling with addiction an appropriate method in connecting all factors that contribute to Gabriel's issues. Incorporating family members would be considered an important factor to consider when working with him from a womanist perspective if considered beneficial to the client's positive growth. Therefore, Gabriel's mother and sister may be incorporated into future sessions with Gabriel as a means to help Gabriel make connections with sources of unresolved emotions or potential allies to help him overcome his addiction. Assuming Gabriel's father is still struggling with addiction and has not reached out for help, he would likely not be invited into Gabriel's sessions unless his presence would in some way serve as a source of connection or contribute to Gabriel's positive growth.

Strategies and techniques that could be used by a counselor operating from a womanist framework will likely be based on the needs of the client and founded within the tenets of womanism as described by Phillips (2006). For example, Gabriel appears to have made several, though unsuccessful, attempts to stop or seek help for his addiction to alcohol and drugs through his participation in court-mandated assessment and inpatient treatment centers, working with a sponsor as part of the Alcoholics Anonymous program, and managing 7 weeks without using. Pointing out these attempts to Gabriel is to enact the second tenet, vernacular, which advocates that at the core of every person is a desire to live a fulfilling life, despite choices he or she has made that prevent success. A technique to assist Gabriel in recognizing his attempts as methods of combating addiction can begin by having Gabriel list all of the ways in which he has avoided or attempted to stop the use of drugs and alcohol. The goal of this technique is to make Gabriel aware of the depth of his desire to be free from drugs and alcohol. In addition, Gabriel's attempt to avoid his niece when he has been using can be pointed out as recognition of a problem and a desire to change one's behavior on behalf of self and others. This is a reflection of the fourth tenet, communitarian, which acknowledges how personal actions, behaviors, and decisions impact others and inevitably ourselves. A technique to assist Gabriel in taking responsibility for his participation in his struggle against drugs and alcohol would be to write two unique scenarios that connect his

addiction to decisions and their impact on others. One scenario could represent how Gabriel's life might look if he continued in his dependency on drugs and alcohol and how this would eventually impact his relationship with his niece and other people. The second scenario could represent how Gabriel's life might look if he were successful in overcoming his dependency on drugs and alcohol and how this outcome could impact his relationship with his niece and other family members.

A counselor operating from a womanist framework is encouraged to allow the client to define his or her challenges based on lived experiences. This approach may prove difficult with a client expecting the counselor to take on the role of expert on his or her problems and anticipate a direct approach toward facilitating a successful future. A womanist perspective deliberately avoids playing the role of expert over the lived experiences of others and also avoids suggesting there is only one path of success to be achieved by every person. Therefore, one of the challenges of using womanism as a theoretical approach toward helping clients struggling with addiction is assisting a client who may be seeking a more direct approach in counseling.

Despite the lack of a directive approach, a major strength of using womanism as a theoretical approach for clients struggling with addiction is the self-empowering aspect of allowing individuals to acknowledge their struggle, name the sources that contribute to the addiction, and form a growth or treatment plan uniquely designed to assist them in overcoming their addiction. Most importantly, the acknowledgment that their recovery is based on their strengths and knowledge is crucial, as opposed to their success being directly tied to the counselor. Empowering clients through their own efforts is believed to prevent future setbacks and promote continual inner well-being.

Narrative Theory Case Study Response

From a narrative theory framework, the counselor working with Gabriel is initially concerned with the history of Gabriel's addiction experience. For instance, the narrative counselor asks Gabriel when and where he first encountered the addiction. So, the counselor is quite interested in the timeline of Gabriel's addiction. Then, the counselor assesses the context of his addiction, including when the addiction is most likely to be present. For instance, the narrative counselor inquires how these contextual factors show up in his life. Then the counselor explores the effects of Gabriel's addiction on his life and his relationships. This exploration includes family members and other relationships (e.g., work, community). Next, the counselor inquires about interrelationships and how other issues (e.g., internalized racism, rural community) influence and escalate his addiction experiences. Finally, the counselor explores what strategies the addiction has used to direct his life.

After the assessment of these areas, the narrative counselor begins to assess the times Gabriel has been able to turn the addiction away—externalizing the problem from Gabriel as a person. In this exploration, the counselor asks how Gabriel was able to get to the point of turning addiction away. Next, the counselor explores how Gabriel was

able to tell himself this turning away from addiction was different, as well as what it says about him that he had the ability to turn addiction away. Unique outcomes are sought and used as competency-based strategies to ward off the influence and power addiction has over Gabriel's life. Narrative counseling continues in this manner, with a focus on empowerment, storytelling, and supporting Gabriel in recognizing his active role in his own life narrative.

Summary

In this chapter, the unique approaches that feminist, womanist, and narrative theoretical approaches bring to addiction counseling were described. Across each theoretical perspective, attention to clients' presenting concerns regarding addiction has been contextualized with an understanding of systemic structures of injustice and their influence on client well-being. From this stance, issues of gender and other social identity socialization, power, privilege, and the stories that these components shape regarding clients' experiences of addiction were recognized.

Resources for Continued Learning

Books

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Morgan, A. (2000). What is narrative therapy? An easy-to-read introduction. Adelaide, South Australia: Dulwich Centre.

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Dulwich Centre: www.dulwichcentre.com.au.

Feminist Therapy Code of Ethics: http://chrysaliscounseling.org/feminist-therapy-ii.html.

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16 Behavioral Addictions

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Although the concept of behavioral addictions is relatively new to the mental health field, information surrounding behavioral addictions is quite old. Emperor Commodus of ancient Greece was described as having out-of-control gambling habits that may, in fact, have contributed to the decline of the Roman Empire (Hekster, 2002). The word *addiction* is derived from the Latin *addictus*, a legal term referring to a person enslaved for a debt, highlighting the loss of personal control in those deemed addicts (Sadoff, Drogin, & Gurmu, 2015). Accordingly, the word *addiction* was not originally used for substances but was rather a term used in ancient Rome to refer to a legal dependency of the bond of slavery that lenders imposed on delinquent debtors; as such, it originally referred to enslavement or bondage. From the second century AD well into the 1800s, the term *addiction* defined a predilection toward many preoccupations, including reading, writing, or compulsive dedication to a hobby, generally carrying the connotation of weakness or moral failing. So, for the better part of modern history, *addiction* was used to refer to behaviors rather than substances. It was only in the late 19th century that *addiction* entered the medical lexicon as a function of physicians overprescribing opium and morphine, leading to drug addictions (Merkel, 2012).

Behavioral Addictions

Increasingly, however, experts have noted that key criteria for substance addictions also apply to a range of behaviors. In some cases, this is referred to as a behavioral addiction, a process addiction, or, in the case of behaviors necessary for the survival of the individual (food) or the species (sex), a natural addiction. The American Society of Addiction Medicine (ASAM) formally recognized this in 2011, when it released a new definition of addiction that included behavioral addictions:

> Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. (ASAM, n.d.)

This definition goes on to characterize addictions with the "ABCDE" model:

- Inability to **a**bstain
- Impairment in **b**ehavioral control
- **C**raving
- **D**iminished recognition of significant problems with behaviors and relationships
- Dysfunctional **e**motional response

Others (Griffiths, 2005) have established six core components of behavioral addictions:

1. *Salience*—the behavior ultimately becomes the most important thing in the

individual's life, often to the exclusion of relationships and other activities.
2. *Mood modification*—the behavior serves a coping function, typically involving an increase in neurotransmitters that either cause a rush or provide a numbing tranquilizing effect.
3. *Tolerance*—over time, behavioral increases are required to create mood modification. This may include increases in time spent in the behavior but also may include increases in intensity, risk, destructiveness, and the ego-dystonic nature of the behavior.
4. *Withdrawal*—difficult feeling states (e.g., irritability, impatience, anxiety) or physical effects when the person is unable to engage in the behavior.
5. *Conflict*—difficulties with relationships (including intrapsychic conflict), other activities (e.g., work, social life, hobbies), and subjective feelings of loss of control.
6. *Relapse*—frequent return to patterns of excessive behavior, commonly to the most extreme patterns of the behavior after a period of control.

Taken together, these six components define a behavioral addiction. Behavioral addictions exist when an individual engages in a behavior to self-regulate (mood modification) and ultimately loses control over the ability to refrain from the behavior (conflict), engages in more of the behavior over time (tolerance), becomes preoccupied with the behavior (salience) even when not engaged in it, and experiences discomfort when unable to engage in the behavior (withdrawal), even in the face of often dire consequences (conflict). Attempts to control the behavior may be successful for short periods of time, followed by return of the behavior (relapse).

Currently, however, gambling disorder is the only behavioral addiction included in the *Diagnostic and Statistical Manual of Mental Disorders* (5th edition) (*DSM-5*; American Psychiatric Association [APA], 2013). Other behavioral addictions were considered for the *DSM-5*. Internet gaming disorder was relegated to Section III (Emerging Measures and Models) of the *DSM-5* (Petry & O'Brien, 2013). Other potentially addictive behaviors, such as Internet addiction and hypersexual disorder (referred to by some as sexual addiction) were not included, with calls for additional research. Exercise addiction does not yet merit a stand-alone diagnosis, but "excessive exercise" is mentioned in the *DSM-5* criteria under Bulimia Nervosa as a potential "compensatory behavior to prevent weight gain" (APA, 2013, p. 345). Nonetheless, many mental health professionals treat a broad range of behaviors that have the hallmarks of behavioral addictions (Grant, Schreiber, & Odlaug, 2013). Similarly, social scientist researchers expend great energy studying these phenomena. Currently, however, it appears that even experts have not yet reached a consensus on what disorders qualify as behavioral addictions (Black, 2013).

Box 16.1 Components of Addictive Behavior
Using these six components of addictive behavior, what are some behaviors

that have addictive potential?

One reason for this is that researchers are striving to catch up with the theoretical literature. Behavioral addictions are primarily understood through a biopsychosocial model, considering the interaction of biological (e.g., genetics, impact of addiction on the brain), psychological (e.g., emotions, behaviors, and cognitions), and social (e.g., influence of peers, family, and broader society) factors that influence addictive behaviors (Rosenberg & Feder, 2014). Clearly, the interplay between these three facets is nuanced and complex, and ongoing interdisciplinary research is needed to more fully understand the interactions among and between the three factors.

Increased complexity in neuroscience research and attention to behavioral addictions show great promise for distinguishing addictive behaviors. Rosenberg and Feder (2014) provided three neurobiological models of behavioral addictions, each emphasizing a different aspect of brain function. The reward/executive function model posits that addictive behaviors alter the mesolimbic system and medial frontal cortex in a manner that perpetuates the addictive cycle and explains the preoccupation with and relentless pursuit of the behavior in spite of often dire consequences (O'Brien, Volkow, & Li, 2006). Another theory posits that fast, reward-based networks (largely reinforced with dopamine surges) replace more discriminating neural networks that work more slowly, often creating a trance-like state while engaged in the behavior (Redish, Jensen, & Johnson, 2008). Finally, a third set of theories suggest that cellular memory is integrally involved in the maintenance of memories of reward cues (Sacktor, 2011). A full review of neuroscience research on behavioral addictions is beyond the scope of this chapter, but readers interested in behavioral addictions are encouraged to review empirical neuroscience literature to fully understand the state of current research on specific behavioral addictions.

The key issue derived from neuroscience, however, is that the difference between those who have a behavioral addiction and those who do not is *not* just the frequency of the addictive behavior (such as gambling, masturbating, or spending). Behavioral addictions are, in fact, characterized by the way an individual responds to exposure to stress and environmental stimuli. That is, behavioral addictions are characterized by preoccupation, obsession, and pursuit of rewards in spite of negative consequences. Behaviorally, this manifests as excessive engagement in the behavior (often more frequently or intensely than the individual intended), persistent desire to control the behavior, excessive time lost in the behavior (including time lost in preoccupation prior to the behavior and time recovering after the behavior), continuance despite consequences (both physical and psychological), negative impact on social and occupational functioning, an increasingly narrowing focus on achieving the rewards that are part of the addiction, denial that a problem exists, and an inability or lack of readiness to take curative action even when there is recognition that a problem exists (ASAM, n.d.).

One of the complexities of behavioral addictions is the emotional aspect. Some persons develop behavioral addictions almost solely as a function of seeking the reward or euphoric state of engaging in the behavior. In other cases, however, the behavior is occasioned more by negative reinforcement or relief from undesirable dysphoric emotional states (e.g., to reduce anxiety or alleviate boredom associated with depression). When anyone engages in addictive behavior, there commonly is the "rush" experience during the behavior. Unfortunately, however, there commonly is a neurochemical rebound in which the reward function does not just return to baseline but actually rebounds below baseline (ASAM, n.d.). Early in the behavioral addiction cycle, this may be virtually imperceptible, but as the addiction progresses, the neurochemical rebound and chronicity of the behaviors often leave the individual in an enduring dysphoric mood that is generally alleviated only by the addictive behavior, often at increased frequency, intensity, or riskiness (i.e., tolerance occurs). Accordingly, ceasing the behavior often leaves the individual in a dysphoric mood state (withdrawal).

Within these parameters, many behaviors potentially could become addictive. Though it is not possible to chronicle every potentially addictive behavior, we turn our attention now to eight behaviors (gambling, sex, food, exercise, Internet, gaming, shopping, and work) commonly recognized in the professional literature as potentially addictive.

Gambling

Gambling holds a unique place among the behavioral addictions in that it is the only one to be recognized and included in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*). Regarding its inclusion in the chapter "Substance-Related and Addictive Disorders," the *DSM-5* states that "this chapter also includes gambling disorder, reflecting evidence that gambling behaviors activate reward systems similar to those activated by drugs of abuse and produce some behavioral symptoms that appear comparable to those produced by the substance use disorders" (APA, 2013, p. 481). The move to the chapter on substance use disorders indicates a significant shift in how gambling disorder is conceptualized, for the *DSM-III* and *DSM-IV* placed gambling disorder in the Impulse Control Disorders category (Clark, 2014; Grant & Odlaug, 2014). Many believe this opens the door for the inclusion of other behavioral addictions in future editions of the *DSM* (APA, 2013; Clark, 2014; Polychronopoulos, Carlisle, Carlisle, & Kirk-Jenkins, 2014).

To meet the *DSM-5* criteria for gambling disorder (and consistent with criteria for behavioral addictions chronicled earlier in the chapter), an individual must meet four or more of the following in a 12-month period:

1. Needs to gamble with increasing amounts of money in order to achieve the desired excitement.
2. Is restless or irritable when attempting to cut down or stop.
3. Has made repeated unsuccessful efforts to control, cut back, or stop gambling.

4. Is often preoccupied with gambling.
5. Often gambles when feeling distressed.
6. After losing money gambling, often returns another day to get even ("chasing" one's losses).
7. Lies to conceal the extent of involvement with gambling.
8. Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling.
9. Relies on others to provide money to relieve desperate financial situations caused by gambling (APA, 2013, p. 585).

> Box 16.2 Gambling
> Why do you think gambling is included in the *DSM*-5 whereas other behavioral addictions are not yet recognized?

Prevalence rates of gambling disorder have been documented at anywhere from 0.2% to 4.0% of the general population (APA, 2013; Rash & Petry, 2015). It is very important to consider other diagnoses because there are high comorbidities of substance use disorders as well as mood and anxiety disorders with gambling disorder (Rash & Petry, 2015). The *DSM-5* includes "The gambling disorder is not better explained by a manic episode" as part of its exclusionary criteria (APA, 2013, p. 585).

Several treatment options have been proven effective in reducing symptoms for individuals struggling with gambling disorder, including cognitive behavioral therapy (CBT), motivational interviewing and intervention techniques, and family therapy (Grant & Odlaug, 2014; Rash & Petry, 2015). The National Council on Problem Gambling provides information and direction to access local resources on its website (www.ncpgambling.org) and through a 24-hour telephone helpline (1-800-522-4700). The National Council on Problem Gambling also provides information on becoming a National Certified Gambling Counselor (NCGC) and maintains a directory of certified gambling counselors available on its website.

In addition, many self-help programs are available, with the two most common being Gambler's Anonymous (www.gamblersanonymous.org), a 12-step program, and Gam-Anon (www.gam-anon.org), for spouses, family members, or close friends of people with gambling problems.

Sex

Though there is considerable agreement in the scholarly literature about the existence of out-of-control and compulsive sexual behavior, there is some controversy regarding how best to characterize this behavior as either an addiction (Carnes, 1991), hypersexual behavior (Kafka, 2010), impulsive-compulsive sexual behavior (Mick & Hollander, 2006), or paraphilia-related behavior (Stein, Black, & Pienaar, 2000). Many researchers, however, have posited that *sexual addiction* most clearly captures the nature of out-of-control sexual behavior (Garcia & Thibaut, 2010; Hagedorn & Juhnke,

2005; Samenow, 2010) with neuroscience scholars and researchers supporting this assertion (Hilton, 2013; Kühn & Gallinat, 2014; Phillips, Hajela, & Hilton, 2015; Voon et al., 2014).

