Preface

Things are changing in the addiction world, and every day we try to make things better. As I travel around the country giving workshops on addictive disorders, I have the privilege of listening to the leaders in the field speak, and I find they are all saying the same thing. Addiction is a brain disease that needs long-term management. For decades, the field of addiction was living in the belief that treatment takes a few weeks (28 days). This is not true for any chronic disease, including hypertension, diabetes, asthma, or addiction. Addiction needs management for a lifetime. The gold standard in addiction treatment is found in programs designed for physicians and airline pilots. This starts off with 90 days of inpatient treatment, followed up by an aggressive relapse prevention plan that requires contact with patients and one random urinalysis (UA) a week for the first 6 months; then the successful client can extend random UAs to every month and finally every year. Random drug screening means clients never know when they will get called in for a UA. Sometimes counselors use hair drug testing that can tell if a client has been using for the last few months. The clients are monitored by weekly phone calls as long necessary to stabilize recovery. One 12-step meeting is required every day for the first 90 days, and each client must acquire a sponsor. Once a year, clients attend a weekly return to the treatment center with the clients they went through the original program with, solidifying how they are doing in recovery and discussing what worked and what didn't work to maintain their sobriety.

Clients who get well need an individualized number of days, weeks, months, or even years and are then followed in continuing care for at least the next 5 years. That is when the relapse rate drops to around zero. Continuing care should include random drug screens, therapy, motivational enhancement, cognitive behavior therapy and treatment for co-occurring disorders, mandatory attendance at 12-step meetings, sponsorship, spiritual direction, lifestyle management, enhanced recreation, and support from the family and finding new friends in recovery. There is no easy fix or magic bullet; recovery is hard work. However, it is incredibly rewarding. We are fortunate in addiction treatment to see our clients literally blossom into health before our eyes. Advancements in new treatments and medications will continue to change the field on a daily basis, so we must remain open to new treatments possible. In any field, change occurs slowly in incremental steps. We now know from animal studies that substance abuse changes genes and now with gene editing we can change genes. We know how to use new therapies that are evidence based.

Unfortunately, along with huge advancements in recovery, the field of addiction treatment is shrinking. This is a catastrophe because millions of our brothers and sisters will die. Most addiction programs today occur in outpatient settings with an average of 6 to 10 counselors working with 150 to 500 clients. This results in poor treatment outcome. Research says that approximately two-thirds of clients relapse in the first year. Only 40% of these treatment programs offer individual sessions, they have no medical professional or medication support and are overwhelmed with paperwork. The turnover of staff is dismal—about 50%, which is as high as the fast-food industry. Because of managed care, we have been trying to make treatment cheaper and more effective. This has led to cost cutting, usually via staff cutting, and this leads to fewer professionals working with more clients. A few hospitals such as the Talbott Recovery Addiction Treatment Center and Hazelden and Betty Ford Center are doing things differently. They focus on the client first, believing that better care leads to a more stable system, better outcomes, and greater financial rewards. They concentrate on prevention, treatment, and continuing care.

It is possible to treat addiction the right way the first time. Most addicts come through treatment three or four times. Some addicts eventually stop on their own by making a motivated life-changing decision, usually with the help of someone in recovery or a health care professional (McLellan, 2006). Still, many clients will not be able to recover without treatment. "I have spent my whole career looking at all of the kinds of things that have been tried—at least in the country—to reduce substance use problems, and treatment is by far the best" (Tom McLellan, quoted in White, 2010b, p. 26).

Because of third-party payers, thousands of treatment centers have closed. There are over 24 million diagnosed addicts in the United States on any given day, and only 3%–10% are in treatment. Worst of all, most professionals in the field are not using evidence-based treatments but rather are using treatments they learned in their own recovery or on-the-job training. These treatments do not work as well as evidence-based treatment programs. When we see a client, we want to know we are giving that person the best treatment in the world.

For the first time, science has shown us how to keep most addicts clean after only one treatment. If you read articles or hear speeches by the leaders in the field, you will read about this new revolution. Treatment that works developed in the programs where the cost of treatment was irrelevant because the cost of relapse was deadly to the public. This initially came from physicians and then branched out to other professionals such as airline pilots. No one wants a pilot flying a plane or a physician doing surgery while intoxicated. No price was too high to pay these professionals to stay clean and sober. These people had to be clean to protect all of our lives. These programs developed markedly higher recovery rates hovering around 90%. If we develop similar programs for all substance abusers, our clients will stay clean and sober. It is obvious that this will be more effective and cheaper in the long run. Until now, third-party payers were reluctant to pay for treatment because it rarely worked. However, the treatment success rate in addiction is like that of other chronic diseases. Third-party payers should be willing to pay for treatment that restores a client to health (Marlatt & Donovan, 2008; J. R. McKay, 2005; Skipper & DuPont, 2010; White, 2009).

There are many treatments for addiction, and most of them work, but it is important to note that when physicians treat their own, all these successful programs focus on 12-step facilitation and sponsorship as the core of treatment (Skipper, 1997; Skipper & DuPont, 2010). Studies show that if abstinence is the desired outcome, consistent involvement with 12-step meetings produces the best results. About 76% of treatment programs use the 12 steps as the basis for their program (Florentine & Hillhouse, 2000).

Robert L. DuPont, MD, the founding director of the National Institute on Drug Abuse (NIDA), said the following:

> Today, I see these fellowships as a modern miracle and the key to sustained recovery for most, but not all, addicts. In fact, these programs created the entirely new concept of "recovery," which is much more than mere abstinence. The 12-step fellowships support a new and better way of life. (White, 2010a, p. 43)

These programs for professionals also use evidence-based therapies such as motivational enhancement, cognitive behavioral therapy, and medication including disulfiram, naltrexone, acamprosate, methadone, buprenorphine and many others. The change required is an emotional, interpersonal, and spiritual shift (Earley, 2009). This same treatment should be available for clients.

This manual will concentrate on five evidence-based treatments:

1. Cognitive behavioral therapy
2. Motivational enhancement
3. Medication-assisted treatment
4. Skills training
5. 12-step facilitation

The Minnesota Model is the gold standard for alcohol and drug treatment. The research evidence for this treatment says that it is a good start, but continuing care in most pro- grams is lacking. Two-thirds of clients going through these programs relapse in the first year after treatment. This is exactly like the treatment of other chronic relapsing diseases such as hypertension, asthma, and diabetes. These chronic diseases have almost identical genetic concordance rates, about 50%–60%; treatment compliance rates, about 50%–60%; and relapse rates, about 50%–60%. Health care has become an acute care business, but many chronic diseases need lifelong management. In acute medicine, clients learn what they need to do to stay healthy, but about half of them do not comply with treatment. Only half of substance abuse

clients are encouraged to go to 12-step meetings, and we know that these meetings help addicts recover. Clients may be encouraged to get a sponsor, go to some kind of counseling, and take their medications, but most of them are not followed up with, do not comply, drop out, and relapse.

This book outlines the best evidence-based treatment in the world. The leading treatment centers and addiction professionals have contributed to and approved of this text. You might not work at a large treatment center that has these services available, but the more of these components you add, the better your treatment will become. The best treatment centers have a large, multidiscipline staff, but even these treatment centers fail miserably when it comes to continuing care. They fail because they are not paid for the continuing care that works. It must become a part of your mission to change this policy. Recovery does not take a set number of days, weeks, months, or years but usually takes a lifetime of vigilance and hard work. The opioid crisis saw nearly 70,000 Americans die or overdose in 2024, and this amounts to more deaths than the Vietnam, Iraq, and Afghanistan wars put together. This is a national emergency. Many addiction professionals are using more medication-assisted treatment with long-term use of methadone or buprenorphine with a slow taper over weeks, months, or years. This is great for some and disastrous for others. Addiction treatment has to be individualized because some patients on maintenance get worse and some get better. Addicts with multiple unsuccessful treatments may need maintenance, and some may need a longer-term halfway house or recovery home, like Delancey Street.

I have had the honor of living inside of Keystone Treatment Center for over 30 years. We currently have 120 inpatients, 60 outpatients, and 212 staff. We have a heroic staff of professionals who never give up.

You are reading this book because you are interested in working with addicts. Congratulations! You can be proud of yourself, because addiction treatment is effective and fun. You belong in one of the most rewarding professions in the world. In addition, with counseling, you will watch your clients change from being at death's door to being happy, joyous, and free. Treating alcoholics and addicts, you will be working with some of the most caring and dedicated professionals in the world. You will save lives, change the world, and have loads of fun. Because of who you are and what you do, you have my greatest respect. I hope this manual, developed by thousands of treatment programs and professionals in the world, will benefit you in your work.

—Robert R. Perkinson

Chapter 1

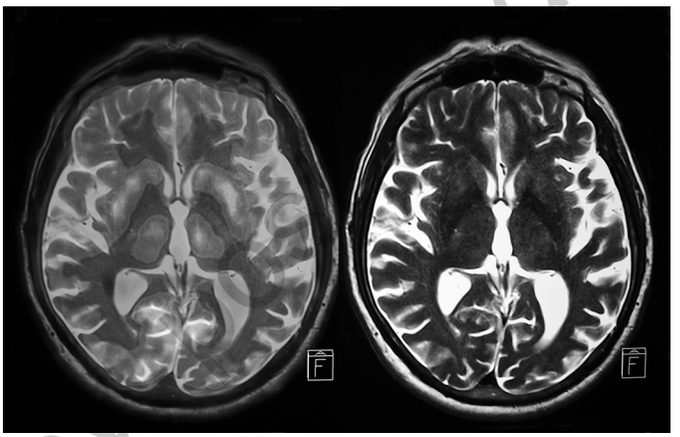
First Contact

iStockPhoto/alvarez

Someone you know and love is dying of addiction. No one, not even the addict, knows the extent of the disease that is poisoning this person's body. More than half of Americans drink alcohol, and many of them innocently fall victim to this silent killer. Addicts are good people with a bad disease. One hundred years ago, doctors couldn't see anything wrong with alcoholics, so they turned them over to the criminal justice system. In the last 20 years, with the advent of imaging techniques, we have learned to recognize addiction as a genetic brain disease. An addicted brain is hijacked by the addiction. Craving gets worse throughout the history of a person's addiction, but because of a genetic feedback loop, the pleasure caused by the addiction lessens. So, in time, the addict can't get high and can't get clean. The brain needs to make sense of what makes no sense, so the addict needs many unconscious distortions of reality to make life livable. These defense mechanisms are many, but the main ones are minimization (making the problem seem smaller than it is), rationalization (a good excuse for the problem), and denial (an angry refusal to see the truth). Addicts live their lives deeply alone and immersed in these self-told lies. They do not know what the truth is. They are living in a world of carefully constructed self-betrayal: "I am fine. I can stop anytime I want. I do not drink or use any more than my friends

drink." "Everybody loves to gamble. It is so much fun, and I win." "I was born to use speed." At times, the addicts want to cut down or stop and they try, but they always fail—repeatedly, they fail. Addicts live in world full of self-hatred and shame. They do not want anyone to know the terrible truth. They put on a false front of being fine. You might suspect something is wrong, and you would be right, but there seems to be little you can do to help an addict see the truth. Most addicts die of their addiction. Ninety-five percent of untreated alcoholics die of alcoholism an average of 26 years too early. The death certificate might read heart disease, cancer, or something else to protect the family, but the real reason is addiction.

Addiction is more than a behavior problem. Repeated drug use causes long-lasting changes in the brain, so the addict loses voluntary control. The prefrontal lobe of the brain where we make decisions, plan, organize, reason, and resist primitive impulses goes offline. Clients are obsessed with doing what they hate doing. They try to stop many times, but they can't. The addiction is the only way they know how to feel more normal. Their brain is cut off from the truth. Not to use causes withdrawal, which causes craving that is too painful to endure. Craving is not like wanting. You might like chocolate a lot, but craving is pacing the floor at 3 in the morning while saying to yourself, "Just one more time." The addicted brain adapts to the point that the addict cannot get high or get sober. This is when addicts feel hopeless, helpless, and powerless, and their lives are unmanageable. This is when many of them commit suicide or come in for treatment.



iStockPhoto/semnic

In the United States, 51.1% of the population drinks alcohol, and a little less than a third of these individuals will have a substance use disorder in their lifetime Substance Abuse and Mental Health Services Administration [https://www.samhsa.gov].

Almost 1 million Americans die of substance use disorder annually. This does not count the people who die of diabetes, coronary artery disease, and cancer caused by drinking, smoking, poor eating, and lack of exercise. Heavy drinking or drug use con- tributes to illnesses in each of the top three causes of death: heart disease, cancer, and stroke. At least 13.8 million Americans develop problems associated with drinking. Over many years of following alcohol and drug problems, studies have found that 78% of high school seniors have tried alcohol. Fifty-three percent have tried illegal drugs. Fifty-seven percent have tried cigarettes, and 14% are current smokers. Addiction is one of the most horrible plagues to attack humans. According to the National Institute on Drug Abuse (NIDA, 2022).

- 480,000 die of abuse of tobacco products.
- 178,000 die of alcohol abuse.
- 111,000 die of drug overdose.
- 43,000 die of injury from automobile accidents.
- 48,000 die of violence by firearms.

- 49,000 die of suicide. (Drug Policy Facts, 2022)

Treatment Works

Some addicts will quit on their own by making a highly motivated personal choice, then working hard at recovery, usually with multiple attempts at quitting and periods of relapse and reevaluation. Most of the people who quit on their own have learned about treatment and recovery through someone who is in recovery, a health care professional, or a friend. These people decide that the negative consequences of continued use outweigh the rewards. They go through the same motivational steps that a client needs to take in treatment (DiClemente, 2006b). Other addicts cannot seem to quit on their own and they need treatment. We know from many years of scientific experiments that addiction treatment works. For every dollar spent on treatment, the economy saves $7 in health care and costs to society. Most clients who work on a program of recovery stay clean and sober. To get clean, clients must come out of hiding and use their journey to help others. By sharing our experience, strength, and hope, addicts in recovery give other people reasons to get clean. Working the program means getting honest, going to recovery group meetings and making conscious contact with a higher power of their own understanding (Johnston et al., 2008; McLellan, 2006).

Your first meeting with a client might be accidental, or it might be by appointment. During the interview, if you look and listen carefully—you will sense something is wrong with this person, but you do not know what it is. You have a clinical thermometer inside of you that you will learn to trust over time. This is more than intuition; it is a gift. The skill is to watch the client so carefully and listen so intensely that you pick up cues that others miss. Clients like this might look depressed and anxious. Their faces may be red and swollen, their eyes watery and red, or they may be markedly thin with scabs caused by "meth bugs." They might have a fine hand tremor or have difficulty sitting still. Sometimes a client's head hangs in depression that looks like shame. Something is wrong, and it will nag at you. That clinical thermometer inside of you feels uncomfortable, and you do not like it.

If you are reading this manual, you have probably been a natural-born healer all of your life. When you were a little kid, you cared more about puppies and kittens than others did. People in school talked to you and told you secrets when they would not talk to anyone else. People recognize a healer when they see one.

There is another side of you that is very different. It has been in trouble with clients like this before. Sometimes being a healer is not good. Sometimes you have to tell people the truth when they do not want to hear it. They can rebel against you and fight. You have learned that sometimes it is best to let the truth go—or worse, lie to yourself and your clients and let them go. You hate that part of yourself, but you have learned how to live with it. After all, you live in a world full of litigation and managed care. Fear has overcome your best judgment many times.

And there is that client sitting in your office, crying out for the healer in you. Clients desperately need someone to tell them the truth. This time, if you let the problem go, if you take the easy way out, the client may die. Addiction is like brain cancer. To let this client out of your office without confronting the truth is to be responsible for the client's death.

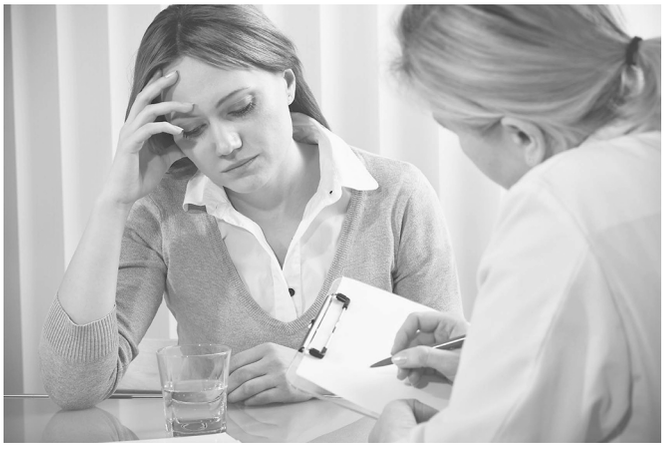
Yet you have confronted drug addicts before. Addicts seem to have two sides. One knows they are in trouble while the other knows they can continue the addiction safely. You and your client are in a life-or-death battle with the truth. The trick is to help the client win. You are up against a great enemy. Alcoholics Anonymous (AA, 2001) says this illness is "cunning, baffling and powerful" (pp. 58–59).

The battle lines are drawn. The illness inside of the client is confident of victory. It thinks that you will take the easy way out. You will handle the acute problem and let the client go home. You will not ask the questions that could lead to the truth. That would be too much trouble; besides, you are too busy.

The enemy does not know that you are a healer. You will not lie, and you will not let the addict go home to die. You are going to fight. This is who you are, and it is who you will always be.

The Motivational Interview

So you decide to take action. Either you do this yourself, or you call in an addiction professional to do it for you. You suspect your client is addicted. Your client does not even want to know the reason because to know the truth confronts the addict with change. Your job is to go with the client toward the truth. It does no good to go against such clients' idea of themselves. Arguing with them will not work because addicts are expert at giving every excuse in the world for abnormal behavior. If you argue, they will win because they will leave your office convinced you are a bad person. Walk with the client toward the truth.



iStockPhoto/AlexRaths

Listen and seek out ambivalence about the negative consequences of continuing the addictive behavior. This is client-centered counseling, not self-centered counseling. You must listen so you can step into your clients' world and connect with that gentle voice of reason inside of them. That healthy voice is there, and your job is to connect with it, empathize with it, and pull for more. The other voice in clients' heads says something else is to blame. They might have another problem, but it has nothing to do with addiction.

As a professional, you are used to your clients being honest with you, but this one is going to lie. The client is not a bad person; the client is a good person with a bad disease. The disease of addiction lives in and grows in the self-told lie. Clients like this must lie to themselves and believe the lie, or the illness cannot continue. These clients will have a long list of excuses for their behavior:

My spouse has a problem.

The police have a problem.

The school has a problem.