Part of the challenge in conceptualizing sexual addiction is that sexual behavior (i.e., what is healthy or normal versus aberrant) is driven, in part, by personal and cultural values, so it can be difficult to determine where loss of control exists and the extent to which culture might be a factor (Carnes, 1994). For example, a client might come to you presenting as highly religious and reporting that he masturbates two to three times per month and feels deep shame over this behavior because it conflicts with religious convictions. He may even self-label as a sex addict. Whereas the client can self-determine what behaviors he wants to change, part of good clinical work would be normalizing the behavior and countering the addiction label for this client, who clearly does not meet the criteria for sexual addiction.

> Box 16.3 Sexuality
> In addition to religion, what other social and cultural factors influence sexuality and sexual behaviors?

Generally, prevalence estimates range from 3% to 6% of the population, though the ubiquitous nature of the Internet may be driving these numbers higher. Approximately 1 in 7 sex addicts is a woman (Carnes, 1991). Sex addiction was included in the *DSM-III-R* under the diagnostic category of Sexual Disorder Not Otherwise Specified (APA, 1987). Sex addiction was removed from the *DSM-IV*, largely due to a lack of clear empirical research and consensus about sex as a behavioral addiction (APA, 1997). Although a diagnosis of hypersexual disorder was considered for the *DSM-5*, it was not included.

Carnes (cited in Rosenberg, O'Connor, & Carnes, 2014) proposed diagnostic criteria for sex addiction, including the following:

1. A minimum of three criteria met during a 12-month period:
    1. Recurrent failure to resist impulses to engage in specific sexual behavior.
    2. Frequent engaging in these behaviors to a greater extent or longer duration than intended.
    3. Persistent desire or unsuccessful efforts to stop, to reduce, or to control behaviors.
    4. Inordinate amount of time spent in obtaining sex, being sexual, or recovering from sexual experiences.
    5. Preoccupation with the behavior or preparatory activities.
    6. Frequently engaging in the behavior when expected to fulfill occupational, academic, domestic, or social obligations.
    7. Continuation of the behavior despite knowledge of having a persistent or recurrent social, financial, psychological, or physical problem that is caused

or exacerbated by the behavior.
8. Need to increase intensity, frequency, number, or risk of behaviors to achieve the desired effect or diminished effect with continued behaviors at the same level of intensity, frequency, number, or risk.
9. Giving up or limiting social, occupational, or recreational activities because of behavior.
10. Distress, anxiety, restlessness, or irritability if unable to engage in the behaviors.

2. Has significant personal and social consequences (such as loss of partner, occupation, or legal implications).

Many assessment instruments have been developed to screen for sexual addiction. One of the most prominent is the Sexual Addiction Screening Test—Revised (SAST-R; Carnes, Green, & Carnes, 2010), which has 20 core items. Additionally, a brief screen called PATHOS (preoccupied, ashamed, treatment, hurt, out of control, sad) (Carnes et al., 2012), which is similar to the CAGE (cut down, annoyed, guilty, eye-opener) (Ewing, 1984), has been developed for sex addiction screenings in settings such as hospitals and churches where more formal and extensive screens may not be feasible. Using a cut score of three yes responses to the following six questions, the PATHOS screen demonstrated sound sensitivity and specificity scores:

1. Do you often find yourself preoccupied with sexual thoughts? (Preoccupied)
2. Do you hide some of your sexual behavior from others? (Ashamed)
3. Have you ever sought help for sexual behavior that you did not like? (Treatment)
4. Has anyone been hurt emotionally because of your sexual behavior? (Hurt)
5. Do you feel controlled by your sexual desire? (Out of control)
6. When you have sex, do you feel depressed afterward? (Sad)

It is important to note two caveats with the PATHOS screening tool. First, it is not used to diagnose sex addiction but only to identify people who are at risk and need additional assessment. Second, developmental context must be considered in considering responses. For example, in response to Question 2 of PATHOS, a middle-aged woman who hides sexual behavior from her husband is qualitatively different from a college student who hides sexual behavior from her parents.

Treatment of sexual addiction often includes group and individual therapy, motivational interviewing, cognitive behavioral approaches and dialectical behavioral approaches to address triggers and cravings, respectively, relapse prevention strategies, psychopharmacological approaches, referral to 12-step peer support groups, and treatment of comorbid mental illness (Rosenberg & Feder, 2014). It is important to note that the goal of treatment is not for the person to be asexual but rather to develop a healthy sexuality. Because of the shame and secrecy often associated with sex addiction, group therapy is commonly used and is often considered more effective than individual therapy alone. Many peer support group fellowships are modeled after Alcoholics

Anonymous, including Sex Addicts Anonymous (SAA), Sexaholics Anonymous (SA), Sex and Love Addicts Anonymous (SLAA), and Sexual Compulsives Anonymous (SCA). Similar to Al-Anon, there are 12-step fellowships established for partners and family members of sex addicts.

Food

The term *food addiction* has risen in popularity but continues to be a controversial term. Whereas it has attracted much attention in recent research, there is no official diagnosis of food addiction in the *DSM-5*. There is a diagnosis for binge-eating disorder (BED), and although there may be some overlap, BED does not fully encompass the term *food addiction*.

It is not unusual to hear addiction language around certain foods, typically those foods that are considered hyperpalatable and have high amounts of sugar and fat (Blundell, Coe, & Hooper, 2014; Curtis & Davis, 2014; Davis, 2014; Yau, Gottlieb, Krasna, & Potenza, 2014). Perhaps you have heard people says things such as "I'm addicted to chocolate" or have seen a potato chip commercial claiming that once you start eating their product, you will not be able to stop.

Some common features that food addiction shares with substance use disorders include trying unsuccessfully to cut down, continued use despite negative consequences, increased amounts consumed, feeling a loss of control, or withdrawal symptoms when not using (Gold, Teitebaum, & Gold, 2015; Yau et al., 2015). Researchers also point to evidence that the brain may have a reaction to certain foods similar to the one it does with drugs such as cocaine or heroin (Gold et al., 2015; Yau et al., 2015), including the effects on dopamine, a brain chemical known as the "neurotransmitter of addiction" (Joranby, Pineda, & Gold, 2005, p. 205).

> Box 16.4 Interdisciplinary Approaches
> What are some of the advantages and challenges of interdisciplinary approaches like working with nutritionists and dietitians?

Despite the lack of an official diagnosis, there are still assessment tools for food addiction, the most notable one being the Yale Food Addiction Scale (YFAS). The YFAS was developed in 2009 by applying criteria in the *DSM-IV* for substance dependence to behaviors around food and eating (Pursey, Stanwell, Gearhardt, Collins, & Burrows, 2014). Population prevalence rates for food addiction have been estimated anywhere from 5% to 19.9% (Davis, 2014; Pursey et al., 2014). Counselors should also consider how food issues may play a role in other mood disorders, such as depression. An increased appetite is one symptom of major depressive disorder, and food is often used as a coping mechanism (APA, 2013). There is a reason some foods might be referred to as "comfort" foods.

Treatment options for those exhibiting food addiction are similar to those available for substance use disorders and include self-help recovery groups such as Overeaters

Anonymous (OA) and Food Addicts Anonymous (FAA), as well as cognitive behavioral therapy (CBT), mindfulness-based therapy, motivational interviewing approaches, and dialectical behavior therapy (DBT) (Gold et al., 2015; Joranby et al., 2005; Yau et al., 2014). Because many traditional substance use disorder treatments are abstinence based, however, approaches are not completely parallel and need to be flexible in that it is not possible to abstain from all food. Some treatment programs do advocate for abstinence from certain types of food such as sugar or processed food, and some programs integrate nutrition counseling and registered dieticians into their treatment (Yau et al., 2014).

Exercise

The idea of diagnosing and treating an exercise addiction can present many challenges. The behavior of exercise, perhaps more so than any of the other process addictions, is generally seen as highly valued and encouraged. Many medical professionals prescribe exercise to address a multitude of health issues and to extend life, and many mental health professionals recommend exercise as a method to reduce stress and symptoms of depression (Dakwar, 2015; Landolfi, 2013). Some have even referred to exercise as a "positive addiction" that can replace other addictions (Landolfi, 2013).

However, when done to excess, exercise can be viewed through the lens of addiction. It does not have a stand-alone diagnosis in the *DSM-5* (and has not in previous editions) (Berczik et al., 2012; Berczik et al., 2014; Dakwar, 2015), but exercise can still be assessed with many addiction criteria including the presence of cravings; continued use or behavior despite negative consequences (such as injury); prior unsuccessful attempts to reduce the behavior; withdrawal; and interference with relationships, work, or school (Dakwar, 2015; Landolfi, 2013).

Exercise addiction is sometimes divided into two categories and distinguished as either primary or secondary. In a primary exercise addiction, exercise *is* considered the objective, whereas in secondary exercise addiction, the objective is weight loss, and exercise is seen as a means to that end (Berczik et al., 2014). Though not referred to as an exercise addiction, "excessive exercise" does get a mention in the *DSM-5* criteria for bulimia nervosa as a potential "compensatory behavior to prevent weight gain" (APA, 2013, p. 345).

Other hypotheses around the concept of exercise addiction include that those who use exercise as a stress relief come to depend on exercise and need it in increasing amounts to manage stress (Berczik et al., 2012; Landolfi, 2013) or the idea of a "runner's high," which refers to the euphoria some experience with the rush of endorphins accompanying some types of exercise (Landolfi, 2013).

Counselors should use caution and be aware of potential comorbidities or differential diagnoses when assessing for exercise addiction, including strong links with eating disorders, and the potential for exercise to be a symptom of a manic episode (Berczik et al., 2012; Dakwar, 2015).

Prevalence rates have been difficult to pinpoint with exercise addiction, but it is believed to be relatively rare, especially in comparison with other addictions (Berczik et al., 2014; Landolfi, 2013). Therapeutic guidelines have also been challenging, in part because whereas many of the traditional addiction approaches may be helpful, complete abstinence from exercise is not an option without the strong potential for negative health effects. However, the approaches of cognitive behavioral therapy (CBT), motivational interviewing, and mindfulness-based methods have been proven effective in addressing problematic exercise (Berczik et al., 2014; Dakwar, 2015).

Internet

Internet addiction (IA) began to appear in the scholarly literature in the 1990s. IA is characterized by excessive or undercontrolled preoccupations, urges, and behaviors that occasion distress or some level of impairment (Weinstein, Feder, Rosenberg, & Dannon, 2014), often including isolation from other forms of social contact. Internet use is multifaceted. Weinstein et al. (2014) identified three IA subtypes: online gaming or gambling, sexual preoccupation, and socializing or social networking, including e-mail and messaging. Individuals with IA may identify solely with one of these three subtypes or may combine multiple subtypes. Additionally, although it is not a type of IA, texting is a form of technology use that can become a behavioral addiction.

IA was considered for the *DSM-5* and one subtype, Internet gaming disorder, was included in Section III, the Appendix, for areas for future consideration and further study (APA, 2013). Because there is no official list of criteria or assessment procedure, however, research has been conducted with inconsistent criteria, measurements, and methodological limitations (Byun et al., 2009). Block (2008) proposed four criteria as essential to the diagnosis of IA:

1. Excessive Internet use, often associated with a loss of sense of time or a neglect of basic drives.
2. Withdrawal, including feelings of anger, tension, and/or depression when the computer is inaccessible.
3. Tolerance, including the need for better computer equipment, more software, or more hours of use.
4. Adverse consequences, including arguments, lying, poor school or vocational achievement, social isolation, and fatigue.

Because of the lack of consistently used criteria and measurement approaches, researchers have not homed in on prevalence rates, with estimates ranging from less than 1% (Shaw & Black, 2008) to 6% (Greenfield, 1999) in the United States. One group of researchers (Forston, Scotti, Chen, Malone, & Del Ben, 2007) found a prevalence rate of 25% among southern U.S. university students, raising questions about whether IA will become increasingly prevalent as college students today grow up with Internet access. If so, prevalence numbers likely will grow in the future.

A major complicating factor in the assessment of IA is whether it occurs as a

comorbidity of an existing disorder or as a consequence of one. This is a critical issue because it informs whether IA should be treated as an independent condition. For example, Ko et al. (2006) found that IA may be simply an unhealthy coping strategy for developmental transitions and crises that, over time, becomes an addiction, suggesting that IA, at least in some cases, should be a primary focus of treatment, including the development of healthier coping strategies to deal with distress. In other cases, IA may provide a form of social interaction that is a lower risk than face-to-face interactions and may become an addiction for people who are fearful of conventional social situations, suggesting that therapy should be directed at helping individuals overcome their fear of social situations and reducing Internet-based behaviors (Campbell, Cummings, & Hughes, 2006).

On the other hand, it seems apparent that many cases of IA exist comorbid with other disorders. A review of 20 studies (Carli et al., 2013) found that problematic Internet use was correlated significantly with symptoms of ADHD in 100% of cases, depression in 75% of cases, hostility/aggression in 66% of cases, obsessive-compulsive symptoms in 60% of cases, and anxiety in 57% of cases. Additionally, Luo, Brennan, and Wittenauer (2015) emphasized the importance of ruling out bipolar disorder in which the excessive Internet use occurs within a manic or mixed episode. Finally, alcohol and drug use have been found to be associated with problematic Internet use (Weinstein et al., 2014). Comorbidity data highlight the critical nature of a thorough assessment to inform the treatment process.

Treatment, then, depends on the existence of comorbid disorders. Where comorbid disorders exist, failure to treat the underlying disorder likely will impede any improvement in the IA. In the absence of comorbid disorders, however, there remains no consensus about treating IA. Accordingly, treatment is symptom focused with goals of reducing Internet usage, developing strategies for coping with social isolation and cravings, and improving cognitive and psychosocial functioning that have become impaired by the IA (Luo et al., 2015). A period of self-imposed abstinence from Internet access may be required in some situations (Shaw & Black, 2008).

Gaming

Video games include a broad range of electronic games, some of which depend on an Internet connection and some of which do not. Although video games have been around for many years, the increased popularity of online video games has led scholars to pay more attention to gaming as a potentially addictive behavior. Offline video games typically have no social element and have a distinct end to the game; as such, they typically are seen as having less potential for problematic use. Accordingly, although offline gaming can be problematic, most of the scholarly attention has turned to online gaming, which is thought to occasion problematic or addictive use more frequently because of the simultaneous play with other players, often remotely, and the lack of a predetermined end point (Taneli, Guo, & Mushtaq, 2015). Additionally, developers and

game operators update the games after the initial release, so that new quests become available. This novelty also may feed the addictive process. In the United States, estimates are that approximately 9% of adolescents engage in problematic game use that has the potential to become addictive (Gentile et al., 2011), with estimates in other countries being generally lower, in the 3% to 5% range (Demetrovics & Griffiths, 2012; Pápay et al., 2013).

The *DSM-5* taskforce asked the Substance-Related Disorders work group to consider behavioral addictions. As previously mentioned, gambling was included as a primary diagnosis, but Internet gaming disorder was included in Section III, "Emerging Measures and Models," because there is growing empirical evidence of the severity of consequences and a growing body of research (Taneli et al., 2015).

Young (1998) developed a comprehensive theoretical framework for problematic online gaming. This theory emphasizes that some gamers gradually lose control over their game play, including the amount of time spent playing and inability to fulfill other obligations. Such gamers are unable to decrease the amount of time spent playing even after recognizing that their gaming behavior has become problematic; they become increasingly immersed in the virtual world and, as a consequence, develop real-world problems (Young, 2009). In Young's nomenclature, this progresses to an addiction when the gamer becomes preoccupied with gaming, thinking of the game when he or she should be focused on other things. Interestingly, researchers (Nagygyörgy et al., 2013) found that 79% of their sample of online gamers played a single online game, suggesting deep immersion in a single virtual world.

Researchers have extensively examined comorbidity with most attention going to attention problems (ADD and ADHD), depression, anxiety, and social phobia. In particular, attention problems are found about twice as often in problematic gamers as in those who play recreationally (Batthyany, Muller, Benker, & Wolfling, 2009; Gentile et al., 2011). Additionally, depressive symptoms, anxiety, and social phobia are found at higher levels among problematic gamers than among recreational users (Gentile et al., 2011). Unfortunately, however, to date much of the research has been correlational, leaving open the question of reciprocal relationships between gaming and comorbid problems.

There are a variety of treatment programs available, but there is limited published data about their effectiveness. Most follow either a total abstinence model or a harm reduction model that promotes moderate and balanced gaming usage. Regardless of the model, all treatment should focus on (a) increasing prosocial skills and increasing real-life activities that decrease time spent gaming, (b) treatment of comorbid or underlying issues, and (c) managements skills, such as goal setting and time keeping (Griffiths, 2008). A thorough assessment is necessary to inform treatment, including exploration of depression, social anxiety, obsessive-compulsive disorder, and attention-deficit/hyperactivity disorder (Taneli et al., 2015). Additionally, it may be useful to

assess the motives behind gaming, with researchers suggesting that the primary motivations are social, escape, competition, coping, skill development, fantasy, and recreation (Demetrovics et al., 2011). Understanding the motives behind gaming can inform alternative behaviors and treatment strategies.

In addition to formal treatment, a variety of online peer support groups are available. Gamers Anonymous provides online support based heavily on the Minnesota 12-step model (Griffiths & Meredith, 2009). Additionally, there are online forums run by parents and family members, gamers, and professionals (Griffiths, 2008).