My boyfriend has a problem.

I have a physical problem.

I am depressed.

I am anxious.

I have a stomachache.

I cannot sleep.

The excuses go on and on, and they might confuse you if you are caught up in them. They are all part of a tangled web of deceit. Remember, your job is to walk with the client toward the truth, not against the client toward the truth. You are going to spend most of your time agreeing with the client. When the client is honest, you are going to agree. When the client is dishonest, you are going to probe for the truth. Look at it this way: If the client is listening to you, you can work. If the client is not listening to you, anything you say is useless.

Watch the client's nonverbal behavior very carefully. You are a healer, and you have the gift of supersensitivity. Your intuition will tell you whether the client is going with you or resisting. When the client goes with you, you feel peace. When the client goes against you, you feel uncomfortable. When the client is ready, you will educate the client about the disease. This is a gentle process, and it takes time. If you are in a hurry, this is not going to work.

The client has been using the addiction for a long time to relieve pain. All addictions tell the brain, "Good choice!" All organisms have a way of finding their way in a complicated environment. They learn which foods are good and which are bad. They find the best way through the jungle. They learn

what is safe and what is dangerous. We learn these things deep in the reptilian brain. What is good is remembered as if it is very good, after one experience. The addiction has been good to this client for many years, but now it is destructive. The very thing that gave the client joy now gives pain. This process fools the client. Remember, the addiction has always said, "Good choice!" So how can it be a bad choice? You are fighting with the client's basic understanding of the world, and the client will be convinced that you are wrong. You must help the client see that the addiction is no longer a good choice, it is a deadly choice. The addict cannot see this alone, but AA has an old saying: "What we cannot do alone, we can do together." The client cannot discover the truth without your help. You must guide clients like this toward a decision they find impossible. You need to help these clients see that they need to stop the addictive behavior.

What you are looking for is the truth. The client will rarely tell you accurate symptoms. You have to look for signs of the disease. Symptoms are what the client reports. Signs are what you see. You will continue to investigate—testing; smelling the air; ordering laboratory studies; and, if you get a release, talking to family, friends, court workers, school personnel, and anyone else who can help you uncover the truth.

Your client cannot tell you the truth because the client does not know the truth. Addiction hijacks a client's thinking, a web of self-deception. Remember, you are the healer. You care for your clients even if they hate themselves. You are going to love them even though they are being deceptive. You are going to help them even though they do not understand what you are doing.

How to Develop the Therapeutic Alliance

From the first contact, your client is learning some important things about you. You are friendly. You are on the client's side. You are not going to beat up, shame, or blame your client. You answer any questions. You are honest, and you hold nothing back. You discuss every option in detail. You are committed to do what is best for the client. You provide the information, and the client makes the decisions. The client sees you as a concerned professional. You are asking questions no one else has asked. This leads the client to believe you are a skilled professional. In time, the client begins to hope that you can help. The therapeutic alliance is built from an initial foundation of love, trust, and commitment.

You show these clients that they do not have to feel alone. Neither of you can recover alone. Both of you are needed in cooperation with each other to solve the problem. These clients know things that you do not know. They know themselves better than anyone else does, and they need to learn how to share their life with you. Likewise, you have knowledge that the clients do not have. You know the tools of recovery.

Your clients must trust you. To establish this trust, you must be honest and consistent. You must prove to your clients, repeatedly, that you are going to be actively involved in their individual growth. You are not going to argue or shame your clients; you are going to try to understand them. When you say you are going to do something, you do it. When you make a promise, you keep it. You never try to get something from a client without using the truth. You never manipulate, even to get something good. The first time a client catches you in a lie, even a small one, your alliance is weakened.

If you work in a treatment facility or group practice, your clients must learn that your staff works as a team. You can share with the whole team what a client tells you— even in confidence. Some clients will occasionally test this. They will tell you that they have something to share, but that it can only be shared with you. They want you to keep it secret. Many early professionals fall into this trap. The truth is that all facts are friendly and all information is vital to recovery. You must explain to your clients that if they feel too uncomfortable sharing certain information with the group, they should keep it secret for the time being. Maybe they can share this information later when they feel more comfortable.

Your clients must understand that you are committed to their recovery, but you cannot recover for them. You cannot do the work by yourself. You must work together, cooperatively. You can only teach the tools of recovery. The clients must use the tools to stay sober.

How to Do a Motivational Interview

Read *Motivational Interviewing*, 4th Edition by Williiam R. Miller and Stephen Rollnick 2023. In the first interview, you begin to motivate clients to see the truth about their problem. Questions about alcohol and other drug use are most appropriately asked as a part of the history of personal habits, such as use of tobacco products and caffeine. Questions should be asked candidly and in a nonjudgmental manner to avoid defensiveness. Remember that this is client-centered interviewing, not professional-centered, and the interview should include the following elements (with the client being free of alcohol at the time of the screening) (DiClemente, 2006a; Prochaska, 2003, 2019):

- Offer empathic, objective feedback of data.
- Work with ambivalence.
- Meet the client's expectations.
- Assess the client's readiness for change.
- Assess barriers and strengths significant to recovery efforts.
- Reinterpret the client's experiences in light of the current problem.
- Negotiate a follow-up plan.
- Provide hope.

Example of a Motivational Interview

Professional: Hello, Frank, I am [your name]. Why did you come in to see me today?
Client: My wife wanted me to talk to you.
Professional: Why did she want that?
Client: I don't know.
Professional: I talked to your wife on the phone yesterday, and she said she was concerned about your drinking.
Client: She is always concerned about something. Her father was an alcoholic, so she thinks everyone drinks too much. [The client looks irritated.]
Professional: Sounds like things are not going well at home? [The professional mirrors the client's feelings and facial expression. When you mirror people's expression, you validate their worldview.]
Client: I don't know. It is just that she gets all worked up about everything.
Professional: Your wife said you have been drinking heavily every day. She is afraid for you.
Client: I work hard, and I like to come home and relax with a few beers. Is anything wrong with that? [The client is obviously irritated with coming to the interview. So far, the client is saying, "My wife has a lot of problems."]
Professional: There's nothing wrong with relaxing. How do you relax? [The professional goes with the client's point of view.]
Client: I have a couple of beers. So what?
Professional: Your wife says you have been drinking a 12-pack a day.
Client: It's not that much.
Professional: Are you drinking more than a couple of beers a day? [The professional is gently pulling for the truth.]
Client: Maybe a little more.
Professional: Is it around 12?
Client: I work hard, and I deserve to relax. [The client is resisting, and the professional backs off a little. It is important to keep the client's ears open. Be empathic, tender, and understanding. Try to see the problem from the client's point of view. Once you enter the client's world and understand that point of view, you will get clues about what will motivate the client to change. This client is mad at his wife and needs some help with that, but what is his real problem?]

Professional: I like to relax after a hard day, too. Your wife sounds afraid for you. What is frightening her?

Client: My wife just sits around all day and watches television while I am working my tail off.

Professional: So you really need to relax when you come home. Particularly if you feel like you are pulling the load all by yourself?

Client: Yeah, she sits around and thinks about things to argue with me about.

Professional: Do you think your wife loves you? [This is pulling the client toward the truth. Why is his wife worried about him?]

Client: Well, yeah, I think she does. [The client visibly softens.]

Professional: It is great to have a wife who loves you. Sounds like you are a lucky man. [The professional reinterprets the client's experience in light of the alcohol problem.]

Client: But I am not drinking too much. I am just drinking a few beers.

Professional: You said it was 12. [The professional reminds the client what he said earlier to cement the fact.] What is the most beer you have ever drunk in a full day?

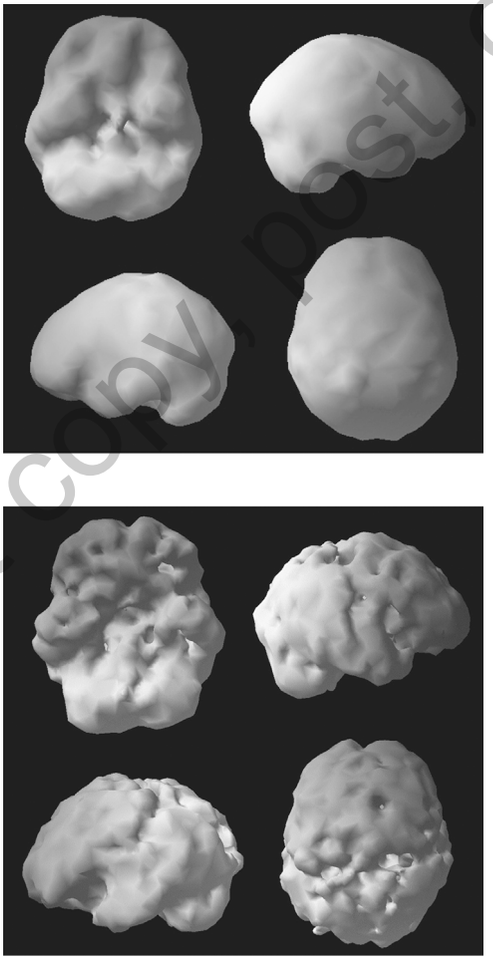
Client: Oh, I do not know.

Professional: Give me a guess.

Client: Well, on the weekends I can drink up to a case if I am watching a ball game.

Professional: That is a lot of beer. [The professional determines the client is an alcoholic but does not jump the gun; the client is not ready yet.]

Client: Not if I am drinking all day.



Amen Clinics alcohol abuse brain.
More substance abuse pictures are available at www.brainplace.com.

Professional: Did you know that if you drink more than three beers a day, more than three times a week, your organs are dying? Alcohol is a poison. It kills the brain, heart, kidneys—every cell in the body. If you are drinking more than three drinks per day, you are literally killing yourself. That might be why your wife is worried about you. [The professional believes the client's ears are open, so it is time to try a little education.]
I want to show you two single photon emission computed tomography, or SPECT, scans: pictures of a healthy brain and a brain of someone who abuses alcohol.

The client quickly looks away. He does not want to see a picture of his brain dying. However, he has seen it, and he cannot make that fact go away. He has to rapidly deny the professional's statements and the pictures or admit that he has a problem. A part of him knows he has a drinking problem, and now it is confirmed. It is not only his wife's opinion, but now a picture and a professional's opinion confirm the diagnosis. He has not admitted it yet, but he knows he has been drinking too much.

The professional begins negotiating and assessing the client's readiness for change.

Professional: Frank, have you ever worried about your drinking?

Client: No, honestly, I have not. [This comes across as real. When clients' words and affect match, they are probably telling the truth. Most addicts think their addictive behavior is normal.]

Professional: Maybe that is because you did not understand how much you could drink safely. If alcohol is killing you, don't you want to know?

Client: Well, sure.

Professional: Looking at these pictures, and thinking about how much you have been drinking, do you think you have been drinking too much? [The professional is taking the biggest chance of all.]

Client: Maybe? [A maybe is very close to a yes. The client has admitted that he drinks too much. That moves him from the precontemplation phase to the contemplation phase. For the first time, he is considering the negative consequences of his drinking. This is a huge step toward recovery.]

Professional: Did you know that 95% of untreated alcoholics die of alcoholism? They die 26 years earlier than they would otherwise?

The client says nothing.

Professional: Knowing what you know now, would you like to learn how to drink less or even stop drinking entirely? [The professional is negotiating how far the client is willing to go to get better.]

Client: I didn't know it was that bad. [Now the client is contemplating change. We are on the road to recovery. With a gentle approach, the professional can negotiate and listen to the client's life from his perspective, allowing the client to move toward the truth.]

Professional: Why don't we meet again with your wife and talk about what we can do to help you two feel better? Would that be all right with you?

Client: If you think it will help.

Professional: Most people who try to get better get better.

Client: Okay, let's do it. [A commitment to change has occurred. Now the client realizes he has a problem and is making plans to take action. These are the first giant steps toward recovery.]

Questions to Ask the Adult Client

The National Institute on Alcohol Abuse and Alcoholism (NIAAA, 2020) has developed the following low-risk drinking guidelines:

Men should drink no more than two drinks a day and no more than four drinks on a single occasion.

Women and clients over 65 years of age should drink no more than one drink a day and no more than three drinks on a single occasion.

Pregnant clients and those with medical problems complicated by alcohol use should abstain completely (U.S. Department of Health and Human Services, 2005).

We could also add that no person should ingest an illegal substance. If people cannot stop something they want to stop, they might have an addiction.

At some time during the first interview, certain questions need to be asked to assess addiction problems. They have to be answered honestly to give you a clear picture of the extent of the problem. Most clients who have addiction problems will be evasive or deny their addiction, so the questions should be asked of the client, as well as a reliable family member.

The following questions and flags are taken from the American Society of Addiction Medicine (ASAM; see www.asam.org):

1. Have you ever tried to cut down on your drinking?
2. Have you ever felt annoyed when someone talked to you about your drinking?
3. Have you ever felt bad or guilty about your drinking?
4. Have you ever had a drink in the morning to settle yourself down?
5. Has your use of alcohol or drugs ever caused you family problems?
6. Has a physician ever told you to cut down on or quit use of alcohol?
7. When drinking/using drugs, have you ever had memory loss or a blackout?

Similar questions could be asked about gambling or any other addictive behavior. If clients answer yes to any one of these questions, it is a red flag for addiction. If they answer yes to two questions, it is probably addiction. Make sure you do not just ask the client. Ask family members, friends, and anyone else who can give you collateral information. (See Boxes 1.1 through 1.5.)

Box 1.1 Client History/Behavioral Observation Red Flags for Addiction

Tremor/perspiring/tachycardia
Evidence of current intoxication
Prescription drug-seeking behavior
Frequent falls; unexplained bruises
Diabetes-elevated blood pressure; ulcers nonresponsive to treatment
Frequent hospitalizations
Gunshot/knife wound
Suicide talk/attempt; depression
Pregnancy (screen all)

Box 1.2 Laboratory Red Flags for Adult Alcohol/Drug Abuse

Mean corpuscular volume (MCV)—Over 95
Mean corpuscular hemoglobin (MCH)—High
Gamma-glutamyl transferase (GGT)—High
Serum glutamic-oxaloacetic transaminase (SGOT)—High
Bilirubin—High

Triglycerides—High
Anemia
Positive urinalysis for alcohol

Box 1.3 Client History/Behavioral Observation Red Flags for Adolescent Alcohol Abuse

Physical injuries: motor vehicle accident (MVA), gunshot/knife wound, unexplained or repeated injuries
Evidence of current use (e.g., dilated/pinpoint pupils, tremors, perspiring, tachycardia, slurred/rapid speech)
Persistent cough (cigarette smoking is a risk factor)
Engages in risky behavior (e.g., unprotected sex)
Marked fall in academic/extracurricular performance
Suicide talk/attempt; depression
Sexually transmitted diseases
Staphylococcus infection on face, arms, legs
Unexplained weight loss
Pregnancy (screen all)

Box 1.4 Laboratory Red Flags for Adolescent Alcohol/Drug Abuse

Positive urinalysis for alcohol/illicit drugs
Hepatitis A-B-C
GGT—High
SGOT—High
Bilirubin—High

Box 1.5 Interview Questions for Suspected Addiction Among Adolescents

Questions to Ask the Adolescent Client

1. When did you first use alcohol on your own, away from family/caregivers?
2. How often do you use alcohol or drugs? When was your last use?
3. How often have you been drunk or high?
4. Has your alcohol or drug use caused you problems with your friendships, family, school, community, etc.? Have your grades slipped?
5. Have you had problems with the law?
6. Have you ever tried to quit/cut down? What happened?

7. Are you concerned about your alcohol or drug use?

Questions to Ask the Parent/Caregiver

1. Do you know/suspect your child is using alcohol/other drugs?
2. Has your child's behavior changed significantly in the past 6 months (e.g., sneaky, secretive, isolated, assaultive, aggressive, hostile)?
3. Has the school, community, or legal system talked to you about your child?
4. Has there been a marked fall in academic/extracurricular performance?
5. Do you believe an alcohol/other drug assessment might be helpful?

What to Do If There Are One or More Red Flags

Once you have one or more red flags, you have several important actions to take:

1. Advise the client of the risk.
2. Advise abstinence or moderation. Men should be advised to drink no more than three drinks a day no more than three days a week. Women should be advised to drink no more than two drinks a day no more than three days a week. More drinking than this will result in disease. This is a harm reduction approach where you teach a client how to drink responsibly. This would not be appropriate for someone who has a serious drinking problem.
3. Advise against any illegal drug use.
4. Schedule a follow-up visit to monitor progress.

Natural History of Addiction

Addiction can begin at any age, and it often occurs in individuals with no history of psychological problems. When the addictive substance is readily available, inexpensive, and rapid acting, the incidence of use increases. Whenever the individual is ignorant of healthy alcohol or drug use, is susceptible to heavily using peers, or has a high genetic predisposition to abuse or to antisocial personality disorder, abuse may increase. This is also true if the client is poorly socialized into the culture or in pain, or if the culture makes a substance the recreational drug of choice.

Risk Factors

Risk factor 1: Substance or behavior is readily available.

Risk factor 2: Substance use or addictive behavior is cheap.

Risk factor 3: The addictive chemicals reach the brain quickly.

Risk factor 4: Addiction is a pain reliever.

Risk factor 5: Addiction is more common in certain occupations (e.g., bartending).

Risk factor 6: Addiction is prevalent in the peer group.

Risk factor 7: Addiction is preferred in deviant subcultures.

Risk factor 8: Social instability is found.

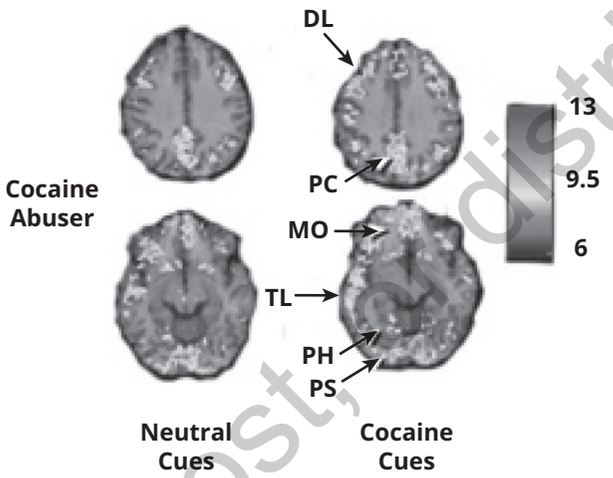
Risk factor 9: There is a genetic predisposition.

Risk factor 10: The family is dysfunctional.