Shopping

Addictive or out-of-control shopping, often referred to as compulsive buying disorder in the scholarly literature, has not been recognized in the *DSM*. In part, this rests in disagreement among scholars as to whether out-of-control shopping is best characterized as compulsive, impulsive, or addictive, because it shares traits of each. Proposals were made to include shopping addiction in the *DSM-5*, but these efforts were unsuccessful. Shopping is, of course, a popular U.S. pastime, with Americans spending an average of 6 hours per week shopping (Grant, Potenza, Krishnan-Sarin, Cavallo, & Desai, 2011). Shopping becomes pathology, however, when time and money dedicated to it get out of control (Hussain, Guanci, Raza, & Ostrovsky, 2015). The proliferation of online shopping has undoubtedly increased shopping addiction.

> Box 16.5 Shopping
> What are the ways that our society encourages shopping or overspending?

Individuals with a shopping addiction commonly follow a negative-positive-negative emotional cycle common to behavioral addictions. That is, one of the core triggers is an undesirable emotional state, often anxiety. Engaging in the behavior (shopping) provides temporary amelioration of the undesirable emotional state and may even occasion a sense of euphoria (occasioned by a surge of dopamine). This is generally short-lived, however, as the guilt and shame of repeating the pattern of overspending occasions an undesirable mood. As the addiction progresses, this may escalate to the point that the individual can only reduce the guilt and shame of overspending with another shopping binge. Depending on the criteria used, researchers estimate the prevalence of shopping addiction at from 2% to 9% in the United States (Karim & Chaudhri, 2012; Kukar-Kinney, Ridgway, & Monroe, 2009). Researchers find that most people with shopping addiction are fairly young, often in their early 20s (Black, 2011), and researchers are divided on whether there are gender differences in spending addiction. Of further interest, socioeconomic status (SES) is not a predictor of spending addiction. Whereas people in higher SES groups may spend more money than those in lower SES groups, the neuroadaptation is much the same for both groups.

Diagnostic criteria have been proposed (McElroy, Keck, Pope, Smith, & Strakowski, 1994) for compulsive buying disorder that include the following:

- Preoccupation with shopping or intrusive impulses to shop
- Clearly buying more than necessary or than can be afforded by the individual
- Significant distress caused by shopping
- Significant interference with other domains of life (e.g., social functioning and work)

These criteria highlight the complexity of this phenomenon in that they include references to both the compulsive *and* impulsive nature of shopping, while also including elements commonly seen in substance and behavioral addictions.

Individuals who engage in addictive shopping often experience a range of consequences, including financial difficulties (including severe debt), relationship problems (occasioned by out-of-control spending and, in many instances, "hidden" spending), occupational difficulties (including underfunctioning because of preoccupation with shopping, including online shopping at work), and, in some cases, legal difficulties (most commonly bankruptcy or stealing [shoplifting or embezzling] to pay off debt) (Racine, Kahn, & Hollander, 2014).

Unfortunately, shopping addiction has remained controversial in the professional literature, with many mental health professionals failing to see the severity of this disorder (Benson & Gengler, 2004), leading to ineffective treatment and those suffering from spending addiction finding little relief or discontinuing help-seeking behavior.

Researchers have found that people with more severely out-of-control shopping habits have higher rates of psychiatric comorbidity (Black, Monahan, Schlosser, & Repertinger, 2001; Mueller et al., 2010). In a study of those with a spending addiction, Mueller et al. (2010) examined the lifetime comorbidity of various psychiatric disorders and found that 74% had a mood disorder, 57% had an anxiety disorder, 21% had an impulse control disorder, and 21% had a history of some other type of behavioral addiction.

Treatment research on addictive spending has been limited by the fact that various scholars characterize such behavior as an impulse control disorder, an obsessive-compulsive disorder, a behavioral addiction, or simply a symptom of an affective disorder. Accordingly, no clear treatment protocols have emerged. Most notable in the literature are treatment of the comorbid disorders; cognitive behavioral therapy to address shopping behavior problems, emotions, and self-esteem; and group therapy to empower individuals to develop skills to combat shopping urges (Benson & Gengler, 2004). Additionally, Debtors Anonymous is a 12-step fellowship established for those with a spending addiction (Hussain et al., 2015).

Work

Perhaps more than any other behavioral addiction, work addiction can be difficult to assess and treat because many cultures view the willingness to work excessively as a strength. The term *workaholism* was coined more than 45 years ago by Wayne Oates (1971) and is used interchangeably with the term *work addiction*. Work addiction has a

prevalence rate of 8% to 17.5% among those with a college education, with these numbers possibly as high as 25% in professions such as law, medicine, and mental health (Ascher, Avery, & Holoshitz, 2015).

Although paper-and-pencil measures exist, such as the Work Addiction Risk Test (Taris, Scharufeli, & Verhoeven, 2005), the Workaholism Battery (Andreassen, Hetland, Molde, & Pallesen, 2011), and the Dutch Work Addiction Scale (Shimazu, Schaufeli, & Taris, 2010), work addiction is commonly identified by interview and self-report (Ascher et al., 2015). Experts generally agree that work addiction must include a behavioral (i.e., excessive time spent in work activities) and a cognitive (compulsion and preoccupation) component that includes excessive time spent at work, frustration when unable to work, compulsively rigid working style, and negative outcomes that include low self-esteem, excessive stress, and diminished life satisfaction (Ascher et al., 2015).

The combination of behavioral and cognitive components is important to distinguish between a healthy high level of enthusiasm for work, which can be life enhancing, and work addiction, which ultimately diminishes life satisfaction and well-being (Griffiths & Karanika-Murray, 2012). In fact, it appears that work addiction often culminates in serious health problems, including weight gain, sleep deprivation, hypertension, anxiety, psychosomatic complaints, and mood disorders (Ascher et al., 2015). Further, work addiction appears to negatively impact intimate partnerships and children of the work addict (Carroll & Robinson, 2000).

Unfortunately, there are no evidence-based interventions for working with work addiction (Ascher et al., 2015). In fact, because work addiction often is egosyntonic, it is unlikely that an individual will seek help for a work addiction until he or she experiences serious consequences, such as serious health issues or relationship distress. It is important to rule out comorbid conditions, such as a mood disorder (Ascher et al., 2015) that can be treated with therapy or medication while the work addiction is being addressed. Treatment for work addiction must go beyond a simple behavioral intervention of planning for better work-life balance to address the underlying causes of the work preoccupation and addiction. The best hope for recovery involves a holistic approach to treatment that addresses diet, sleep, stress management, assertiveness (to set work-related boundaries), and spiritual or existential issues (Ascher et al., 2015). Additionally, treatment may include 12-step work through Workaholics Anonymous (WA). Participants often work from *The Workaholics Anonymous Book of Recovery* (Workaholics Anonymous World Service Organization, 2009a) or *The Workaholics Anonymous Book of Discovery* (Workaholics Anonymous World Service Organization, 2009b).

Cultural Issues in Behavioral Addictions

Although research regarding cultural issues and ethnic diversity in the area of process addiction is quite limited and, in the case of some behavioral addictions, nonexistent,

there are still some important considerations for clinicians. For example, whereas studies on gambling addiction have traditionally been focused on men, it has become more evident that gambling addiction crosses all cultural lines, including ethnicity, gender, social class, and age (Ashley & Boehlke, 2012). This wide spectrum is reflected in the rates of gambling addiction, which are on the rise in adolescents, seniors, and females, with region having no significant impact on the prevalence of problem gambling (Ashley & Boehlke, 2012; Suissa, 2011; Westermeyer, Canive, Garrard, Thuras, & Thompson, 2005).

Similarly, the focus of most research on sex addiction has also been on men, with very limited information on prevalence rates among women (McKeague, 2014; Roller, 2004), although estimates suggest that approximately 1 out of every 7 sex addicts is a woman (Carnes, 1991). More broadly, it is important for clinicians to keep in mind that different cultures may have different sexual norms, so exploring cultural considerations with clients is important in an assessment for sex addiction (Iwen, 2015). In contrast to the bulk of research done on gambling and sex addiction, the focus of most studies on food addiction has been on white middle-aged women (Berenson, Las, Pohlmeier, Rahman, & Cunningham, 2015), leaving a strong limitation in our understanding of different issues for different genders, races, and ages.

Clearly, then, additional research on cultural issues in behavioral addictions is badly needed. In the absence of clear research on cultural issues, counselors should consider and broach the topic of culture with their individual clients with compassion and valuing of cultural differences and support the client in exploring individual and cultural experiences within the addiction and recovery process.

Case Study Responses

The case of Gabriel demonstrates the complexity of addiction counseling. The case presents many challenges, including the possibility of comorbid disorders, underlying trauma, and addiction interaction. For the purpose of this chapter, however, we focus on the potential addiction interaction between alcohol and drug use and sexual behaviors. Clinical studies suggest a relationship between substance use disorders and behavioral addictions (Grant, 2008), such that many individuals with a substance use disorder also have one or more behavioral addictions. The term *addiction interaction disorder* has been coined to describe a phenomenon whereby multiple addictive behaviors occur concomitantly (Carnes, Murray, & Charpentier, 2005). This term is chosen to explain that multiple addictions sometimes do more than coexist but actually *interact* in some way. At the outset of treating Gabriel, given the initial information we have, a counselor would be well advised to assess for sexual addiction as part of a comprehensive assessment process. It would be important to explore Gabriel's sexual history, including his shame over his initial sexual experience and his history of relationship infidelity, particularly if these infidelities are egodystonic. Whereas Gabriel may believe, as clients often do, that he is only acting out sexually because of the alcohol and drug use

(i.e., a disinhibiting interaction), he had multiple sexual partners while in his most recent inpatient treatment, presumably while sober from alcohol and drugs. Addressing any comorbid disorders and addictions that exist will be essential to successful treatment for Gabriel.

Summary

Clearly, an understanding of behavioral addictions is vital to a counselor's education. Whereas the diagnostic codes may be slow to fully embrace the concept of behavioral addiction, counselors must understand that behavioral addiction does exist and how devastating it can be for their clients. Counselors will continue to see clients present to them with struggles and addictive behaviors in the areas of gambling, sex, food, exercise, Internet, gaming, shopping, and work, with potentially more areas in the future. In some cases, these behavioral addictions may not be the original presenting complaint and are easily missed without a thorough assessment.

This topic is rapidly evolving, in both our understanding and treatment options. There are, however, many resources available to counselors (see Resources for Continued Learning) and much overlap in behavioral addictions and substance addictions, including symptomatology, comorbidities, and treatment possibilities. Additional research, including the neurobiology of behavioral addictions, will continue to build a more informed understanding of the etiology and treatment of behavioral addictions.

Resources for Continued Learning

Websites

Debtors Anonymous (DA): www.debtorsanonymous.org.
Food Addicts Anonymous (FAA): www.foodaddictsanonymous.org.
Gamblers Anonymous: www.gamblersanonymous.org and www.gam-anon.org (for family and friends of problem gamblers).
National Council on Problem Gambling: www.ncpgambling.org (includes information on becoming a National Certified Gambling Counselor [NCGC] and provides a directory of certified gambling counselors).
Online Gamers Anonymous: www.recovery.org/topics/about-the-online-gamers-anonymous-12-step-recovery-program.
Overeaters Anonymous (OA): www.oa.org.
Sex Addicts Anonymous (SAA): www.saa-recovery.org.
Sex and Love Addicts Anonymous (SLAA): www.slaafws.org.
Sexaholics Anonymous (SA): www.sa.org.
Sexual Compulsives Anonymous (SCA): www.sca-recovery.org.

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17 Theory and Practice of Group Work With Addictions

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Group work is one of the most common forms of treatment for addictions and has been deemed clinically effective and cost-effective (Brook, 2015). According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2013 National Survey of Substance Abuse Treatment Services, 94.6% of substance abuse treatment programs reported offering group counseling as a treatment option, and a majority of these programs reported that 76% to 100% of their clientele received group counseling (SAMHSA, 2014). As such, the majority of individuals who participate in addiction treatment will engage in group work.

Group work requires the group leader to apply specific knowledge and skills to facilitate the interdependent group members' progress toward mutual goals (Wilson, Rapin, & Haley-Banez, 2000). Although group work might also include treatment with couples or families (see Chapter 9), this chapter focuses on group work with unrelated persons. In such groups, members have the opportunity to experience mutual support and understanding with others who also have addiction-related issues. In addition to giving and receiving social support, group members' additional therapeutic needs can be addressed, such as raising awareness that a problem exists or learning skills to refuse substances when they are offered (i.e., refusal skills training). This chapter starts with a brief account of the history of group work in addictions treatment and then describes the key concepts and theoretical underpinnings of this treatment modality. Next, how practitioners implement group work is explained, including a brief description of two evidence-based practices applied to group work. The strengths and weaknesses of group work with addictions are then presented, and finally, a case example illustrates how group work can be applied in addictions treatment.

A Brief History of Group Work in Addictions Treatment

According to Blume (2002), the use of group work to treat addictions in the United States began in 1908 when group methods were applied by physicians to groups of individuals with alcohol dependence. In 1935, the origination of Alcoholics Anonymous (AA) further connected a group recovery setting with addiction. AA was founded on the basis of self-identified alcoholics helping one another maintain sobriety by sharing their stories in group meetings. Such meetings are typically not considered therapy but rather self-help or mutual-help groups (a detailed description of AA and other 12-step and mutual-help groups is provided in Chapter 14). With the success and growing popularity of AA, the Minnesota Model was developed based on the 12-step approach used by AA. The Minnesota Model incorporated didactic educational group sessions as well as peer group sessions to supplement the AA groups that were required as part of the

treatment program. In the 1950s, therapeutic communities were developed and relied heavily on group work, including encounter groups, in their treatment programs. In the 1960s, group treatment for alcohol dependence began to include applications of Jacob Moreno's psychodrama, further connecting group therapy and addiction treatment (Blume, 2002). By 1965, several inpatient rehabilitation programs reported relying heavily on group methods, and many outpatient treatment programs offered both individual and group therapy. Today, group work is widely incorporated into addictions treatment granting the majority of clients who seek addiction treatment the opportunity to engage in group work. Further, AA and other mutual-help groups are used in conjunction with formal treatment.

Key Concepts and Theoretical Underpinnings of Group Work in Addiction Treatment

Group work lends itself as an ideal treatment for addictions. Addiction has been characterized as "a disease of isolation" in which recovery is possible within the context of a group (Roth, 2004). People who experience addiction are often isolated from others as a result of relationships being harmed or severed, therefore allowing the primary relationship to be with the substance or behavior. Further, people with addictions have often been part of impaired groups (e.g., family, social groups), and group work grants group members an opportunity to recapitulate and heal in a group of others who express acceptance and understanding. Given that it requires a *therapeutic alliance*, or a working relationship between the group leader and group member, group work can be effective in helping members experience healthy relationships. In addition, group work also requires *group cohesion*, or the relationships among the group members as well as the leader. Such relationships have implications for correcting group members' faulty attachments to others as well as providing the opportunity to correct interpersonal defenses that commonly manifest among people with addiction, such as denial, projection, or rationalization (Brook, 2015). As one of the therapeutic factors of group work, group cohesion is further described in the next section of this chapter.

Content and process are also important concepts in group work. The *content* of the group is the topic of discussion or the actual words used in the group. The content is typically consistent with the goals and purpose of the group. For example, for a group of individuals in the maintenance stage of change (the fifth stage of change in the transtheoretical model; see Chapter 10 for a full description), the content of the group may be relapse prevention. *Group process*, or the "nature of the relationship between interacting individuals—members and therapists" is of equal importance in group work (Yalom & Leszcz, 2005, p. 143). Group leaders must attend to the process of the group by observing how and why group members are making the statements they do and taking an active role in ensuring a healthy and productive group process for all members.

Groups in addictions treatment can be *open or closed* with open groups having ongoing admission and closed groups having all members beginning and terminating at the same time. Groups can be used in a variety of treatment settings, including outpatient, inpatient, and partial hospitalization. Two types of group formats are common among addictions groups: psychoeducation and counseling/psychotherapy groups.
Psychoeducation groups are typically brief and can be offered to a larger group compared with counseling or psychotherapy groups. Psychoeducation is often focused on prevention of substance use/addiction issues or relapse prevention. Examples include groups focused on the psychological and physiological effects of substance use and addiction, information about standard drinks and use patterns, impact of addiction on interpersonal and occupational functioning, and education about the recovery process and resources (Kominars & Dornheim, 2004).
The terms *counseling* and *psychotherapy* are commonly used interchangeably because both formats use specific interventions to address personal and interpersonal problems; however, distinctions can be made in that counseling groups focus on transitory issues whereas psychotherapy groups focus on chronic issues and restructuring personality (Morgan, 2004; Wilson et al., 2000). Common goals of counseling and psychotherapy groups include establishing and maintaining abstinence, learning and improving coping skills, identifying and managing emotions, and developing healthy relationships (Kominars & Dornheim, 2004).

Therapeutic Factors in Group Work

In group work, the group itself is the agent of change, which is particularly important in addictions treatment considering the isolation and relational issues with which clients enter treatment. Yalom and Leszcz (2005) outlined the therapeutic factors, or specific human experiences, that account for the effectiveness of group work. They are as follows: instillation of hope, universality, imparting information, altruism, corrective recapitulation of the primary family group, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis, and existential factors (Yalom & Leszcz, 2005, pp. 1–2).
Each of the therapeutic factors is meaningful and important in addictions group work. Concerning *instillation of hope*, clients often present for addictions treatment feeling hopeless. They commonly have a trail of wreckage in their lives as a result of the addiction and have difficulty seeing that there is another way to live. Even when they decide to pursue recovery, it is a bumpy and difficult journey. Having hope for a positive future can be unfathomable. Contact with group members who have successfully made healthy changes instills hope for clients that they too can make changes to improve their quality of life. The group leader can further instill hope by believing in and treating each and every client as if he or she is indeed capable of making positive changes and helping to build client self-efficacy.
Universality can directly counteract the feelings of isolation and loneliness that are

common in addiction. By coming together to discuss experiences and grow, group members learn firsthand that they are indeed not alone and that addiction affects others in similar ways. Yalom and Leszcz (2005) cautioned that group members of a cultural minority might feel excluded, limiting the therapeutic factor of universality. To mitigate this possibility, group leaders are encouraged to acknowledge cultural differences but then move past the differences to the common human—or transcultural—experiences.

Imparting information is a common task of addiction groups, especially in didactic psychoeducational groups. Although the information itself is valuable, it is not uncommon for clients with addiction to be skeptical or hesitant to truly receive information imparted by "experts" or a person holding a position of authority (e.g., the group leader). As such, clients with addiction may be more inclined to receive information when it is imparted by their peers. Further, advice is often provided in group settings among members. Yalom and Leszcz (2005) noted that although the content of this advice is rarely useful, the process of offering it is indeed beneficial because it demonstrates care and understanding, which people with addiction may not experience in their daily lives.

Concerning *altruism*, given the toll addiction can take on personal relationships, clients with addiction often perceive themselves as having nothing positive to offer others or as being a burden in others' lives. When group members recognize that they can be helpful to others, it provides them with a counterperspective that they can indeed be of use to others in a positive way. This change in perspective can serve to boost a client's self-esteem as well.

Because many clients with addiction come from addicted families or families that were dysfunctional in some other way, the therapeutic factor of the *corrective recapitulation of the primary family group* is valuable in addiction treatment. Yalom and Leszcz (2005) noted that the therapy group can mimic the family group in that similar components occur, including authority/parental persons, peers/siblings, personal revelations, strong emotions, intimacy, and hostile or competitive feelings. Such experiences provide group members with the opportunity to become aware of, relive, and correct conflicts experienced in the past with their primary family groups. Yalom and Leszcz (2005) emphasized the importance of correcting, not just reliving, the experience while engaged in group work, for it can be harmful to relive the experience in the group without a correction. Thus, it is important for the group leader to be aware of the therapeutic process and foster corrective experiences for group members.

People with addiction often use substances in social situations to manage perceived deficits in this area. Thus, *the development of socializing techniques*, or basic social skills (Yalom & Leszcz, 2005), is an important therapeutic factor in addictions treatment. Such learning can be explicit, such as when communication skills are the content of the group session, but it also occurs indirectly as group members provide each other feedback on how they interact and communicate on other content. For

example, a group member might provide another member feedback such as, “It's difficult to understand what you're saying when you speak so softly that I can barely hear you.”

Imitative behavior can be linked to developing social skills in that group members commonly mimic the behaviors of the group leader and of other (typically senior) group members. As such, the group leader can model appropriate communication skills and offer support and acceptance to group members to help members develop these skills as well as to help create the culture of the group. Further, group members' self-efficacy can be increased through the vicarious experiences of other members. Bandura (1994) noted that when individuals witness others similar to them put forth effort and succeed, their beliefs that they too are capable of such behaviors and success increase.

Yalom and Leszcz (2005) considered the group to serve as a social microcosm in that group members represent a sample of the greater social world. Therefore, group members have the opportunity to learn how to develop and maintain healthy, satisfying relationships, or engage in *interpersonal learning*, with their group members. Weegmann (2004) emphasized that addiction is perceived as a “lonely business” in which the afflicted individuals seem unable to create healthy relationships (p. 36). As such, this therapeutic factor is extremely valuable among addiction group work in which group members become aware of and take responsibility for their interpersonal tendencies and then make changes inside and outside of the group to form healthy relationships.

As previously mentioned, *group cohesiveness* describes the relational climate of the group as a whole. Yalom and Leszcz (2005) likened the importance of group cohesion on treatment outcomes to the counselor-client relationship in individual counseling. They elaborated to say that members of a group with strong cohesion “feel warmth and comfort in the group and a sense of belongingness; they value the group and feel in turn that they are valued, accepted, and supported by the other members” (p. 55). As noted in previous factors, the relationships between group members are essential to foster healing and recovery, especially among persons with addiction who have struggled with feeling worthy and accepted in their interpersonal relationships. Khantzian, Golden-Schulman, and McAuliffe (2004) noted that although it is natural for group cohesion to initially develop surrounding the common experience of being an addict, it is important for the group's cohesion to mature to other common experiences in order for group members to begin to associate with the “human mainstream.” They contended that “ordinary problems, part of everyday life beyond the addiction, offer the group members a way into the ordinary world” (Khantzian et al., 2004, p. 460).

Catharsis is the emotional discharge of members in the presence of the group. Although this is an important factor in group work, Yalom and Leszcz (2005) clearly noted that catharsis alone is not sufficient for group members to make changes. The final therapeutic factor, *existential factors*, involves group members recognizing that life is

indeed unfair at times and that this is inescapable. Further, it emphasizes that group members are responsible for how they live their lives. The implications of this factor among clients with addiction are important. The presence of the addiction itself can be perceived as an unjust circumstance. After all, no one asks to become addicted. Further, although the addiction itself cannot be avoided, individuals must take responsibility for how they are living their lives under the given circumstances.

Stages of the Group

In one of the most well-known theories of group development, Tuckman (1965) described five sequential stages: forming, storming, norming, performing, and adjourning. In the forming stage, the group members become acquainted with one another and with the group. Group members typically dread the first group meeting and therefore group leaders might employ interventions to alleviate anxiety and discomfort. As they become oriented to the group, members begin to conceptualize how they will meet their primary goal for joining the group as well as develop their niche within the social context of the group (Yalom & Leszcz, 2005).

Conflicts often arise in the storming stage of the group, and as group members struggle to determine issues of power and control, negative comments and criticism are common. Hostility toward the group leader also emerges because group members are often disappointed by the limitations of the leader. During the norming stage, group members acclimate to the norms of the group and group cohesion develops, including trust between group members and the establishment of a safe environment. As the group moves into the performing stage, they work together to achieve their goals. In this stage of the group, members are actively engaged in reflection, authenticity, self-disclosure, and feedback (Yalom & Leszcz, 2005). In the adjourning stage, the important tasks of termination are addressed.

The process of termination warrants careful consideration especially when taking into account the importance of the relational components of group work. Unfortunately, oftentimes termination cannot be predicted, such as in the case of client premature termination or the need to terminate a client from a group for a rule violation or another issue that might be harmful to the client or the group (e.g., suicidal or homicidal ideation). Termination has the potential to initiate discomfort among group members and the group leader because it can be colored by previous good-byes in their lives. Therefore, the group leader must be self-aware to be certain not to avoid issues of termination. Termination should be approached as a process, as opposed to a single event. As such, to the extent possible, the group leader should help the group members be mindful of the impending close of the group and incorporate interventions to help group members process and achieve closure related to their personal group work journey.

Box 17.1 Small-Group Discussion

Have you experienced the therapeutic factors in groups other than therapy groups? If so, describe your experience. What did you find to be helpful? What was not helpful?

Group Work in Practice

With the key concepts and theoretical underpinnings of group work in addictions treatment described, the focus of this chapter now turns to group work in practice. Essential components to implement group work include being an effective group leader, creating and maintaining the group, and building a group culture.

Effective Group Leader

Based on the research of Kurt Lewin, there are three primary leadership styles for group leaders to consider: autocratic, democratic, and laissez-faire. Autocratic leaders do not involve members in decision making but act as a dictator of the group. Democratic leaders facilitate group discussion and decisions and consider group members' needs and feelings. Laissez-faire leaders are disengaged from the group and the decision-making processes. Research has shown that the most effective style of leadership is one in which the leader shows care and concern about the group members while maintaining structure within the group, such as with a democratic leader (Johnson & Johnson, 2013). In order to effectively lead a group, the characteristics and skills of the group leader must be carefully considered. First, the group leader should demonstrate the common factors known to enhance any therapy process, including empathy, active listening skills, and the ability to establish a strong therapeutic alliance (Miller, Forcehimes, & Zweben, 2011). The group leader must have a stance of concern, acceptance, genuineness, and empathy toward group members (Yalom & Leszcz, 2005). Further, the group leader might avoid confrontation, for this has been linked to poorer outcomes in substance abuse counseling (see Miller, Benefield, & Tonigan, 1993) and has been cautioned against in group work for addictions (Matano & Yalom, 1991). Instead of confrontation, the group leader can seek to understand resistance to change and help group members take an honest look at their behaviors, without judgment or blame (Khantzian et al., 2004). Brook (2015) suggested the use of "supportive confrontation" in which the leader fosters an atmosphere of empathic "holding" within the group, which is characterized by understanding and acceptance, as a member explores difficult emotions or dysfunctional behaviors (p. 465). Group leaders should avoid behaviors that would elicit resistance, such as blaming, criticizing, labeling, and shaming (Miller et al., 2011).

Self-awareness and monitoring are essential tasks of the group leader to ensure he or she is staying focused on the group and treating group members appropriately and respectfully. Further, because all groups will be multicultural, group leaders must strive to be multiculturally competent to be able to effectively work with diverse group members and have an awareness of how social oppression and privilege can impact

group process (Singh, Merchant, Skudrzyk, & Ingene, 2012). Concerning the tasks for the group leader, per Yalom and Leszcz (2005), the leader is responsible for (a) creating and maintaining the group, (b) building a group culture, and (c) activating and illuminating the here and now.

Creating and Maintaining the Group

In order to implement a successful group, practitioners must consider several clinical and logistical issues. Such considerations include the time and location of group meetings, the goal of the group and its members, the composition of the group, and processes for screening group members. Ideally, group members have the opportunity to attend successive group meetings with the same members in order to develop maximum cohesiveness to provide members with the greatest possible benefit of group work.

Accessibility of the Group

Group meeting times and places are ideally set to enhance members' abilities to access the group meeting. For example, the leader should avoid establishing a group meeting time that might conflict with a popular 12-step group meeting, especially if self-help or mutual-help group attendance is a required or an encouraged component of the treatment program. Concerning location, groups should meet in an accessible location taking into account various degrees of ability (e.g., accessible for clients who use assistive technology) and means (e.g., accessible by public transportation). Further, social issues should be taken into consideration, such as offering excuses for time off work, providing bus passes or parking validations, and child care considerations. Issues of literacy and potential clients' native languages should be taken into consideration when developing print materials related to the group.

Goals

In addiction treatment groups, abstinence is often a prescribed goal either by virtue of the treatment program or by the referral source (e.g., probation or parole, a drug-free workplace employer). The goal of the group, whether it be abstinence, harm reduction, or otherwise, should be made clear to group members prior to members joining. In terms of goals and group compositions, the group leader should decide whether all members must have the same goal upon entering the group or if goals can vary. If goals can vary, it is important to consider how one member who is focusing on harm reduction and continuing to use might influence another member who is pursuing abstinence. Some treatment programs structure the groups so that members are grouped according to their readiness to change, and therefore, members are more likely to have compatible goals. Regarding the duration of the group, some groups may be ongoing whereas others have a fixed number of sessions. Research has shown outcomes are improved as a result of a longer duration in group treatment (Brook, 2015). Makeup policies and procedures should be established and implemented whenever a member misses a group session. Another consideration concerning treatment goals is whether goals can extend beyond

addiction into broader life issues (Miller et al., 2011). Because addiction impacts all of life's facets, group members will likely have concerns beyond the addiction itself, such as mental health concerns (e.g., depression, anxiety), relationship issues, or career-related difficulties. The parameters of the group should be described to prospective group members, including a description of what is to be of focus beyond the addiction itself.

Composition of the Group

The size of a group can vary contingent on the purpose of the group. For example, a psychoeducational group with the primary purpose of imparting information might consist of many members. On the other hand, a group that focuses on cognitive behavioral skills training with the purpose of group members learning, trying out behavioral skills, and receiving feedback during group sessions might include no more than 10 members.

The group leader must consider the impact of having a homogeneous group versus a heterogeneous group related to specific member characteristics. Differences based on gender, age, race, ethnicity, and culture should be considered. If a member is a minority in a group, the group leader must be sensitive to this. Maintaining a person-centered approach by approaching all clients as individuals and as experts on themselves and their own lives can help to mitigate some of the difficulties that arise with a heterogeneous group (Miller et al., 2011).

At times a homogeneous group is beneficial in order to provide culturally relevant treatment. For example, women have been found to have greater success and treatment retention when participating in women-only groups compared with mixed-gender groups (Stevens, Arbiter, & Glider, 1989). Further, LGBTQ individuals might benefit from an LGBTQ-affirming group (Center for Substance Abuse Treatment, 2009), and veterans might fare better in homogeneous groups given the group members will share common experiences and enhance the therapeutic factors. However, according to SAMHSA's (2014) 2013 National Survey of Substance Abuse Treatment Services, addiction treatment groups specific to veterans were offered by only 13% of providers, and only 12% of providers offered groups specific to LGBTQ individuals. According to this same study, 86% of addiction treatment providers offered at least one program or group for a specific population (SAMHSA, 2014). Groups for women were the most popular, and 44% of providers reported offering them. However, only 17% of providers offered groups for pregnant women or women who were postpartum. Thirty-nine percent of providers offered groups specific to men, and 30% offered adolescent groups. Only 12% of providers reported offering groups for older adults. Groups for people with co-occurring disorders were offered by 43% of providers whereas groups for people who experienced trauma were offered by 29%, persons who experienced intimate partner violence by 20%, and people who experienced sexual abuse by 20%. Pertaining to people experiencing criminal justice issues, 33% of providers offered groups for

criminal justice clients with concerns other than driving under the influence (DUI) or driving while intoxicated (DWI) whereas 29% offered DUI/DWI-specific groups. These findings are promising in that gender-specific groups are more commonly offered, and yet other groups for individuals who would likely benefit from a more homogeneous group, such as veterans, LGBTQ individuals, and older adults, are sparsely offered. Clients' stages of change (see Chapter 10 for a full description) should also be considered in a group's composition. Group members will have varying needs depending on their readiness for change. For example, a group member in the fifth stage, maintenance, might benefit from focusing on relapse prevention whereas a member in the second stage, contemplation, might benefit from exploring his or her ambivalence about change. Velasquez, Maurer, Crouch, and DiClemente (2001) developed a manual for group treatment based on the stages of change. In this model of treatment, a group might be formed with members who are all in the precontemplative stage of change, and the group's focus might be on raising problem awareness. Another group may consist of members who are in the action stage of change and focused on abstaining from substance use. However, group members may benefit from hearing about the experiences of other members who are further along in their change process, which serves as a benefit to a heterogeneous group.

Screening

Once the goals and the group composition are determined, selecting group members is an important task of the group leader. Not every client will be appropriate for the group setting in addictions treatment. Individuals who are suicidal, homicidal, or acutely psychotic, who experience antisocial personality disorder, or who might deviate from the group are typically not appropriate for group work in addictions treatment (Brook, 2015; Yalom & Leszcz, 2005). The leader might also consider another form of treatment if the individual refuses to attend the group or expresses a lack of interest, expresses strong discomfort in groups, has impulse control or anger management problems, is disrespectful to the group rules, has language barriers, or is a young person who may be negatively influenced by other group members (Miller et al., 2011). The leader must also match group members to the appropriate group based on ability to function, maturity, level of motivation to change, and phase of recovery (Brook, 2015). Recommendations for member screening include the group leader meeting with each prospective group member individually to assess for appropriateness for the group (Miller et al., 2011) as well as to observe prospective members in the group setting (Yalom & Leszcz, 2005). Individual meetings with group members can also be used to answer any questions the member might have about the group and to enhance the member's motivation to engage in the group to help prevent premature termination (Brook, 2015; Miller et al., 2011).

Building a Group Culture

An essential factor in the success of group work in addictions treatment is fostering a culture that promotes recovery (Margolis & Zweben, 2011). The group culture is largely composed of the rules and norms of the group. The rules of the group are typically established by the group leader; however, in some cases group members might collaborate on the group rules. The rules greatly impact the culture of the group and should be focused on fostering the goals of the group and the growth and development of the group members. The group leader is responsible for reinforcing the rules of the group to create structure within the group. Structure is especially important in addictions group work due to the relative lack of structure in the lives of the group members (Brook, 2015). Further, by setting appropriate limits, the group leader fosters safety within the group setting.