Risk factor 11: Comorbid psychiatric disorders are present. (Vaillant, 2003)

How to Diagnose an Addiction Problem

In the assessment, you must determine if the client fits into your range of experience and care. Do you have the ability to deal with this client's problem, or do you need to refer the client to someone else? Does the client have a problem with chemicals or addictive behavior? Is the client motivated to get better? Does the client have the resources necessary for treatment? Is the individual well enough to see you? For the most part, you will start by asking yourself certain basic questions: Does this person have signs and symptoms of addiction? Does the client need treatment? Is the client motivated for treatment? What kind of treatment does the client need? For the benefit of third-party payers, it is important to use assessment instruments to document (1) diagnosis, (2) severity of addiction, and (3) motivation and rehabilitation potential. Third-party reviewers will often have more faith in a test battery than your clinical opinion.



From "Activation of Memory Circuits During Cue- Elicited Cocaine Craving," by S. Grant et al., 1996, Proceedings of the National Academy of Sciences, USA, 93, pp. 12040–12045.

Several companies sell inexpensive, disposable Breathalyzers and drug screening instruments. There are also hair screens gamma-glutamyl transferase (GGT) alcohol screen that will test for alcohol ingestion for 80 hours after use; and ankle bracelets that measure alcohol in the sweat of probationers 24 hours a day, 7 days a week. Order a number of these tests, and have them readily available for assessment, treatment, and continued care monitoring. Positive tests are only suggestive of drug and alcohol use, so before any legal or workplace action is taken, the test should be confirmed by both an approved immunoassay and gas chromatography/mass spectrometry, which can be administered and analyzed by a health care provider.

Two quick screening tests for alcoholism have been developed: the Short Michigan Alcoholism Screening Test (SMAST), provided in Appendix 1 (Selzer et al., 1975), and the CAGE questionnaire (Ewing, 1984; Selzer et al., 1975). The SMAST, as well as the more extensive Michigan Alcoholism Screening Test (MAST), has greater than 90% sensitivity to detect alcoholism. It can be administered to either the client or the spouse. The World Health Organization collaborative project developed the alcohol use disorders identification test (AUDIT) (Appendix 2) as a tool to detect persons with harmful alcohol consumption around the world. The screen is in the public domain and comes in most languages (Saunders et al, 1993).

The Substance Abuse Subtle Screening Inventory, or SASSI (www.sassi.com), was developed to screen clients when defensive and in denial. The SASSI measures defensiveness and the subtle attributes that are common in chemically dependent persons. It is a difficult test to fake, unlike the SMAST or the CAGE. Clients can complete the SASSI in 10 to 15 minutes, and it takes 1 or 2 minutes to score. It identifies accurately 98% of clients who need residential treatment, 90% of nonusers, and 87% of early-stage abusers. This is a good test for those clients whose diagnosis you are still unsure about after your first few interviews—clients who continue to be evasive (Miller, 1985).

The Addiction Severity Index (ASI) and the Teen Addiction Severity Index (T-ASI) are widely used, structured interviews for adults and teens and are designed to provide important information about the severity of the client's substance abuse problem. These instruments assess seven dimensions typically of concern in addiction, including medical status, employment/support status, drug/alcohol use, legal status, family history, family/social relationships, and psychiatric status. The tests are administrated by a trained technician. The ASI is an excellent tool for delineating the client's case management needs (Kaminer et al., 1991; McLellan et al., 1980).

The Adolescent Alcohol Involvement Scale (AAIS) is a 14-item, self-report questionnaire that takes about 15 minutes to administer. It evaluates the type and frequency of drinking, the last drinking episode, reasons for the onset of drinking behavior, drinking context, short- and long-term effects of drinking, perceptions about drinking, and how others perceive one's drinking (Mayer & Filstead, 1979; Mee-Lee, 1988; Mee-Lee et al., 1992). The Recovery Attitude and Treatment Evaluator–Clinical Evaluation (RAATE-CE) is a 35-item scale that assesses treatment readiness and examines client awareness of problems; behavioral intent to change; capacity to anticipate future treatment needs; and medical, psychiatric, or environmental complications. The RAATE-CE determines the client's level of acceptance and readiness to engage in treatment and targets impediments to change. Adolescents prefer the CRAFFT (Brooks et al., 2019; see Appendix 3), which was developed to screen adolescents for alcohol and other drug use. Compared to being interviewed by a professional, adolescents say they are more likely to answer correctly in a self-report (Knight et al., 2019).

How to Intervene

- No problem usage: If the client is at low risk for addiction, you should provide positive prevention messages that support the client's continued positive lifestyle. Clients with a positive family history of addiction should be warned about their increased vulnerability to addiction and the need for vigilance.
- Problem with addiction: The client who has had recurrent problems due to addiction should be encouraged to abstain from, or at least reduce, the addictive behavior. A client such as this should be strongly encouraged to abstain from using all illegal drugs and addictive behaviors. You should discuss the biopsychosocial complications of addiction (see Appendix 4). Clients who are encouraged to cut down on their addictive behavior should be provided with the brochure from NIAAA (see Appendix 5). It is essential that these clients be reassessed frequently to monitor their ability to comply with your recommended limits.
- Addiction: Addicts need to have their diagnoses carefully discussed with them and a treatment plan negotiated. You need to be empathic and address the problems that seem to be caused by or made worse by the client's continued addictive behavior. These clients need to hear that this illness is not their fault and that there is excellent treatment available that will help them to stay clean and sober. These clients need to hear that only 4% of addicts can quit on their own over the course of a year, but 50% can quit over the course of a year if they go through treatment. Seventy percent can quit over the course of a year if they also attend recovery group meetings regularly, and 90% can stay sober if they go through treatment, attend meetings, and go to continuing care once a week for a year (Hoffmann, 1991, 1994; Hoffman & Harrison, 1987). These clients should also be told about the potential benefits of naltrexone, acamprosate, methadone, and butyrophenone maintenance and disulfiram when used along with formal treatment programs. Carefully discuss the ASAM client placement criteria to help you and your clients negotiate the best treatment plan possible to bring the addiction under control. (See Box 1.6.) The following questions may be helpful in negotiating a treatment plan:

1. Is the client a danger to self or others (suicidal and homicidal ideation, impaired judgment while intoxicated, history of delirium tremens)?
2. Has the client ever been able to stay clean for 3 or more days?

3. What happened when the client stopped the addictive behavior in the past? How serious were the withdrawal symptoms?
4. Has the client ever been able to stay completely abstinent for long periods?
5. Why did previous attempts at staying clean fail?
6. How does the family understand alcoholism and its treatment?

Box 1.6 Positive and Negative Prognostic Factors

Positive Prognostic Factors

- Lack of physical dependence
- Intact family
- Stable job
- Presence of prior treatment (prognosis improves for clients who have been through one to three treatments)
- Absence of psychiatric disease
- Presence of long-term monitoring arrangement, such as a Physician Effectiveness Program or Employee Assistance Program

Negative Prognostic Factors

- More severe, advanced dependency
- Presence of intoxication at office visits
- Loss of job
- Loss of home
- Loss of family
- Multiple, unsuccessful attempts at treatment
- Severe physiological dependence
- Coexisting psychiatric disorders
- Absence of long-term monitoring (Conigliaro, Reyes, Parran, & Schultz, 2003)

How to Assess Motivation

Constantly ask yourself about the client's stage of motivation and introduce appropriate motivating strategies to move the client up a motivational level. This book will give you many ways of doing this. No client is alike, so you must be creative in helping all clients to see the inaccuracies in their thinking and move away from the lies toward the truth.

The Stages of Motivation

Precontemplation

The individual is not intending to act in regard to the substance abuse problem in the near future.

Tasks: Try to increase awareness of the need to change; increase concern about the current pattern of behavior.

Goal: Make a serious consideration of change.

Contemplation

The individual examines the current positive and negative effects of drinking behavior and the potential for change in a risk–reward analysis.

Tasks: Analyze the pros and cons of the current behavior and of the costs and benefits of change.

Goal: Write a list of the positive and negative consequences of continued use.

Preparation

The individual makes a commitment to take action to change and develops a plan for change.

Tasks: Increase commitment and create a change plan.

Goal: Create an action plan to be implemented in the near future.

Action

The individual implements the plan and takes steps to change and begins new behavior patterns.

Tasks: Implement change and revise the plan as needed while sustaining commitment in the face of difficulty.

Goal: Develop a successful action for changing behavior and establish a new pattern of behavior for a significant period of time (3–6 months).

Maintenance

The new behavior is sustained for an extended period of time and is consolidated into the lifestyle of the individual.

Tasks: Sustain change over time and integrate the behavior into everyday life.

Goal: Sustain long-term change of the old behavior and establish a new pattern of behavior. (DiClemente, 2006a; Prochaska, 2019; Prochaska & DiClemente, 1983; Prochaska et al., 1992; Prochaska et al., 1994)

Motivating Strategies

Clients at different stages of motivation will need different motivating strategies to keep them moving toward recovery, and these stages are not static. Clients can shift back and forth through the stages for various reasons or spontaneously. Clients in the precontemplation stage underestimate the benefits of change and overestimate its cost. They are not aware that they are making mistakes in judgment, and they believe they are right. Environmental events can trigger a person to move up to the contemplation stage. An arrest, a spouse threatening to leave, or a formal intervention can all increase motivation to change. Persons in the precontemplation stage cannot be treated as if they are in the action stage. If they are pressured to take action, they will terminate treatment (Prochaska, 2003, 2019).

Client in the preparation stage have a plan of action to cut down on or quit their addictive behavior in the near future. Such a client is ready for input from professionals, counselors, or self-help books. The client should be recruited and motivated for action. Action is the client changing behavior to cut down or quit the addiction. This is the client who has entered early recovery and is involved in treatment (DiClemente, 2006a).

In the maintenance stage, clients are still changing their behavior to be better and are working to prevent relapse. A client who relapses is not well prepared for the prolonged effort it takes to stay clean and sober. All clients need to be followed in long-term containing care because addiction is fraught with relapse and clients need encouragement and support for years to stay in recovery. Addicts typically do not have the skills to work a program in early recovery. This takes time, commitment, and discipline, constantly trying to raise the client's consciousness about the causes, consequences, and

possible treatments for a particular problem. Defense mechanisms, minimization, rationalization, and denial are unconscious and automatic. You must help the client raise the material from unconscious to conscious. Clients can make a better decision consciously than they can without automatically thinking about the consequences of their addictive behavior. Interventions that increase awareness include observation, confrontation, interpretation, feedback, and education, pointing out the need to reevaluate the environment and change behavior. Encourage your clients to reevaluate their self-image and explain how this is negatively affected by the addictive behavior. Encourage them to learn the new skills of being honest, helping others, and seeking a relationship with a higher power (DiClemente, 2006a).

In order to help motivate clients to progress from one stage to the next, it is necessary to know the principles and processes of change (DiClemente, 2006a; Prochaska, 2003, 2019; Prochaska & DiClemente, 1983; Prochaska et al., 1992; Prochaska et al., 1994).

The following process should be applied to clients in the precontemplation stage (see Box 1.7) (DiClemente, 2006a; Prochaska, 2003; Prochaska & DiClemente, 1983; Prochaska et al., 1994).

Helping relationships combine caring, openness, trust, and acceptance, as well as family and community support for change.

Box 1.7 Processes of Change for the Client in the Precontemplation Stage

1. Consciousness raising involves increasing the client's awareness of the causes, consequences, and responses to the alcohol problem.
2. Dramatic relief involves increasing the client's emotional arousal about one's current behavior and the relief that can come from changing.
3. Environmental reevaluation has the client assess the effects the alcohol problem has on one's social environment and how changing would affect that environment.
4. Self-reevaluation has the client assess his or her image of one's self free from alcohol problems.
5. Self-liberation involves the belief that one can change and the commitment and recommitment to act on that belief.
6. Counter-conditioning requires the learning of healthier behaviors that can substitute for drinking alcohol.
7. Contingency management involves the systematic use of reinforcers and punishments for taking steps in a particular direction.
8. Stimulus control involves modifying the environment to increase cues that promote healthy responses and decrease cues that lead to relapse.

Chapter 2

First Hours of Treatment

iStockPhoto/SDI Productions

The First Hours

The first thing that clients need when they come into treatment is a warm welcome. Most clients entering treatment feel demoralized and ashamed. They feel like the scum of the earth. You need to show them encouragement, support, and praise. Show them that they are people of worth, that they are important, and that they matter to others. Nothing gives this feeling better than a warm welcome. A warm welcome helps them to understand that they are entering a caring environment. They do not need to be afraid.

How to Greet Clients

You need to convey to clients that you understand how they feel and that you will do everything in your power to help them. When greeting a new client, it is as if you are welcoming a long-lost brother or

sister back into your family. This person is not different from you; this person is you. Treat the person the same way in which you would want to be treated. The more the client senses your goodwill and unconditional positive regard, the less alienated and frightened they will feel.

If you feel as though you can shake a client's hand, then do this. Make it a warm handshake. As you do these things, you are developing your therapeutic alliance, and you are giving your clients the most important thing that they need—acceptance.

The initial words you choose are important. Clients remember your words. Clients come back after years and describe their first few hours in treatment. They remember the exact things that people say. Because coming into treatment is a highly emotional experience, they seal these words inside their hearts. You want them to remember the good things. Think of it like this: These people have been living a life full of no love, no light, no beauty, and no truth. You are walking them toward a new life full of love, light, beauty, and truth. Life in the darkness is lonely and painful. As you welcome them home, clients should clearly see that they are entering a new world full of hope.

Example Greetings

Introduce yourself and say something like the following:

> "Welcome. You have made a very good choice. I am proud of you. This is a victory not only for you but for all of the people in the world that you will help recover."
>
> "This is a new start. Good going." [Give the thumbs-up sign.]
>
> "Please ask us if there is anything you need. We are going to take good care of you."
>
> "I know this was a difficult decision for you, but you will not be sorry. This is the beginning of a new life you have not even dreamed about."
>
> "Try everything in your power to stay in treatment. If you feel uncomfortable, tell one of the staff. We are here to give you the best treatment possible. You will feel better every day."

Notice how each of these statements welcomes the client and enhances the client's self-esteem. Welcome. You are a good person. You made a good choice. We are going to take good care of you.

Ask whether the client wants anything. How can you help? Nothing shows that you care better than to offer to get the client something small—juice, food, milk, or coffee. This shows that you care and, more importantly, that the client is worth caring for. You are giving the client new ideas. Treatment is not going to hurt. The staff is willing to respond to the client's needs. "This treatment thing might be OK," the client begins to think. "I just might be able to do this."

How to Handle Family Members

If the client comes into treatment with family members, then make sure to tour the facility with the family as a whole. This helps the client to make the transition between the family at home and the new family in treatment. When you have all the information that you need from family members, they should be encouraged to leave. Having them linger unnecessarily can be detrimental to the client's transition. Clients need to focus on themselves and orient themselves to treatment. Family members who cling are rare, but they do exist. These people need to be separated from the client and given reassurance that the client is in a safe place. Someone in the family program might be willing to talk to the family members to encourage them and answer any questions they might have. Remember that you are bonding with the client and the client's family members. You want them all to see you as someone they trust.

Beginning the Therapeutic Alliance

From the first contact, your clients are learning some important things about you. You are friendly. You are on their side. You are not going to hurt, shame, or blame them. This is a disease like cancer, hypertension, asthma, or diabetes. People should not be ashamed of being sick. No one wants to become addicted, just like no one wants to have cancer.

Freely answer any questions about treatment and the treatment center. Take new clients on a tour and introduce them to other clients. Be honest and hold nothing back. You provide the information,

and the clients make the decisions. They see you as a concerned professional. The clients begin to hope that you can help them. The therapeutic alliance is built from an initial foundation of love, trust, and commitment.

After your welcome and in your first interview after introducing yourself, ask the client to share their story. This shows the client is the expert in their life. They know themselves better than anyone. They will decide what they want to do and how they want to do it. Read the book *Motivational Interviewing* by William R. Miller and Stephen Rollnick (4th ed., 2023) from cover to cover.

1. Say, "Go back into your childhood as early as you think is important and tell me where things began to go wrong for you in your life. From that point, tell me the whole story including why you are here now." Be quiet and listen to the client's whole story.
2. After the story, ask, "What do you want to do here?" The client is the expert about their life. They know what is wrong and how to fix it. You can help them with this plan.
3. After they answer this question, ask, "Do you think you can do that?"
4. After you receive their answer, ask, "How can I help you? Can we make a treatment plan and walk it together?"

Give new clients the idea that you are going through treatment with them. They do not have to feel alone. Neither of you can do this alone. Both of you need to cooperate with each other. Clients know things that you do not know. They have knowledge that you do not have. They know themselves better than they know anybody, and they need to learn how to share themselves with you. Likewise, you know things that they do not know. You know the tools of recovery. You have to share these tools and help the clients to use them. This is a cooperative effort. It is as if you are on a wonderful journey together.

The Importance of Trust

Your clients must develop trust in you. To establish this trust, you must be consistent. You prove to the clients, repeatedly, that you are going to be actively involved in their growth. When you say that you are going to do something, you do it. When you make a promise, you keep it. You never try to get something from the clients without using the truth. You never manipulate, even to get something good. The first time your clients catch you in a lie—even a small one—your alliance will be weakened.

Clients must understand that you are committed to their recovery but that you cannot recover for them. You cannot do the work by yourself. You must work together cooperatively. You can only teach the tools of recovery. The clients have to use the tools to establish abstinence.

Example of an Initial Contact

Approach the client. Reach out and take the client's hand and say, "Hi, [client's name]." Use the client's first name. "I am [your name]. I am going to be your counselor. How are you doing?"

The client looks at the floor and then at the wall.

You know the importance of silence and wait. The client finally looks up. "I am OK," they say, "I guess."

"The first few days are going to be the hardest. After that, it is going to be a lot better. This is the beginning of recovery. Is there anything I can do for you right now to make you feel more comfortable?"

"I don't think so," the client says, looking relieved.

"If you feel uncomfortable, I want you to tell the nurse or one of the staff, OK? If you cannot find anyone else, come and see me. My door is always open to you. We want you to feel calm through withdrawal, not anxious or tense. Do not try to get through this by yourself. Let's help you. How you feel is important to us."

A therapeutic alliance is being established.

The client might never have experienced unconditional positive regard before. It might seem strange to the client. To many clients, it is unbelievable. They come into treatment with preconceived ideas about how treatment is going to go. Many think they are going to be punished. When they are greeted with

love and affection, it comes as a great surprise. Your words of support and concern are as soothing as a warm bath.