Group rules often include an expectation that group members will keep confidentiality, meaning that members will not discuss the identities of group members or other group members' experiences outside of the group. This rule, although difficult to enforce, is essential in creating the safe environment needed to promote trust and group cohesion. The group rules can also include guidelines about which group members can talk and when during group work sessions. For example, a group may begin with a round in which each member has a turn to speak about his or her successes or struggles with maintaining abstinence. Talking rules might also include guidelines for when and how members can respond to each other's comments, or engage in "cross-talk" (i.e., group members sharing how they feel about one another) (Matano & Yalom, 1991). Other group rules may pertain to physical contact between group members. For example, are group members permitted to hug one another or to pat one another on the back as demonstrations of support? The answer should take into consideration the unique histories and cultural backgrounds of the group members, and the leader should decide what will be most appropriate and helpful for the group members.

Another group rule might apply to group members' contact with each other outside of the group. Although a supportive network is provided in the group setting, group members' convening outside of the group could possibly lead to intimate or romantic relationships and perpetuating unhealthy relationship patterns, including engaging in additive behaviors or substance use. Thus, the group leader may be tempted to prohibit or discourage members from convening outside of the group; however, this rule can be impractical and difficult to enforce (Margolis & Zweben, 2011; Miller et al., 2011). Margolis and Zweben (2011) noted that the norm of the group of providing support can be helpful to group members beyond the specified meeting times and suggested the group leader invite conversation about the possible risks of out-of-group interactions and encourage discussion about such contacts within the group setting.

Box 17.2 Small-Group Discussion

Imagine you are leading an intensive outpatient group for clients with addiction. This is a closed group of eight members that meets three times per

week for 3 hours. Sam, a group member who is abstaining from cocaine and marijuana for the first time, has been doing well in the group and tested negative on all drug screens. Then, about halfway through treatment, Sam seemed to have difficulty staying awake during a group session. Sam's eyes were red and glassy, and the group members did not speak to Sam as they typically would. As the group leader, how would you proceed?

A group rule should also be established related to intoxication. It is common for members to be prohibited from participating in group when they are under the influence of alcohol or a drug. Individuals who are intoxicated will not benefit from the group and may even pose harm to other group members. Thus, the group leader should have predetermined ways of confirming intoxication (e.g., a urine drug screen, a breathalyzer) and then assist the intoxicated individual in leaving the agency in a safe manner. To minimize the disruption to the group, the group leader will likely need to draw on agency resources or other professionals to assist in the alcohol and/or drug screening and transporting the individual (Miller et al., 2011). The group may also benefit from an open discussion about such situations (Margolis & Zweben, 2011).

Norms of the group are important to consider when building the culture of the group. Yalom and Leszcz (2005) described norms as "an unwritten code of behavioral rules … that will guide the interaction of the group" (p. 120). Yalom and Leszcz (2005) encouraged group leaders to establish norms derived from the therapeutic factors of acceptance and support, universality, imparting information, interpersonal learning, altruism, and hope. By doing so, group leaders foster a group culture that will maximize the group as an agent of change. For example, the group leader might encourage and reinforce members' providing spontaneous support to each other when describing their struggles in remaining abstinent. The leader can also model nonjudgmental acceptance and genuine care and concern of members. In another example, the group leader might model a certain skill (e.g., refusal skills, relaxation skills) prior to asking members to try out new skills themselves. In this way, the leader models taking risks without adverse effects. The group leader is responsible for activating the here and now in group work (Yalom & Leszcz, 2005). In doing so, the leader maintains the culture of the group by attending to the group process and fostering group cohesion.

How members are oriented to the rules and expectations of the group is an important consideration. When conducting open groups, the majority of the group orientation is typically covered with the new member in an individual meeting with the group leader. It should be considered how the new member will be introduced and assimilated into the ongoing group. For example, is the new member expected to share his or her background with the group? Do existing members share their story with the new member? Miller and colleagues (2011) suggested that existing members share how long they have been part of the group and some of the benefits they have experienced as a result of their attendance. In a closed group, the orientation can begin in an individual

meeting with the group leader and continue with all group members during the first group meeting. In the orientation to the group, whether this occurs with the group or on an individual basis, the details, expectations, and rules of the group should be presented and agreed on by each member to facilitate a group culture that promotes recovery. A written form can be helpful to clearly provide the rules and expectations of the group and to have a written commitment from group members to abide by these protocols (Margolis & Zweben, 2011). Exhibit 17.1 provides an example of such a form.

Box 17.3 Application Activity

In groups of three to five, develop an addictions treatment group. With your classmates, determine the purpose and goals of the group, the group composition, the details of the group (meeting time and location, open or closed group, duration of the group), the rules of the group, and the norms you would like to establish as group leaders. What other considerations would you need to have in order to help your group be successful?

To participate in the (insert group name) group, we ask that you make the following commitments to help the group run well for the benefit of all members:

1) Group members must come to each group. If you cannot make it to group, please let the group leader know in advance if possible.
2) Please be on time to each group session.
3) Group members must come to each group sober. If you come intoxicated, you will not be permitted to attend group and arrangements will be made so that you can safely leave the agency.
4) Group members are expected to be open and honest in group, including while discussing alcohol and/or drug use and addictive behaviors.
5) Group members must keep the identities of group members *confidential*. This means you will not provide information about who is in the group with people who are outside of the group.
6) Group members do not discuss the experiences of other members outside of the group. This information is *confidential* and must stay in the group setting.
7) Contact with group members during group sessions is encouraged. Although contact outside of group sessions can be helpful, group members do not become involved in relationships that may be harmful, including any relationship that would prevent group members from being open and honest in the group sessions. Romantic and sexual relationships with group members are prohibited.
8) In this program, you are committing to complete a minimum of 12 weeks of group sessions. Please let the group leader know if you plan to terminate the group early.

I have read and agree to abide by the above rules and expectations of the group.

Name: _____ Date: _____

Note: Adapted from Margolis and Zweben (2011).

Note: Adapted from Margolis and Zweben (2011).

Types of Group Treatment

There are many types of group work for addictions treatment. Although group treatment can require 12-step meeting attendance and/or incorporate 12-step work in group treatment, there is a clear distinction between the mutual help offered by 12-step meetings and the professional help and methods provided in group work, and these differences should be made clear to group members. Psychodynamic, interpersonal process, motivational enhancement, and cognitive behavioral groups are all common approaches used in group work in addiction treatment. Exhibit 17.2 provides resources to learn more about group work grounded in these approaches. Due to their status as evidence-based practices in addiction counseling, the following is a review of group applications of motivational interviewing (MI) and cognitive behavioral therapy (CBT). Both MI and CBT have been successfully applied to group work and can be used together in sequence or integrated to have a synergistic effect to enhance treatment outcomes. For example, MI can be used prior to a CBT group to enhance motivation for change and engagement in treatment. Or MI and CBT can be integrated in that the group leader uses MI and CBT with group members.

Type of Group	Resources
Psychodynamic	Albanese, M. J., & Khantzian, E.J. (2002). Self-medication theory and modified dynamic group therapy. In D. W. Brook & H. I. Spitz (Eds.), *The group therapy of substance abuse* (pp. 79–96). New York: Haworth. Flores, P. J. (2007). *Group psychotherapy with addicted populations: An integration of twelve-step and psychodynamic theory* (3rd ed.). New York: Haworth. Khantzian, E. J. (2012). Reflections on treating addictive disorders: A psychodynamic perspective. *American Journal of Addiction, 21,* 274–279.
Interpersonal process	Leszcz, M. (1992). The interpersonal approach to group psychotherapy. *International Journal of Group Psychotherapy, 42,* 37–62. Malat, J., Leszcz, M., Negrete, J. C., Turner, N., Collins, J., Liu, E., & Toneatto, T. (2008). Interpersonal group psychotherapy for comorbid alcohol dependence and non-psychotic psychiatric disorders. *American Journal on Addictions, 17,* 402–407. doi:10.1080/10550490802268223 Malat, J., Morrow, S., & Stewart, P. (2011). Applying motivational interviewing principles in a modified interpersonal group for comorbid addiction. *International Journal of Group Psychotherapy, 6,* 557–575. doi:10.1521/ijgp.2011.61.4.556
Motivational enhancement	Miller, W. R., Zweben, A., DiClemente, C. C., & Rychtarik, R. G. (1992). *Motivational enhancement therapy manual: A clinical research guide for therapists treating individuals with alcohol abuse and dependence* (NIAAA Project MATCH Monograph Series, Vol. 2. DHHS Pub. No. [ADM] 92-1894). Rockville, MD: National Institute on Alcohol Abuse and Alcoholism. Velasquez, M. M., Maurer, G. G., Crouch, C., & DiClemente, C. C. (2001). *Group treatment for substance abuse: A stages-of-change therapy manual*. New York: Guilford Press. Wagner, C., & Ingersoll, K. (2013). *Motivational interviewing in groups.* New York: Guilford Press.
Cognitive behavioral	Carroll, K. M. (1998). *Therapy manuals for drug addiction: A cognitive-behavioral approach: Treating cocaine addiction* (NIH Pub. No. 98-4308). Bethesda, MD: Department of Health and Human Services, National Institutes of Health, National Institute on Drug Abuse. Wenzel, A., Liese, B. S., Beck, A. T., & Friedman-Wheeler, D. G. (2012). *Group cognitive therapy for addictions.* New York: Guilford Press.

Motivational Interviewing

As previously noted, clients pursue addiction treatment on a continuum of readiness for change. Indeed, most clients who present for addiction treatment lack sufficient motivation to change their behaviors. Because motivation affects treatment adherence and outcomes, interventions designed to enhance client motivation are often implemented. When motivational interviewing is used in a group setting, the group leader is nonconfrontational and draws on the power of intrinsic motivation. Strategies used to enhance motivation can include providing psychoeducation about the stages of change and about the effects of addictive behaviors, raising members' awareness about their addictive behaviors, exploring who has expressed concern about the group members' behaviors, identifying and clarifying values, and evaluating relationships and the group members' role in their relationships and overall environments (Velasquez et al., 2001). Such strategies are employed in the style of MI, including creating an environment grounded in compassion and empathy (Miller & Rollnick, 2013). Group leaders using MI use counseling skills that encourage clients to engage in the group process, such as open questions, reflections and paraphrases, and summarizations (Krejci & Neugebauer, 2015). Krejci and Neugebauer (2015) proposed the following suggestions when using MI in group addictions treatment:

- Talk less, listen more. Remember that the primary goal is to facilitate, elicit, and evoke, rather than to teach.
- Focus on the process of change. Listen for underlying commonalities across problem areas and use [reflective listening] to highlight MI-related themes, such as ambivalence, discord, stages of change, etc. Try to avoid prolonged discussions of the specifics of particular problem areas, unless you are certain they apply to everyone.
- Listen carefully. Model careful and empathic listening in every group interaction.
- Address group processes. Where there is conflict, boredom, anger, etc., be willing to address these in an open-minded and respectful manner.
- Highlight strengths. Openly affirm effort, strength, courage, honesty, etc.
- Avoid excessive “solution talk.” Many group members (and some therapists) are quick to offer solutions and suggestions. (p. 29)

Research on MI groups has found that this approach can increase clients' perceived autonomy and self-efficacy; enhance their readiness to change, including intentions to change specific behaviors; and increase treatment engagement and retention, including participation in aftercare. MI groups have also been found to increase problem recognition and reduce social isolation and negative group processes (Wagner & Ingersoll, 2013).

Cognitive Behavioral Group Therapy

Research has shown CBT groups to be effective in reducing substance use, reducing

emotional distress, and improving coping (Irvin, Bowers, Dunn, & Wang, 1999; Miller & Wilbourne, 2002). These groups are typically structured and include cognitive and behavioral strategies to assist clients in modifying their addictive behaviors. The group leader will often teach clients about the cognitive model (Beck, 2011) and then apply group members' experiences to the cognitive model (Wenzel, Liese, Beck, & Friedman-Wheeler, 2012). Cognitive strategies to facilitate change include identifying and evaluating thoughts and beliefs that encourage addictive behaviors. Coping skills are often taught to help group members learn to manage difficulties in their lives without using. Such skills might include learning how to manage cravings to use, moderating intense emotions, or using effective communication in relationships. Skills are often learned via the group leader first describing the skill and how it can be useful. Then, the leader demonstrates the skill to show members how to use it. By demonstrating the skill, the group leader also models taking risks for the sake of growth and development and cultivates a culture of embracing vulnerability. Finally, the group members try out the new skills and often receive feedback from the group leader and members (Miller et al., 2011). Homework derived from the group session is typically assigned toward the end of each group meeting to help members progress toward their goals in between sessions (Wenzel et al., 2012).

Strengths and Weaknesses of Group Work With Addictions

Like all treatment formats, group work offers strengths as well as some possible disadvantages to consider. Both the benefits and the costs should be considered when employing group work in addictions treatment, and efforts to prevent or mitigate disadvantages should be made prior to and during group work.

Strengths

Group work touts many benefits compared with other types of treatment, including individual counseling. The group format is often desirable to providers and to clients due to its cost-effective nature. Group work can be offered less expensively compared with individual therapy because one therapist can assist multiple clients simultaneously. Further, from a provider's perspective, group work reduces the negative financial impact of no-show clients.

As described earlier in this chapter, group work provides opportunities for clients to experience the therapeutic factors unique to group work. These include experiencing a sense of connectedness to others and opportunities to learn from other group members, which are the antithesis to the isolation caused by addiction. Groups can provide a sense of hope, and members are likely to receive more helpful information in the group setting compared with individual formats. Group members can also transition in their self-perception as a drain to others to someone who is dependable and capable of helping others. They can also correct faulty experiences from their primary family

group. In addition, the content of therapy can also be better suited for group formats. For example, clients in need of social skill development will be better able to try out these skills and receive feedback in a social (i.e., group) setting.

> Box 17.4 Class Discussion
> As a practitioner, would you prefer providing individual or group counseling with addictions treatment? Discuss your reasons with your classmates.

Weaknesses

Given the lower professional-to-client ratio, clients are provided less individual attention in group work. As such, certain clients might be more apt to take a passive approach to treatment or mentally disengage during group sessions. In order to mitigate this possibility, group leaders can structure group sessions and incorporate group interventions that foster client engagement and involve the entire group or as many members as possible.

In addition, group work is more complex on a relational level. The group leader must create and maintain a therapeutic alliance with each group member as well as manage relationships between group members, including fostering and maintaining group cohesion, or rapport within the group. In addition, group work often moves at a faster pace compared with individual therapy, and interactions between group members require spontaneous yet thoughtful responses from the group leader. Redirection of group members is often needed in order to ensure the group remains focused and productive. For example, clients might be apt to tell “war stories” of their using days in an effort to establish credibility or to compete with their peers. Such conversation is not beneficial, and the group leader should redirect when such conversation ignites.

Another potential disadvantage to group work in addiction treatment is the issue of confidentiality. In individual counseling, the clinician is bound to ethical codes that require confidentiality. Although confidentiality is commonly established as a group rule, it is difficult to monitor and enforce. Because group members are not held to professional standards to maintain confidentiality for their peers, group work relies on group members' trustworthiness in upholding the confidential nature of the group sessions. In addition, addictions affect all types of people and professionals. Therefore, group members “outing” themselves as a person who experiences addiction can have professional and personal implications. For example, consider a surgeon who is well connected in the community and whose family is well known. The surgeon attends group treatment for opioid addition and discloses his or her addiction to a group of people who are familiar with the hospital at which the surgeon works and with the surgeon's family. Herein the confidentiality of the surgeon's issues with addiction is easily breached.

Case Study Responses

Group work could be a powerful treatment modality for Gabriel. First, let us explore the type of group that would likely be most appropriate. Then, we will look at how the therapeutic factors and specific methods applied to group work might be helpful for Gabriel. Finally, a summary of the possible advantages and disadvantages of group work are described for this client.

Type of Group

If possible, Gabriel would benefit from a group composed of racially diverse members. Regardless, the group should be led by a group leader who practices multicultural group counseling, including having the ability to see each group member as an individual and using an empathic approach. The group leader should also facilitate group members moving past their differences to recognize their similarities in order to instigate cohesion. This would also help activate the therapeutic factor of universality in that Gabriel would be able to recognize that he is not alone in his struggles with substance use and addiction.

Given that he is questioning his sexual orientation, Gabriel may benefit from participating in an LGBTQ-affirming group, or a group specific to LGBTQ individuals. However, the group leader would need to assess whether Gabriel is ready for such a group or if he might need to explore his sexual orientation in individual counseling first to reduce the risk of his own homophobia causing harm to other group members.

Considering Gabriel's mental health symptoms, he would benefit from a group whose scope encompassed mental health as well as substance-related issues. In such a group, Gabriel would be granted opportunities to gain insight into any connections between his substance use and his mental health symptoms and to develop skills to help him manage his mental health symptoms. Overall, Gabriel would likely benefit most from a comprehensive group that he could attend as long as needed, because the longer Gabriel engages in the group, the greater the likelihood he will be successful.