All chemically dependent clients, at some level, want to punish themselves. They feel guilty about what they have done, and they are waiting for the executioner. They expect to be treated poorly. When you treat them with respect, they ask themselves why people are treating them so nicely. Could it be that they are worth it?

Tell your clients that they are important. The staff cares about how they feel and what they want. You are here to help. You want to help. You are going to respond to the clients' needs. It might be tough for a while, but things are going to get better.

Dealing With Early Denial

The first few hours of treatment are a time not for harsh confrontation but for listening, supporting, and encouraging clients to share what they can share. The great healer in any treatment is love (treating others like you would want them to treat you), and love is action in truth. All clients come into treatment in denial. They have been dishonest with themselves and others. They are lying, and they will lie to you. Your job is to search for ambivalence and inconsistencies in their story that reveal the truth. As gently as possible, reflect what you hear. You do not want to hurt the clients or incur their wrath, but you must be dedicated to the truth. This program demands rigorous honesty.

Clients lie to themselves in many ways. They do not want to see the whole truth because the truth makes them feel guilty. They keep the uncomfortable feelings in control by deceiving themselves. They distort reality just enough to feel reasonably comfortable. They defend themselves against the truth with unconscious lies. "As long as we could stop using for a while, we thought we were all right. We looked at the stopping, not the using" (Narcotics Anonymous [NA], 1988, p. 3).

Clients minimize reality by thinking that their problems are not so bad. Then they rationalize by thinking that they have a good reason to use drugs or alcohol. Then they deny by stubbornly refusing to see their problems. Treatment is an endless search for truth.

Those who do not recover are people who cannot or will not completely give themselves to this simple program, usually those who are constitutionally incapable of being honest with themselves. There are such unfortunates. They are not at fault. They seem to have been born that way. They are naturally incapable of grasping and developing a manner of living that demands rigorous honesty (Alcoholics Anonymous [AA], 2001, p. 58).

Your job as an addiction counselor is to help the clients learn the truth, knowing that the truth will set them free from slavery to the lie.

How to Check for Organic Brain Dysfunction

Clients need to be checked for medical problems, particularly organic brain syndrome, as quickly as possible. Some clients coming into treatment are organically compromised and need immediate medical treatment to prevent further damage. Clients may be intoxicated, may be in withdrawal, or may have a serious vitamin deficiency called Wernicke's encephalopathy. They might need 100 milligrams of intramuscular thiamine to stop the death of brain cells. The physician will order the medications determined to be appropriate.

You should be familiar with how to check a client for these cognitive problems. The Cognitive Capacity Screening Examination (CCSE) and the Mini-Mental State Examination (MMSE) can be used, but the professional has to pay for each use. The CCSE is an excellent way of screening for organic brain problems (Jacobs et al., 1977), and the MMSE is a similar assessment test (Folstein et al., 1975). Each of these tests is a brief 10-minute assessment of how the brain is functioning. The test is simple and comes up with a score. If the client falls below the cutoff score, then inform medical professionals of the possible organic problems. If you notice anything unusual about how the client moves, acts, or speaks, then tell a physician or nurse. Always count on your medical staff or the client's family physician. They are more skilled at these examinations than you are.

The Initial Assessment

During the first few hours, you must determine whether clients fit into your program. Do they have a problem with chemicals? What is their level of motivation? Do they have the resources necessary for treatment? Are they well enough to move through your program? The criteria for admission are different for different facilities. For the most part, you will start by asking yourself certain basic questions about a client. Does this person have a problem with addiction? Does the client need treatment? Is this person motivated? What kind of treatment does the client need?

Referral

The counselor will need to establish and maintain relationships with civic groups, agencies, other professionals, governmental entities, and the general recovery community to ensure appropriate referrals, identify service gaps, and help address unmet needs. You will need to network and communicate with a large community resource base. You need to have knowledge and understand the functioning of these agencies:

- Advocacy groups
- Child welfare agencies
- Childcare facilities
- Civic groups and neighborhood organizations
- Criminal justice systems
- Crisis intervention programs
- Employment and vocational opportunities
- Faith-based organizations
- Governmental entities
- Health care systems
- Housing administrations
- Mutual and self-help groups
- Rehabilitation services

The counselor needs to have knowledge about community demographics, political and cultural systems, criteria for receiving community services and access to funding opportunities, state and federal legislative mandates and regulations, confidentiality rules and regulations, effective communication styles, and community resources for both affected children and other household members. If you decide to refer, you must advocate for the client by working with others in the community as a team. You need to respect interdisciplinary service delivery, respect the clients and the agency's services, collaborate and cooperate with respect, and appreciate strengths-based principles that emphasize client autonomy and skills development (Substance Abuse and Mental Health Services Administration [SAMHSA], 2006).

As the counselor, you need to constantly ask yourself about clients' stage of motivation and introduce appropriate motivating strategies to move the clients up to the next level. This manual will give you thousands of ways of doing this. No two clients are alike, so you must be creative in helping the clients to see the inaccuracies in their thinking and move them toward the truth. The precontemplation stage is where the individuals are not intending to take action with regard to their substance abuse problem in the near future. Contemplation is where the individuals intend to take action within the next 6 months. Preparation is where they intend to take action within the next month. Action is where they have made overt attempts to modify their lifestyles. Maintenance is where they are working a recovery plan and attempting to prevent relapse. If you can move the clients up to the next stage, then you can be sure

that treatment is working (Prochaska, 2019; Prochaska & DiClemente, 1983; Prochaska et al., 1992; Prochaska et al., 1994).

Clients at different stages of motivation will need different motivating strategies. In the precontemplation stage, clients underestimate the benefits of change and overestimate its cost. They remember the good things about addiction and forget the bad. They are not aware that they are making these mistakes in judgment and believe that they are right. Environmental events can trigger persons to move up to the contemplation stage. An arrest, a spouse threatening to leave, or an intervention can increase motivation to change.

Clients in the preparation stage have a plan of action to cut down or quit their addictive behavior. These clients are ready for input from their doctors, counselors, or self-help books and should be recruited and motivated for action. Action is where the clients are changing their behavior to cut down on or quit the addiction. These clients have entered early recovery and are actively involved in treatment.

In the maintenance stage, clients are still changing their behavior to be better and are working to prevent relapse. People who relapse are not well prepared for the prolonged effort needed to stay clean and sober. All clients need to be followed in continuing care because they need encouragement and support to stay in recovery. Addicts typically do not have the skills needed to work on a program in early recovery. This takes time, commitment, and discipline.

As the counselor, you constantly try to raise your clients' awareness about the causes, consequences, and possible treatments for a particular problem. Interventions that can increase awareness include observation, confrontation, interpretation, feedback, and action. You point out the need to reevaluate the environment and how to change behavior. Encourage the clients to reevaluate their self-images and how they are negatively affected by addictive behavior. Encourage the clients to learn the new skills of honesty, helping others, and seeking relationships with a higher power (Prochaska, 2019; Prochaska & DiClemente, 1983; Prochaska et al., 1992; Prochaska et al., 1994).

Screening for Chemical Dependency

Two quick screening tests for alcoholism have been developed: the Short Michigan Alcoholism Screening Test (SMAST, presented in Appendix 1) (Selzer et al., 1975) and the CAGE questionnaire (Ewing, 1984).

The Substance Abuse Subtle Screening Inventory (SASSI) was developed to screen clients when they are defensive and in denial. The SASSI measures defensiveness and the subtle attributes that are common in chemically dependent persons. It is a difficult test to fake, unlike the SMAST or the CAGE questionnaire. The SASSI gives clients the opportunity to answer honestly about their problems with chemicals, but it also measures their possible abuse using questions that do not pertain to chemicals (Creager, 1989; G. A. Miller, 1985). Clients can complete the SASSI in 10 to 15 minutes, and it takes only 1 or 2 minutes to score. It accurately identifies 98% of clients who need residential treatment, 90% of nonusers, and 87% of early-stage abusers (G. A. Miller, 1985).

The Addiction Severity Index (ASI) is a widely used structured interview that is designed to provide important information about what might contribute to a client's alcohol or drug problem. The instrument assesses seven dimensions that typically are of concern in addiction: (1) medical status, (2) employment/support status, (3) drug/alcohol use, (4) legal status, (5) family history, (6) family/social relationships, and (7) psychiatric status. The ASI is administered by a trained technician and takes about 1 hour (McLellan et al., 1980).

The Recovery Attitude and Treatment Evaluator–Clinical Evaluation (RAATE-CE) is a measure of client readiness. It assesses client resistance and impediments to treatment. The instrument is a structured interview that measures five scales: (1) degree of resistance to treatment, (2) degree of resistance to continuing care, (3) acuity of biomedical problems, (4) acuity of psychiatric problems, and (5) extent of social/family/environmental systems that do not support recovery (Mee-Lee, 1985, 1988).