Application

Although Gabriel has been in treatment before, he must believe that he can indeed be successful in reaching his goals this time around. The group modality can be helpful by instilling hope and enhancing his self-efficacy as Gabriel engages with other members successfully pursuing recovery. Given that his longest period of abstinence occurred while he worked with a sponsor in AA, the interpersonal nature and cohesion of group work would likely be an effective treatment modality to help Gabriel reach his goals. Interpersonal learning from the group sessions would facilitate Gabriel becoming aware of and modifying unhealthy patterns in his relationships. He would learn that he has something to offer other group members (i.e., altruism), which would then extend into his personal life, such as improving his relationship with his niece. Concerning his family of origin, with effective group leadership Gabriel would have the opportunity to engage in corrective recapitulation of the primary family group, especially related to

Gabriel's relationship with his father.

Concerning group methods, MI could be used in group sessions to create a compassionate and accepting environment based on empathy, which would help Gabriel feel comfortable and accepted as he shares his experiences with the group. This approach also facilitates multicultural counseling given its emphasis on understanding the worldview of the client. By using MI, the group leader would assess Gabriel's readiness to change and employ appropriate interventions. If Gabriel was in an earlier stage of change (e.g., contemplation), the group leader could use MI to help elicit Gabriel's personal motivations for change and for treatment. CBT components could be used to help Gabriel learn skills to help him be successful in his recovery (e.g., relapse prevention), improve his relationships (e.g., communication skills), and manage his mental health symptoms (e.g., thought stopping). The group format would enable Gabriel to learn from other group members, practice new skills in a safe and accepting environment, and receive feedback.

Advantages and Disadvantages

As mentioned, the interpersonal nature of group work would be a great strength of this treatment modality for Gabriel. This format would have the potential to help Gabriel gain insights and develop skills to help improve his relationships and connectedness with others in his personal life, including a recapitulation and correction of his relationship with his father. The group format would also help instill hope necessary for Gabriel to pursue a successful recovery and guide him to see himself as someone who has a lot to offer others. One potential weakness of group work would be the temptation for Gabriel to use the intimacy of the group setting in a misguided way. Given his pattern of sexual relationships with women, if Gabriel participates in a mixed-gender group, he would likely benefit from abiding by a rule that prohibits members from interacting romantically or sexually outside of group meetings. Gabriel's current experience of questioning his sexual orientation would also require careful consideration. The group leader must screen appropriately and be culturally competent to be sure Gabriel is not harmed by any other group member's potential homophobia and vice versa. Ideally, Gabriel would be placed in a group in which the parameters of the group allow him to explore his sexuality, and if not, then he might consider individual counseling to engage in this work.

Summary

Groups are widely used in addiction treatment because group work is cost-effective and has demonstrated efficacy. The therapeutic factors of group work are all present and important in addictions groups. The group leader must be active in facilitating the therapeutic factors of group work, attending to specific considerations when creating the group, and establishing and maintaining the culture of the group so it is an effective treatment modality for its members. Many types of group work are possible in

addictions treatment, including MI and CBT groups, which are evidence-based treatments for substance-related issues. Additional rigorous research is needed to further inform the practice of group work in addictions treatment (Weiss, Jaffee, de Menil, & Cogley, 2004).

Resources For Continued Learning

Books

Bhat, C. S., Pillay, Y., & Selvaraj, P. R. (2015). Group work experts share their favorite activities for the prevention and treatment of substance use disorders. Alexandria, VA: Association for Specialists in Group Work.

Reading, B., & Weegmann, M. (2004). Group psychotherapy and addiction. Philadelphia: Whurr.

Scholarly Journal

Weiss, R. D., Jaffee, W. B., de Menil, V. P., & Cogley, C. B. (2004). Group therapy for substance use disorders: What do we know? Harvard Review of Psychiatry, 12, 339–350.

Websites

SAMHSA's National Registry of Evidence-Based Programs and Practices: www.nrepp.samhsa.gov. *Substance Abuse Treatment: Group Therapy*: www.ncbi.nlm.nih.gov/books/NBK64205.

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18 Approaches to Relapse Prevention

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A return to substance use after a period of abstinence can be devastating for the client, the counselor, and the client's friends and family. Clients may feel hopelessness and shame, counselors may experience frustration or self-blame, and family and friends may react with anger or despair. Addiction counselors not only are charged with working with clients to prevent relapse but also must respond effectively to the diverse emotions that emerge when relapse occurs. One way to attend to these emotional responses is to conceptualize relapse as an important learning opportunity rather than a failure of the client or treatment. Although the goal for most addiction treatment programs and support groups is complete abstinence from drugs and alcohol, approximately 80% of clients will relapse at least once during the first year after treatment (Hunt, Barnett, & Branch, 1971; Miller, Walters, & Bennett, 2001). Specifically, relapse is most prevalent during the first 3 months of recovery (Hunt et al., 1971). Given the prevalence of relapse, some researchers have posited that the term *relapse prevention* should be replaced with *relapse management* with the goal of decreasing the severity, length, and frequency of relapse (Roozen & van de Wetering, 2007). Therefore, as some return to use after treatment is the norm, rather than the exception, counselors must be prepared to help clients avoid as well as manage relapse.

Basic Tenets of Approaches to Relapse Prevention

A Definition of Relapse

In the most basic sense, relapse can be defined as an interruption in one's attempt to change a behavior (Marlatt & George, 1984). Therefore, most individuals have experience with relapse in some area of their lives: when trying to implement a new exercise regimen, changing one's diet for health purposes, incorporating a new spiritual or meditative practice into a daily routine, limiting time on social media, or breaking a potentially detrimental habit such as procrastinating or texting while driving. When compared with other chronic medical conditions, McLellan, Lewis, O'Brien, and Kleber (2000) found, rates of relapse in drug dependence (40%–60%) were comparable to relapse rates in type 1 diabetes (30%–50%) and hypertension or asthma (50%–70%). Relapse also is prevalent in the realm of mental health. Among those with a diagnosis of schizophrenia, relapse rates are comparable to those with substance use disorders (84.41%; Andreasen, Liu, Ziebell, Vora, & Ho, 2013). Additionally, approximately 21% to 55% of clients with bulimia nervosa relapse, depending on how relapse is defined (Olmsted, Kaplan, & Rockert, 2005). Therefore, the idea of relapse is not unique to the addictions field, but it carries a heavier stigma than relapse in other facets of life.

Due to the pervasiveness of the moral model of addiction, in which drug use is perceived as a personal choice and the result of a character flaw or moral failing (Leshner, 2001), individuals may deem relapse as a personal failure rather than an aspect of the disorder. This all-or-nothing thinking can be detrimental to treatment progress. Rather than adhering to the moral model, the biopsychosocial model of addiction, which considers multiple factors in the development of addiction such as genetic predisposition, psychological distress, and social learning, provides a more accurate and less evaluative understanding of relapse.

> Box 18.1 Interruptions to Behavior Change
> Consider a time you tried to change a behavior (e.g., exercise, diet, eliminating a bad habit, increasing a positive activity). Was your change process completely linear, or did you experience hang-ups and difficulties along the way? Make a list of specific thoughts, feelings, behaviors, situations, people, or circumstances that impeded your attempts to change your behavior. How did you respond to each one? What contributed to your ability to overcome these obstacles?

Understanding Relapse From a Biopsychosocial Perspective

In 1956, the American Medical Association labeled alcoholism a disease, highlighting the biological and medical nature of the condition. This was an important step in defusing the public perception that drug and alcohol use was solely a matter of willpower and personal choice. The biological nature of addiction has important implications for relapse. Animal research provides insight into the neurobiology of addiction and relapse. Specifically, researchers have found that stimuli continuously paired with a drug of abuse can become conditioned to trigger the same (albeit smaller) response in the brain's reward pathway, even in the absence of the drug (Kenny, Koob, & Markou, 2003). Therefore, stimuli associated with drug use (such as specific locations, drug paraphernalia, scents, sounds) may increase the reward function of the brain, in the same manner as drugs of abuse. This stimulation of the reward function can lead to cravings for the drug of abuse and increase the probability of relapse (Kenny et al., 2003). A client who has achieved several months of sobriety may unexpectedly come across an old needle used to administer heroin intravenously. The sight of the needle, which the client repeatedly paired with heroin use, may trigger a small release of dopamine (among other neurotransmitters) to create a low-level positive affect and thereby activate the brain's reward mechanisms leading to cravings for the primary drug. These neurological responses to drug-conditioned stimuli give credence to Alcoholics Anonymous's slogan to “change people, places, and things” so individuals in early recovery are able to maintain sobriety.

Neuroadaptations are not the only considerations of relapse from a biopsychosocial

perspective. Counselors also must attend to client psychological states and social learning. Regarding client psychology, the experience of negative affect such as despair, loneliness, sadness, and stress may increase the likelihood of relapse (Stewart, 2000). Drugs of abuse are predictable and reliable in changing the way an individual feels. Therefore, when faced with a stressor, clients in recovery may be particularly vulnerable for relapse to cope and manage the unpleasant psychological response. For example, consider a young adult member of the LGBTQ population in recovery from addiction to alcohol. He has achieved several weeks of sobriety and then experiences bullying at school due to his sexual orientation. The young adult may feel anger, despair, and fear. This psychological distress may trigger his desire to use alcohol to manage his negative emotional states.

Finally, regarding the social aspects of relapse, one's environment is an important consideration. Researchers have found evidence to support the notion that the quality of one's social environment predicts the likelihood of relapse. Specifically, Solinas, Chauvet, Thiriet, Rawas, and Jaber (2008) determined that the environment in which animals resided during periods of abstinence significantly influenced the probability of their return to drug use. Enriched environments, those that were positive and stimulating to the senses, significantly reduced the preference for drugs of abuse. These findings indicate that one's environment may have a profound effect on the risk of relapse. If a client in recovery from drug addiction continues to reside in an environment characterized by social isolation, physical detriment, and minimal stimulation, the return to drug use may be particularly appealing. Clients who work to create quality environments, however, in which their basic needs are met, they have ample opportunities for meaningful leisure activities and social interactions, and they encounter new stimulating experiences, may be less likely to return to substance use. Therefore, it is necessary to adopt a holistic perspective of relapse, including biological, psychological, and social factors, to engage in effective relapse prevention strategies.

Defining Relapse Prevention

Relapse prevention is a critical component of addiction counseling. Counselors may erroneously assume that relapse prevention strategies are relevant only in the maintenance stage of the transtheoretical model (TTM; Prochaska & DiClemente, 1982) to sustain abstinence. On the contrary, preparing for relapse and responding effectively to a client's return to use is necessary from treatment initiation. Marlatt and George (1984) defined relapse prevention as a program to “teach individuals who are trying to change their behavior how to anticipate and cope with the problem of relapse” (p. 261). Therefore, relapse prevention is a way to encourage sustained behavior change by considering future obstacles that clients may face in their recovery. Approaches to relapse prevention provide frameworks for the development of recovery plans, strategies, and coping skills to help clients navigate obstacles without returning to drug

and alcohol use. Counselors should not wait until the maintenance stage of change to begin addressing potential barriers to sustained abstinence. Instead, the counselor and client can identify risks and triggers for relapse early in their clinical work, begin developing effective coping skills, and increase client confidence in her or his ability to employ these skills.

Philosophical Underpinnings and Key Concepts of Relapse Prevention

There are many ways to approach relapse prevention. In this section, we chose to highlight three seminal, empirically supported approaches, yet interested readers can consult Rawson, Obert, McCann, and Marinelliasey (1993) for descriptions of additional applications of relapse prevention. Specifically, we describe Marlatt's cognitive behavioral relapse prevention model, the mindfulness-based relapse prevention approach, and Gorski's CENAPS model.

Relapse Prevention Model

The field of addiction counseling was revolutionized by the relapse prevention model (RPM) proposed by Marlatt and colleagues (Marlatt & George; 1984; Marlatt & Gordon, 1985). Rather than conceptualizing a return to substance use in dichotomous terms (i.e., one is either completely abstinent or fully using, succeeding or failing), Marlatt and colleagues suggested a continuous perspective. Specifically, the authors stated that the journey toward sustained abstinence may consist of progressively shortening returns to use, followed by progressively lengthening periods of abstinence. From this viewpoint, a single return to use is conceptualized as a *lapse*, in which the individual has several options leading to a return to abstinence (referred to as a *prolapse*) or a full-scale *relapse*, meaning a return to baseline substance use (Hendershot, Witkiewitz, George, & Marlatt, 2011). The RPM consists of global and situational interventions, thereby preparing clients to make lifestyle changes to avoid lapses and develop the cognitive and behavioral tools to respond to a lapse in a way that decreases the probability of a full-scale relapse (Hendershot et al., 2011; Marlatt & George, 1984; Marlatt & Gordon, 1985).

Regarding global lifestyle changes, the RPM poses that clients with substance use disorders must work to achieve a balance between perceived obligations (shoulds) and pleasurable activities (wants) in their life. Too many demands without compensatory enjoyment can position an individual for relapse. Essentially, individuals must find joy and satisfaction in their sobriety to maintain it. For those who have used substances for considerable lengths of time, the task of identifying pleasurable, nonusing activities can be quite challenging. Therefore, counselors can work with clients to monitor the number of obligations and pleasurable activities in their daily routine; engage in self-awareness activities to identify interests, passions, and goals; and make changes to achieve lifestyle balance. For the client with many demands and responsibilities, the integration

of self-care activities such as exercise, relaxation, meditation, spiritual or religious practice, pleasurable hobbies, or social engagements may provide substantive rewards throughout the day to reduce the risk of using drugs of abuse (Larimer, Palmer, & Marlatt, 1999; Marlatt & George, 1984).

In addition to global lifestyle changes, the RPM describes situational factors that can increase or decrease the probability of relapse. These factors include high-risk situations, coping strategies, self-efficacy, outcome expectancies, and the abstinence violation effect (Larimer et al., 1999; Marlatt & George, 1984; Marlatt & Gordon, 1985). Individuals with substance use disorders may be at risk for relapse when faced with *high-risk situations* falling into three categories: (a) negative emotional states, (b) interpersonal conflict, or (c) social pressure. Negative emotional states include the experience of unpleasant affect such as sadness, boredom, loneliness, or irritation. Interpersonal conflict refers to tension in relationships with family, friends, coworkers, partners, or acquaintances. The experience of social pressure includes the direct or indirect influence of others to use substances, such as being in the presence of coworkers who are drinking or a friend directly inviting the individual to use a drug. These situations call for the implementation of a *coping strategy*, which the client previously fulfilled by using drugs or alcohol. Therefore, when faced with a high-risk situation, the client must use a new coping response to manage the high-risk situation, such as distraction, imagery, refusal techniques, escaping the situation, meditation, positive self-talk, or calling a sponsor from a 12-step program. If the coping strategy is implemented well and proves effective, the client's *self-efficacy* will increase. Bandura (1997) defined self-efficacy as “a belief about what one can do under different sets of conditions with whatever skills one possesses” (p. 37). Therefore, if a client employs a coping strategy other than substance use in response to a high-risk situation and the results are positive, her belief in her ability to use her skills will strengthen. This increase of self-efficacy serves to decrease the probability of relapse. If, however, a coping strategy proves ineffective, it could lead to decreased self-efficacy. At this point, the client may believe that she is unable to perform the desired task and experience *positive outcome expectancies* regarding the drug or alcohol. In light of a failed coping strategy, the client may begin to reminisce about the ways in which the drug was able to help her cope with life's adversities, albeit temporarily and with negative consequences. She may focus solely on the predictable euphoria and pleasure that occurred when she ingested the drug. These positive outcome expectancies of using the drug, coupled with decreased self-efficacy, put the client at risk for a lapse, or a first return to use. Once she takes the first drink or drug, she often experiences the *abstinence violation effect* (AVE). The AVE is a combination of affective and cognitive responses to the perceived forfeiting of one's goal of abstinence. Emotionally, the client may experience guilt, shame, hopelessness, or self-blame. Cognitively, she may think, *Well, I've blown it!* or *There goes my four weeks of sobriety*. These thoughts and feelings put

the client at risk for continuing her drug and alcohol use leading to a full-scale relapse. Additionally, she now has experienced the initial pleasing effects of the mind- or mood-altering substance. The simultaneous experience of the AVE and positive effects of the substance lead to an increased probability of relapse (Marlatt & George, 1984).

The RPM provides a framework by which counselors and clients can understand lapse and relapse experiences. At each point in the progression toward full-scale relapse, there exists an opportunity for clinical intervention. For example, lifestyle changes can be made to limit the likelihood of experiencing high-risk situations. Clients may develop effective and healthy communication skills, strengthen interpersonal skills, create a social network that shares the goal of abstinence, and work to reduce life stressors. Of course, it is unrealistic to assume that clients will never face high-risk situations; therefore, counselors and clients can develop a repertoire of effective coping strategies to employ in the event of a high-risk situation to manage the experience without returning to substance use. If, however, clients are unable to effectively use a coping strategy, an intervention is needed to improve knowledge and skills regarding the coping response as well as increase self-efficacy. Counselors can draw from motivational interviewing (MI; Miller & Rollnick, 2013) to develop self-efficacy by asking clients to explore past successes ("Can you think of a time in your past when you were able to do something you didn't think you could do?") and consider how the strengths and skills used in past success experiences apply to their current efforts to maintain abstinence.

> Box 18.2 Developing Coping Strategies
> For coping strategies to be effective, clients must have adequate training, be fully informed, and develop confidence in their ability to use the skills. For example, prior to employing the skill of diaphragmatic breathing, the counselor may provide general information and helpful instructions, model the behavior, allow the client to practice in session and receive feedback, and practice outside of session for increased confidence.

To intervene after the client experiences positive outcome expectancies of substance use, counselors can encourage clients to counter these expectancies with realistic perceptions of substance use based on their history. For example, a client may think *Having a joint right now would really ease some of this anxiety and feel relaxing*. He may choose to counter that expectancy, however, with, *but I know where that leads … to failed drug tests at work and higher levels of anxiety later once the high wears off*. Counselors can invite clients to think through the likely chain of events beyond the initial euphoria of the drug use to the inevitable negative outcomes they have encountered in the past (Larimer et al., 1999).

If a client does take the initial drink or drug and lapses, there are several choice points regarding clinical interventions. Counselors and clients can address the AVE by planning and creating a lapse management plan (Larimer et al., 1999). This plan

includes agreed-on steps for the client to take in the event of lapse. Lapse management plans may include calling the counselor, a treatment center hotline, or a 12-step sponsor immediately, countering negative thoughts with cognitive reframing, and removing themselves from the high-risk situation. The client and counselor may write the plan on a card that the client can keep on her or his person if a substance is consumed (Marlatt & George, 1984). A successful intervention after a lapse can help the client reinstate abstinence (prolapse) and thereby avoid the decline toward a full-scale relapse.
Over the last several decades, researchers have found consistent support for the RPM regarding reducing drug and alcohol use. Specifically, the approach is superior to no treatment and equally effective as other active treatment methods (Hendershot et al., 2011). The RPM assists counselors and clients in understanding both global and situational factors that affect the probability of lapses and relapses. Additionally, it provides a framework for tailoring clinical interventions to help clients avoid full-scale relapses. Finally, the model is revolutionary in softening the dichotomous view of relapse to a more realistic and sensitive continuous view of intermittent returns to use and periods of sobriety until clients attain sustained abstinence.

Mindfulness-Based Relapse Prevention

In recent years, a focus on mindfulness has emerged in relapse prevention models of addiction treatment. *Mindfulness* is a dual-faceted phenomenon encompassing an awareness of one's present experience and an attitude of curiosity and acceptance of one's thoughts, feelings, and behaviors (Bishop et al., 2004). Kabat-Zinn (2003) defined mindfulness as “the awareness that emerges through paying attention on purpose in the present moment, and nonjudgmentally to the unfolding of experience moment by moment” (p. 145). The integration of mindfulness and preexisting cognitive behavioral relapse prevention efforts (Marlatt & Gordon, 1985) led to the development of mindfulness-based relapse prevention (MBRP; Bowen, Chawla, & Marlatt, 2010; Witkiewitz, Marlatt, & Walker, 2005). Counselors employing MBRP seek to help clients become fully present in their immediate experience and accept their experience without judgment. In this way, mindfulness approaches to relapse prevention foster greater levels of personal choice and self-compassion in the pursuit of abstinence (Bowen et al., 2010). Additionally, clients learn to use mindfulness-based strategies when faced with high-risk situations as an effective coping strategy. For example, counselors can apply mindfulness-based techniques to the experience of cravings to help clients become aware of their urges to use substances and to accept this awareness without evaluation or judgment.

Box 18.3 AVE Coping Strategy
During a period of sustained abstinence, a counselor and client can construct statements for the client to read in the event of a lapse to counter the catastrophizing thoughts related to the abstinence violation effect. Consider

a client who lapses and thinks, *What's the point of trying anymore? I obviously can't do this*. What are some counterstatements to this thought?

In MBRP, cravings are conceptualized as physiological messages used to alert the client that the substance is desired. Thus, cravings are natural responses to the absence of a substance to which the body has become accustomed (Witkiewitz et al., 2005). Clients can use mindfulness skills to engage in *urge surfing*, in which they visualize riding the urge like a wave as it crests and falls (Bowen & Marlatt, 2009). By increasing their awareness of cravings, breathing through them, and remaining nonevaluative, clients can endure the urge to use until it subsides. An accepting and nonjudgmental stance on cravings makes the experience neutral rather than threatening and thereby easier to withstand without returning to substance use.

Because MBRP is an integration of traditional CBT relapse prevention strategies and mindfulness approaches, counselors continue to help clients identify triggers and high-risk situations as well as develop effective coping strategies. One such coping strategy is mindfulness meditation. Kabat-Zinn (2003) purports that the cultivation of mindfulness skills requires both formal, regular practice and informal, spontaneous practice in response to daily living. Therefore, clients may engage in daily structured meditative practice, as well as incremental integration of awareness and acceptance throughout the day. In MBRP, mindfulness meditative practices are employed both in and out of session. Exercises to facilitate the development of mindfulness may include body scan meditation or mindful eating. It is important to note that counselors facilitating MBRP are encouraged to engage in mindfulness practices themselves to offer authentic and genuine instruction and modeling (Kabat-Zinn, 2003).

According to the manual (Bowen et al., 2010), MBRP sessions ideally last for 2 hours over the course of 8 weeks. The primary focus of the session is on group members' immediate experience in the moment, rather than previous or future experiences. Additionally, counselors invite clients to practice meditation daily with recordings provided by the counselor to develop their mindfulness skills (Bowen et al., 2010). Researchers have found both the cognitive behavioral RPM and MBRP to be more effective than treatment as usual among clients in addiction counseling (Bowen et al., 2014). Specifically, both models reduced the risk of relapse at a 6-month follow-up, with MBRP producing lasting effects at a 12-month follow-up. Additionally, MBRP may be a helpful approach for gender and ethnic minority populations, in that researchers found it more effective than RPM with racial/ethnic minority women (Witkiewitz, Greenfield, & Bowen, 2013).

Box 18.4 Mindful Eating

Practice mindfulness eating with a small piece of fruit (such as a berry or grape). Begin by creating as much silence in your surroundings as possible (e.g., turn off electronic devices). Place the piece of fruit in your hand and

draw your awareness to its shape, color, and smell. How does it feel in your hand? What stands out to you in its appearance? After focusing your attention on the fruit in your hand, place it in your mouth without chewing. Draw your attention to the feel of the fruit on your tongue. As you begin to chew, be aware of the taste and texture of the fruit throughout the process. Allow your total awareness to rest on the fruit as you chew and swallow. What do you notice?

Gorski's CENAPS Model of Relapse Prevention

The CENAPS model of relapse prevention emerged in the early 1970s and has continued to be a foundational approach to relapse prevention over the last several decades (Gorski, 1989, 2000). Based on cognitive behavioral therapy and a biopsychosocial perspective, the model provides a structured protocol for preventing relapse throughout early, middle, and late stages of recovery. The CENAPS model consists of several key components: (a) conducting a thorough assessment of a client's addiction and relapse history, (b) identifying the client's individualized relapse warning signs, (c) developing coping strategies to manage each warning sign, (d) creating a structured recovery program based on a developmental model of recovery, and (e) constructing an early intervention plan for relapse (Gorski, 2000). From this perspective, the client is the expert on the warning signs that signal impending relapse. Therefore, by exploring the client's life and addiction history, the counselor and client can identify thoughts, feelings, and behaviors that may precipitate a relapse. These *warning signs* are identified and labeled for the client and counselor to develop an effective management plan for each. It is important for clients to describe warning signs and list the associated maladaptive thoughts, distressing emotions, and detrimental behaviors. For example, the client may identify a relapse warning sign as “feeling inadequate.” The associated irrational thoughts may be *No matter how hard I try, I am not worthwhile*, *Others seem to have their lives together, and I always fall short*, or *If people spend enough time with me they are sure to realize what a disappointment I am*. The distressing or unmanageable emotions may be loneliness, self-blame, despair, and sadness. The associated self-defeating or harmful behaviors may be isolating, leaving primary responsibilities unfulfilled, disengaging from projects and activities, and reconnecting with drug dealers.

Once a client develops a thorough and personalized list of relapse warning signs, he or she works with the counselor to identify coping skills and strategies to manage each situation. To help a client learn these management techniques, counselors may use psychoeducation, role-playing and modeling, and out-of-session assignments. For example, a client may develop a plan to manage the warning sign of feeling inadequate by disclosing to a trusted other his experience of inadequacy (thereby combating isolation and withdrawal). He may engage in an activity that increases his sense of

purpose such as a spiritual or meditative practice, volunteering or engaging in service projects, or increasing his sense of community. The counselor and client also may develop a list of realistic, positive self-statements for the client to read during times in which he feels inadequate such as “I am valuable and my life has purpose.” In a similar fashion, warning sign management plans are constructed for each warning sign the client identifies.

> Box 18.5 Relapse Warning Signs
> Upon examination of Veneshia's relapse and addiction history, she identifies a relapse warning sign of having large amounts of cash on hand. Veneshia works as a server in a high-end restaurant, and when she collects her tip money at the end of the night, she often is overcome with the urge to buy drugs as a “reward” for her good night's work. Identify the potential maladaptive thoughts, unmanageable feelings, and detrimental behaviors that accompany this warning sign as well as a management plan to address it.

Coupled with an understanding of the developmental nature of recovery, counselors and clients use the warning sign management plans to construct a holistic recovery plan. Gorski (1989, 2000) noted that effective recovery requires both abstinence from drug and alcohol use and healthy psychological and lifestyle changes. Therefore, the recovery plan involves addressing the warning signs to ensure abstinence from drugs and alcohol, as well as assessing, monitoring, and adapting lifestyle and personality issues so the client can progress toward greater degrees of holistic wellness. This recovery plan may include eliciting the support of significant others in the client's life, addressing family-of-origin issues, and engaging in daily self-monitoring to assess progress toward goals.

A final component of the CENAPS model of relapse prevention is the construction of a relapse early intervention plan. If warning signs continue without appropriate and effective management strategies, the client may find herself or himself returning to drug or alcohol use. A relapse early intervention plan consists of steps for the client to take upon initial use of substances to interrupt the use as soon as possible. Both the client and his support system can become familiar with the relapse intervention plan to assist the client in resuming abstinence efforts as quickly as possible. The plan often includes refusal strategies, motivational self-talk statements, and specific help-seeking behaviors such as attending a 12-step meeting or calling the counselor to request an appointment.

As a result of the CENAPS model of relapse prevention, addiction counselors have integrated the concept of relapse warning signs and management strategies into their work. Miller and Harris (2000) developed the Assessment of Warning-signs for Relapse (AWARE) scale based on Gorski's list of potential warning signs that may signal an impending return to substance use. The 28-item measure can help clinicians identify clients who may be at risk for relapse. Each item describes a relapse warning

sign with corresponding answer choices on a 7-point Likert scale ranging from *never* to *always*. Example items include “I keep to myself and feel lonely” and “I feel trapped and stuck, like there is no way out” (Miller & Harris, 2000). The AWARE scale was able to significantly predict participant lapse and relapses in a sample of clients in treatment for alcohol addiction and may be a helpful tool for counselors working from the CENAPS model (Miller & Harris, 2000).

How Approaches to Relapse Prevention Are Used by Practitioners

Initial Responses to Client Relapse

A counselor's response to a client's relapse is a critical moment in addiction counseling. Clients may report lapses and relapses voluntarily, or counselors may discover relapse as a result of systematic drug testing. In either instance, clients often experience debilitating shame as a result of disclosing their return to use (Prosek et al., in press; Wiechelt, 2007). The counselor's response to this shame can be a powerful, corrective emotional experience. Therefore, it is advisable for the counselor to be mindful of her or his own reactions to a client's relapse, for the counselor's projection of failure will only serve to enhance a client's perception of failure. It is critical, at this point, for the counselor to communicate empathy, validate the client's struggle and disappointment, and correct cognitive distortions that deem treatment and/or the client as a failure. For example, upon initial disclosure of a relapse, a counselor may state, “I know that was difficult to share with me and I appreciate your honesty. I am aware of how much your sobriety means to you, and you obviously are disappointed with this setback. I think there is a lot we can learn from this experience to help us as we move forward.” Counselors can take the opportunity after a relapse to model transparency and honesty in the counseling relationship, particularly regarding disclosing the relapse to third parties. At the start of addiction counseling, counselors must explore with clients the implications of a self-disclosure of use or a positive drug screen result as a part of the informed consent process. Clients in addiction counseling often are referred by third parties who may have a combination of personal, legal, or financial interest in client treatment outcomes. Therefore, it is important for both the counselor and the client to understand how a disclosure of use may affect the course of treatment, as well as how it will be reported to a referral source. Counselors also are encouraged to be honest as to how much they can advocate on the part of the client should he or she be referred by a third party or ordered by a court to treatment. This informed consent on relapse disclosure should not be a onetime event but rather integrated throughout the counseling process. Therefore, when a client reports a relapse, or it is revealed through a drug test, both the counselor and the client will be aware of who, if anyone, must be notified.

Integrating Relapse Exploration Into the Counseling

Process

Lapses and relapses are common in addiction counseling and though disappointing can serve as important learning tools to inform future counseling efforts. After addressing the client's emotional response to the relapse, counselors can explore the client's experience. Daley and Marlatt (2006) crafted a Lapse and Relapse Worksheet to help facilitate this exploration. Clients are invited to reflect on their experience and report (a) the main reasons for using, (b) thoughts and feelings triggering the use, (c) circumstances triggering the use, and (d) the first decision made to begin the process of relapse. Counselors can use worksheets of this nature to help unpack and explore the relapse experience (see example worksheet in Exhibit 18.1). The discussion of these prompts can assist counselors and clients in the detection of relapse warning signs if working from the CENAPS model of relapse prevention (Gorski, 1989, 2000) or identify high-risk situations and assess the efficacy of coping strategies if working from the RPM (Marlatt & George, 1984). Exploration of relapse leads to insight into weak areas in recovery plans and provides direction regarding how to strengthen each area. For example, a client may disclose that she felt compelled to use methamphetamine (meth) again after bumping into a using friend who reminded her how fun it was to get high. Therefore, the external circumstance triggering her use was the encounter with a using friend eliciting the internal thought, *I haven't felt good in a long time; I deserve this* coupled with feelings of longing and entitlement. The first decision she made to begin the process of relapse was asking her friend if he had meth.

Internal Factors		External Factors	
What thoughts were you having about yourself?		What stressors were you experiencing in your life?	
What were you telling yourself about your substance?		What celebratory events were you experiencing in your life?	
What thoughts were you having about recovery?		What people, places, and things did you encounter that reminded you of your previous use?	
What positive feelings were you experiencing prior to the lapse?		How would you describe your social interactions and relationships?	
What negative feelings were you experiencing prior to the lapse?		What supportive people or activities were available to you?	

Describe the details surrounding your lapse (who, what, where, when). Consider the weeks and days leading up to the lapse and complete the following chart.

The examination of this series of events reveals several areas that can be strengthened in future counseling sessions. First, according to Marlatt and George (1984), the client may have a lifestyle overwhelmed with obligations and duties devoid of pleasurable activities and healthy self-indulgences. Therefore, the idea of fun seemed like a novelty the client longed to experience, rather than a regular aspect of her life. From a global intervention perspective, the counselor and client can work to find a balance of responsibilities and pleasurable activities so that the prospect of drug use is not as appealing (Marlatt & George, 1984). Additionally, the client did not seem to employ coping strategies in response to her maladaptive thought (*I deserve this*) and accompanying unmanageable feelings (longing and entitlement). If working from the CENAPS model, counselors can assess whether the client included these thoughts, feelings, and behaviors on the relapse warning list. If so, the counselor and client can work to create more effective management plans due to the previously established strategies proving ineffective. If the thoughts, feelings, and behaviors were not on the list, the counselor and client can describe these warning signs in detail and craft management plans for the client to use in the future. In these ways, the counselor and client can continue to revise, strengthen, and augment recovery plans as the client

progresses toward sustained abstinence.

Another way for counselors to integrate a relapse experience into the counseling process is to assess and develop drug refusal skills. Clients often benefit from practicing refusal techniques following a lapse or relapse. As the counselor and client explore situations leading up to the relapse, it may become necessary for the counselor to gently confront the client regarding the strength of his or her refusal techniques. For example, the counselor may say, “I heard you say that you found yourself spending time with your using friends. On the one hand, you enjoy their company because they accept you, and on the other you find it challenging because you have never said no when they offer you a hit.” A gentle confrontation can effectively maintain the therapeutic alliance while bringing insight into the client's need to strengthen refusal skills. With this new awareness, clients are more willing to engage in role-plays to practice refusing an offer to use substances. Clients may have limited experience turning down a drink or drug, and the opportunity to practice in session can familiarize an otherwise foreign experience. Prior to the role-play experience, it is helpful to explore client fears or uncertainties around refusing. For example, a client may reveal that refusing is very difficult because he has a strong desire to be liked and accepted by his peers. This disclosure provides material for further exploration in counseling and may inform clinical interventions such as assertiveness training and increasing self-worth.

Beyond individual or group talk therapy, experiential activities may prove to be a useful component of relapse prevention. Hagedorn and Hirshhorn (2009) described several experiential activities for addiction counseling groups that are relevant to relapse prevention. Following a return to use, clients may experience increased shame and guilt. The counselor may notice that the client has withdrawn from the group or disengaged due to feelings of failure. Experiential group exercises can serve to improve group cohesion, communication, and trust. One such exercise is Crossing the Swamp, in which clients must successfully cross through the “swamp” of the first year of recovery using the 12 steps of Alcoholics Anonymous as “lily pads” while avoiding the “alligators,” which represent relapse risk factors. Group members must cross the expanse of the swamp together without losing contact with their steps and avoiding the dangers of the swamp. In this exercise, clients must become comfortable asking for help from other group members to get out of tricky situations. The ability to ask for assistance is a critical skill in relapse prevention because clients often feel tempted to isolate and hide rather than disclose to a trusted other that they are having thoughts of using. The integration of experiential activities into relapse prevention efforts can provide opportunities for skill building, insight development, and the normalization of difficulties in recovery. See Hagedorn and Hirshhorn (2009) for a detailed description of experiential group activities including relevant process questions.

Assessment and Prevention Implications of Relapse

Prevention

Given the severity and prevalence of relapse in addiction counseling, researchers have investigated both protective and risk factors associated with a return to substance use. The continuous assessment of these protective and risk factors throughout the counseling process can help clinicians tailor their work with clients. Counselors can monitor protective and risk factors for relapse both formally through standardized measures and informally throughout their clinical work.

Formal Assessments in Relapse Prevention

One of the primary protective factors against relapse is self-efficacy. Researchers have found that as one's confidence in her or his ability to abstain from substance use increases, the probability of relapse decreases (Burling, Reilly, Moltzen, & Ziff, 1989; Connors, Tonigan, & Miller, 2001; Kuusisto, Knuuttila, & Saarnio, 2011; Witkiewitz, van der Mass, Hufford, & Marlatt, 2007). Several assessment instruments measure client self-efficacy as it relates to alcohol refusal and abstinence, such as the Situational Confidence Questionnaire (SCQ-39; Annis & Graham, 1988), Alcohol Abstinence Self-Efficacy Scale (AASE; DiClemente, Carbonari, Montgomery, & Hughes, 1994), and the Drinking Refusal Self-Efficacy Questionnaire–Revised (DRSEQ-R; Oei, Hasking, & Young, 2005). These self-report measures provide a score reflecting a client's confidence in abstaining from and/or refusing substances. Counselors may use these instruments in relapse prevention efforts to monitor client self-efficacy and effectively address low self-efficacy levels if revealed (see http://casaa.unm.edu/Instruments to access a variety of assessments).

In addition to self-efficacy, another protective factor against relapse is support, specifically participation in 12-step support programs such as Alcoholics Anonymous (AA; Connors et al., 2001; Krentzman, 2007). Twelve-step programs can be helpful adjuncts to a client's support network, particularly after a relapse. In the case of clients who have estranged relationships with family members, the fellowship of AA may be their only viable option for healthy community. Additionally, after a relapse, clients may become aware that they need more support outside of counseling to maintain sobriety. A variety of support groups are available depending on the presenting concern of the client, including AA, Narcotics Anonymous (NA), and religiously based programs such as Celebrate Recovery (CR). Meeting times and locations can easily be found via the Internet or by calling the fellowship's central office. Beyond informal dialogue during session, counselors may desire to formally assess client involvement in AA or another 12-step support program. It is important to note that meeting attendance is not synonymous with involvement or participation (Tonigan, Conners, & Miller, 1996). Therefore, the Alcoholics Anonymous Involvement scale (AAI; Tonigan et al., 1996) may be a helpful resource. This 13-item scale assesses multiple facets of AA engagement to gauge the extent of client involvement. Example items include “Have you

ever had an AA sponsor?" and "Which of the 12 steps of AA have you worked?" The AAI can provide helpful information regarding client engagement in 12-step programs, which may be an effective supplemental resource to relapse prevention counseling.

A final protective factor against relapse that counselors may choose to assess via formal measures is client religiousness or spirituality. Specifically, researchers have found client religiousness and/or spirituality to be inversely related to substance use (Chitwood, Weiss, & Leukefeld, 2008) and predictive of positive addiction treatment outcomes (Conner, Anglin, Annon, & Longshore, 2009; Petry, Lewis, & Ostvik-White, 2008). In relapse prevention, counselors are encouraged to explore client religiousness and spirituality to understand the nature and function of the client's belief system regarding her or his recovery plan. Because many diverse spiritual and religious frameworks exist, the Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC) developed a list of competencies to help counselors respectfully and ethically attend to clients' unique spiritual identities (Cashwell & Watts, 2010). One way to assess client religious and spiritual beliefs is to use a formal measure such as the Brief RCOPE (Pargament, Smith, Koenig, & Perez, 1998), Daily Spiritual Experience Scale (DSES; Underwood & Teresi, 2002), and Quest Scale (Batson & Schoenrade, 1991). These measures can help counselors develop holistic understanding of their clients' religious/spiritual beliefs and inform the integration of these beliefs into relapse prevention efforts.

Informal Assessments in Relapse Prevention

In addition to formal assessments for self-efficacy, AA involvement, and religiousness/spiritualty, counselors also informally assess client cognitions, affect, and behaviors to identify relapse warning signs.

Cognitive Assessment

Prior to relapse, clients often show signs that they are struggling in recovery through negative self-talk, cognitive distortions, or spending more time thinking about using than recovery. Addiction counselors often use the adage that "relapse happens in the mind long before the drug enters the body." Indeed, cognitive factors are highly related to a client's return to substance use. Counselors must use their clinical skills to identify cognitive warning signs of relapse, such as negative self-talk. This self-talk can be blatant or more covert. An example of blatant self-talk indicating potential relapse might be "I just can't do this anymore; I felt better when I was high," whereas a more discreet example could be, "I've been trying to get along with people, but they keep double-crossing me. You just can't trust anybody." Counselors also are encouraged to pay attention to the percentage of the client's thoughts dedicated to using substances rather than recovery. If clients' disclosures in group or individual session predominantly involve stories about using or examples of times in which they were able to use without negative consequences, the counselor should take notice. A final cognitive warning sign

comes in the form of maladaptive or distorted thinking. Counselors also should note client problematic beliefs such as “I am different from other people with alcohol problems,” “I think I have control over my drinking now and can drink socially,” and “I don't think life is any better clean than when I was using.” These thoughts are warning signs that recovery efforts may be declining and new or renewed relapse prevention strategies are needed.

Emotional Assessment

Lapses or relapses are invariably preceded by unpleasant emotional states. Early recovery is a difficult process, and clients will undoubtedly experience periods of anger, sadness, loneliness, frustration, shame, and nostalgia for drugs of abuse. These emotional experiences may be particularly difficult for clients who began using substances early in their adolescence, thereby obstructing the natural development of coping strategies for unpleasant emotions. Negative affect, therefore, can potentially be a warning sign for relapse, particularly if new, effective coping strategies have yet to be adopted. Additionally, clients often are grieving the loss of their former lifestyle. They likely have changed people, places, and things in their recovery, which means the loss of social connections (though often insincere and centered on substance use), familiar environments, and routines. Further, without drugs of abuse, clients must face the damage caused by their active addiction, which may lead to guilt and shame. A desire to give up can overwhelm the client and ignite an impulse to escape by returning to substance use.

> Box 18.6 Relapse Risk Factors
> Predictors of relapse should be assessed at the beginning of treatment and throughout the counseling process. Some risk factors are static, whereas others are fluid and may change over time. For example, a client's family history of addiction will stay the same, but his engagement with using friends, AA involvement, employment status, and self-efficacy may change throughout treatment. Counselors are advised to assess these more fluid risk factors regularly.

Conversely, positive emotions also may serve as warning signs for relapse. Drugs and alcohol may be paired with celebrations and rewards, making these experiences triggers for clients in recovery until new pairings are made. Further, overconfidence in one's ability to remain abstinent may lead to clients taking risks or letting their guard down. This is why the risk of relapse is high on anniversaries of sobriety dates such as when an AA member receives a 6- or 9-month chip (signifying 6 or 9 months of sobriety, respectively). The AA member may be tempted to test his newfound sobriety by choosing to spend time at a bar with friends to prove to himself and others that he now has his drinking under control. This underestimation of high-risk situations and the biopsychosocial nature of addiction may be costly and potentially dangerous for the

individual. Therefore, both positive and negative emotional states can serve as warning signs for relapse and should be monitored closely by counselors and clients.

Behavioral Assessment

Relapse often is defined not only as a return to regular use of addictive substances but also to manipulative behaviors. Counselors should not be surprised when these behaviors manifest in session. The Big Book of AA refers to these behaviors as character defects (Alcoholics Anonymous, 2001). From the biopsychosocial model, clients employ manipulative behaviors to protect the addiction they feel they need to survive. Therefore, a client may lie about her whereabouts over the weekend, inflate her attendance at 12-step meetings, or hide lapses. It is important for counselors to have signed releases of information from clients giving them permission to speak to family members and friends to assess whether manipulative behaviors have returned, thereby signaling a potential return to substance use. Other behavioral relapse warning signs may include missing counseling sessions; disengaging from 12-step fellowships; isolating; returning to old people, places, and things; and avoiding nonusing family and friends. Counselors should monitor client behaviors for signs of struggle in relapse in order to intervene appropriately.

Strengths and Weaknesses of Approaches to Relapse Prevention

The approaches to relapse prevention covered in this chapter have several important strengths. First, they are collaborative. Relapse prevention efforts position the client as the expert in identifying relapse warning signs and high-risk situations based on her or his own experience and relapse history. Rather than imparting information on to the client, the counselor is working to draw out the client's expertise regarding relapse risk factors as well as preventative efforts. The counselor's expertise comes into play when facilitating the process of learning new coping strategies, increasing self-efficacy, and engaging in cognitive restructuring. Therefore, both the client and counselor contribute to the relapse prevention plan, a process that allows the client to take ownership, feel empowered, and increase personal investment in the approach. The preemptive nature of relapse prevention aligns with the biopsychosocial model of addiction as well as the spiral structure of the TTM (Prochaska & DiClemente, 1982). Due to the biological, psychological, and social facets of addiction, as well as the potential risk to spiral from maintenance back to precontemplation or contemplation, a client is never completely immune to relapse. Therefore, relapse prevention plans parallel a storm shelter stocked with emergency supplies. Although one may never need to use the bottled water, nonperishable canned goods, or flashlights kept in the shelter, it is wise to keep it stocked and ready in the event of a tornado. In the same way, relapse prevention efforts do not imply that a client will experience a return to substance use, but it is wise to develop tools and plans to follow if the storm of relapse hits.

Relapse prevention approaches are not without their weaknesses. It can be challenging for counselors to walk the line between preparing a client for potential relapse without inadvertently giving permission to use. Relapse prevention efforts must be framed in such a way as to maintain hope in abstinence goals, as well as address the reality that up to 80% of clients experience some return to use after initial treatment (Hunt et al., 1971; Miller et al., 2001). This can be a difficult balance to achieve, and the counselor must rely on her or his clinical skills, a strong therapeutic relationship, and knowledge regarding the insidious nature of addiction. Similarly, counselors must uphold the ethical principles of autonomy, respecting the client's right to control her or his life, as well as nonmaleficence, doing no harm (American Counseling Association, 2014). These two ethical principles can conflict during relapse prevention efforts. On the one hand, the client ultimately is in charge of her or his life direction. The counselor can prepare the client, take efforts to prevent harm, and facilitate growth, yet the counselor's influence does not supersede client independence. On the other hand, a return to substance use after a period of abstinence can be harmful and even deadly. Fatal heroin overdoses often are associated with a return to use after a period of no use or significantly reduced use. These abstinence periods lead to a loss of tolerance, and relapse can prove fatal if the individual takes the amount he or she used prior to the period of abstinence (Warner-Smith, Darke, Lynskey, & Hall, 2001). Given the potential severity of a return to use, counselors may struggle with the necessary adherence to both client autonomy and nonmaleficence in relapse prevention. It is advised that addiction counselors regularly seek their own supervision to address this issue and consult with experienced professionals when necessary.

Case Study Responses

Regarding the case of Gabriel, the counselor will begin integrating relapse prevention strategies into treatment from the first session. Gabriel has a history of intermittent substance use and abstinence, and the exploration of this history will provide important information for treatment. Working from Marlatt's relapse prevention model (Marlatt & George, 1984; Marlatt & Gordon, 1985), the counselor will address both global and specific interventions to prevent Gabriel's return to use. From a global perspective, the counselor will work with Gabriel to evaluate the balance between shoulds (perceived obligations) and wants (self-indulgences) in his life. Gabriel reports feeling very responsible for his mother; he has been protective of her since he witnessed the abuse she endured from his father. He works hard to help around the house and tries to limit the amount of stress his mother experiences. Additionally, Gabriel feels responsible for his older sister and niece, both of whom depend on him for assistance with household tasks. When the counselor asks Gabriel what he does for his own personal enjoyment, he has a difficult time answering. He reports feeling good about the time he spends with his niece, particularly teaching her to play soccer, but he is unable to identify activities that he does for himself, aside from using substances. Throughout their work together,

the counselor and Gabriel will engage in an exploration of Gabriel's interests, passions, and values to establish greater lifestyle balance between shoulds and wants. With the regular integration of more pleasurable, healthy self-care activities, the appeal of drug and alcohol use as a source of pleasure will decrease.

The counselor and Gabriel also will work to identify situational factors that may increase Gabriel's probability of relapse. After a thorough exploration of Gabriel's history of drug and alcohol use, he is able to identify several high-risk situations, including (a) arguments with his father, (b) tenuous relationships with girlfriends, (c) social pressure from family members who use substances, (d) experiences of discrimination, and (e) symptoms of anxiety and obsessive-compulsive disorder (OCD). Gabriel reports extremely low confidence in his ability to abstain from marijuana or alcohol if faced with any of these situations. Of particular importance, Gabriel states that he often feels marginalized as a biracial male. He receives pressure to "choose" a primary racial identity from his African American peers and family members, as well as his Native American family members. He is comfortable with his biracial identity yet experiences microaggressions from others who invalidate his experience as both African American and Native American. The experience of discrimination and microaggressions leaves Gabriel feeling ostracized and questioning his core identity. He uses marijuana to alleviate the discomfort, yet he feels as though the drug use may be contributing to his anxiety. He tells the counselor that he does not know how else to manage the experiences of discrimination apart from substance use.

With several high-risk situations identified, the counselor will begin working with Gabriel to develop his coping skills. Specifically, the counselor will use modeling, role-plays, and homework assignments to foster Gabriel's efficacy in assertiveness, drug refusal skills, and progressive muscle relaxation. In addition, the counselor will work to empower Gabriel to respond effectively to experiences of discrimination and to engage in self-advocacy strategies. Over time, Gabriel will acquire both the knowledge and skills to successfully implement these coping strategies. Each successful implementation of a nonsubstance-using coping strategy in response to a high-risk situation will increase his self-efficacy.

The counselor also will work with Gabriel to develop a plan if a lapse does occur. Gabriel identified several thoughts he may encounter if he were to take an initial drink or drug. This self-talk included *I can't believe you blew it again. You are such a loser*, *This is too hard*, and *What is the point? You can't stay clean*. Together, Gabriel and the counselor develop counterthoughts for these statements such as *This is a setback, not a failure*, *You are valued and you have purpose*, and *It is hard work, but it is worth it*. Gabriel writes these positive self-statements on a wallet-sized card along with the treatment center's 24-hour hotline number. He keeps this card in his wallet and knows to read it in the event of a lapse to stop the initial use before it becomes a full-scale relapse. In this way, Gabriel and his counselor address both global and situational

factors to reach his goal of sustained abstinence.

Summary

The potential for relapse is a difficult reality for both counselors and clients in addiction treatment. Several empirically supported approaches to relapse can reduce the probability of a client's return to use or limit the severity of the relapse should it occur. The relapse prevention model, mindfulness-based relapse prevention approach, and CENAPS model share common characteristics such as identifying high-risk situations and relapse warning signs, preparing clients with effective coping strategies, and cognitive reframing to prevent a lapse from becoming a full-scale relapse. Counselors can use these approaches to help a client become knowledgeable about triggers and relapse warning signs and gain confidence in her or his ability to cope with high-risk situations in a way that precludes the use of substances. Relapse prevention is an integral component of addiction counseling from treatment initiation to termination.

Resources for Continued Learning

Websites

Addiction Website of Terence T. Gorski: www.tgorski.com (provides useful information on relapse prevention from the CENAPS model).

Center for Applied Sciences: www.cenaps.com (offers helpful resources regarding the principles and procedures of Gorski's relapse prevention model).

Mindfulness-Based Relapse Prevention: www.mindfulrp.com (provides resources for both clients and counselors pertaining to mindfulness approaches and interventions).

National Institute on Drug Abuse (NIDA): www.drugabuse.gov (provides current articles and resources related to a variety of facets of addiction and treatment, including relapse prevention trends, approaches, and empirical support).

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