Laboratory tests can be used to corroborate suspicions about excessive alcohol use that have been generated by history and physical exams. None of the tests alone or in combination can diagnose alcoholism, but they add to the certainty of the diagnosis and warn clients of physical complications. High serum levels of liver enzymes can represent alcohol-induced hepatic injury. Ethyl glucuronide

(EtG) testing is the newest way to test for alcohol consumption and can detect alcohol use up to 80 hours after drinking (www.toxicology.abbott/us/en/solutions/government.html). The problem is the test is too sensitive. It will pick up any alcohol use, including using common products such as hand sanitizers or aftershave. Therefore, this is not a good stand-alone biomarker to test for relapse. Gamma-glutamyl transferase (GGT) is elevated in two thirds of alcoholics. There are many sources for an elevated GGT, and GGT only elevates with heavy drinking. Aspartate aminotransferase (AST) and alanine aminotransferase (ALT) are elevated in about half of alcoholics. Alteration of fat metabolism causes elevated serum triglycerides in about one fourth of alcoholics. Alkaline phosphatase (ALP) is elevated in about one sixth of alcoholics. Total bilirubin is elevated in about one seventh of alcoholics. Mean corpuscular volume (MCV) is elevated in about one fourth of alcoholics. Uric acid is elevated in about one tenth of alcoholics. A newer biomarker, carbohydrate-deficient transferrin (CDT), is now widely available. It has moderate sensitivity and picks up drinking at least five drinks a day for 2 weeks. This biomarker has been shown to be a good measure to identify relapse. The advantage of CDT over GGT is that fewer things can cause elevation. However, CDT is not as sensitive to heavy alcohol use, resulting in false positives. The best biomarkers for monitoring abstinence are using a combination of urine alcohol and EtG. A follow-up test of CDT could be used to confirm heavy alcohol use (Brostoff, 1994; DuPont, 1994; SAMHSA, 2009; Wallach, 1992).

How to Conduct a Crisis Intervention

Clients who are severely dependent and unwilling or unable to see the severity of their addiction need a crisis intervention. Crisis intervention is a confrontation by a group of concerned family and friends. This confrontation must be gentle and supportive, and it is best to use a trained interventionist to help you develop the intervention strategy. If you want to do the intervention yourself, first read the books *Love First: A New Approach to Intervention for Alcoholism and Drug Addiction* by Jeff and Debra Jay (2008) and *No More Letting Go: The Spirituality of Taking Action Against Alcoholism and Drug Addiction* by Debra Jay (2006). These excellent texts carefully discuss the intervention techniques. Basically, an intervention has to be carefully organized, rehearsed, and choreographed. Each member of the group should be a caring significant other and not an addict. Group members each write a letter stating exactly how the client's addiction has negatively affected their life (see Box 2.1 for an example). In this letter, they share their love and concern for the client and ask that the client enter treatment. They say it is not the client that is the problem but the illness. It is a lethal problem, and it needs treatment. Each person reads a letter of concern and love for the client and asks the client to go into treatment that day. The treatment setting has been arranged, and the client's bags are packed. The intervention needs to be held at a neutral location when the client is clean and sober, not in the client's home or office where the client may feel more comfortable. It is difficult for the wall of denial to hold up under all of this love, and most of the time, the client agrees to go into treatment. If the client refuses, the truth has still come out, and this often leads to treatment later. Participants are each encouraged to exhibit the following behaviors:

- Show positive regard for the client and negative regard for the addiction.
- Give specific situations where the addiction negatively affected them.
- Validate that addiction is a disease, and it is not the client's fault.

Box 2.1 Example of an Intervention Letter

Client's name

, you are my closest friend, and I cannot tell you how much your friendship has meant to me. We have grown up together. Our kids love to play ball together, and you and I enjoy being close friends. There is no one in my life who has had a more positive effect on my life than you. Thank you for all of the years you have stood by me. When I made mistakes, you were always there to comfort me and give me good advice. Now comes the hard part of this letter, and I might not handle this very well, so bear with me.

Lately, I have been concerned with your drinking. I see you driving the car with the children after you have had too much to drink. In fact, after the Halloween party on Saturday, you were so drunk you could hardly walk, yet you insisted on driving your children home. We all tried to stop you, but you would not listen to anyone. [Client's name], addiction is a disease, just like the alcoholism that killed your father. It is genetic and life-threatening. I am here to ask you to get the treatment that you need to get well. It hurts me too much to see you suffer. You and I know you cannot drink in a healthy way anymore. These problems have happened too much. My own kids do not want to come over to your house anymore, and I avoid you myself. This hurts me too much for it to go on. Please help yourself and your family and get the help you need. The counselor has set up treatment for you today at a great treatment center, and we would all be incredibly proud of you if you would go for help. I love you very much. Please do this for all of the people who love you.

Love, [Writer's name]

iStockPhoto/NoSystem images

Save the best letter for last. This is written by someone very tender and special to the client. It might be the client's child, a friend, or another family member. It is someone whose letter breaks your heart. It is very difficult for denial to work in this atmosphere of love and truth. Most clients agree and go to treatment. Remember that no intervention is a failure. Even if the client refuses to get treatment, the truth has come out, and that is always a victory. Interventions and treatment are going to take time. If you are a primary care physician, emergency room doctor, cardiologist, or surgeon, you might not have the time to struggle with this problem. All addiction treatment is a long journey toward the truth, and this journey is slow and painful. Clients have to face the demons they have hidden from for years. They need to walk into the dark forest of fear and need a trustworthy guide. They need someone with time, energy, patience, and love, a person who has been on this journey many times and come out alive. At some point, you need to decide if you are going to take on this problem yourself or refer the client to an addiction professional. Remember that addiction is a chronic relapsing brain disease. It is only at the 5-year sobriety point that the relapse rate drops to around zero (Vaillant, 2003).

Therefore, if you take this battle on, it is going to be a long one. If you look at addiction programs around the United States, you will see that about half of the clients who leave treatment stay sober for the next year. Ninety percent of clients who work the program stay clean and sober. Therefore, if you want to take on this job, remember that you are in a 5-year fight for the client's life. You must do everything in your power to make sure that the client works the program. Because of protracted withdrawal, dual diagnoses, organic brain syndrome, and many other factors, about half of all addicts are not able to work their program on their own. They do not have the spiritual, mental, or physical skills necessary to work a self-directed program of recovery. These clients may need years in a structured facility or a highly structured continuing care program.

Sometimes you will want to refer an addict to an addiction professional. There are excellent alcohol and drug counselors and physicians who specialize in addiction. They are used to the battle, and they have specialized training to deal with the special problems of addiction. A treatment facility locator can be found at https://findtreatment.gov/. Other times, you will want to try to help the client yourself, but remember you are in for a 5-year battle. Never forget that you are the healer, and you will do everything in your power to keep your client sober.

Once the diagnosis of addiction has been made, you will need to decide what level of care the client needs to get the best help possible in the least restrictive environment. This is why the American Society of Addiction Medicine (ASAM) developed the client placement criteria.

American Society of Addiction Medicine Client Placement Criteria

All clients need to be assessed constantly in the six dimensions developed by the ASAM as included in *The ASAM Criteria* (4th ed., 2023). All counselors need to have a copy of this document and use these criteria in deciding which level of care clients need. The manual details specific criteria for admission, continued stay, and discharge for all levels of treatment, adult and adolescent.

For brevity, the present book concentrates on the criteria for admission and discharge of adult and adolescent outpatient and inpatient treatment. These are the criteria that you, as the counselor, will use most often. The criteria are as objective and measurable as possible, but some clinical interpretation is involved. Psychoactive disorders are no different from any other medical evaluation. Assessment and treatment are a mix of objectively measured criteria and professional judgment. The six dimensions that need to be assessed are as follows:

1. Acute intoxication and/or withdrawal complications
   - **a.** What risk is associated with the client's current level of intoxication?
   - **b.** Is there significant risk of severe withdrawal symptoms based on the client's previous withdrawal history and amount, frequency, and recency of discontinuation of chemical use?
   - **c.** Is the client currently in withdrawal? To measure withdrawal, use the Clinical Institute Withdrawal Assessment–Alcohol (CIWA-A) (see Appendix 6), the Clinical Institute Withdrawal Assessment–Benzodiazepines (CIWA-B) (Busto et al., 1989), or the Clinical Opiate Withdrawal Scale (COWS) (see Appendix 7).
   - **d.** Does the client have the support necessary to assist in ambulatory detoxification (or "detox") if medically safe?
2. Biomedical conditions and complications
   - **a.** Are there current physical illnesses, other than withdrawal, that may need to be addressed or may complicate treatment?
   - **b.** Are there chronic conditions that may affect treatment?
3. Emotional, behavioral, or cognitive conditions and complications
   - **a.** Are there current psychiatric illnesses or psychological, emotional, cognitive, or behavioral problems that need treatment or may complicate treatment?
   - **b.** Are there chronic psychiatric problems that affect treatment?

4. Readiness to change
   a. Is the client objecting to treatment?
   b. Does the client feel coerced into coming to treatment?
   c. Does the client appear to be complying with treatment only to avoid a negative consequence, or does the client appear to be self-motivated?

5. Relapse, continued use, or continued problem potential
   a. Is the client in immediate danger of continued use?
   b. Does the client have any recognition of, understanding of, or skills for coping with the addiction problems to prevent continued use?
   c. What problems will potentially continue to distress the client if the client is not successfully engaged in treatment at this time?
   d. How aware is the client of relapse triggers, ways of coping with cravings, and skills at controlling impulses to continue use?

6. Recovery/living environment
   a. Are there any dangerous family members, significant others, living situations, or school/working situations that pose a threat to treatment success?
   b. Does the client have supportive friendships, financial resources, or educational vocational resources that can increase the likelihood of treatment success?
   c. Are there legal, vocational, social service agency, or criminal justice mandates that may enhance the client's motivation for treatment?

Clients must be able to understand treatment. They must be intellectually capable of absorbing the material. They must be physically and emotionally stable enough to go through the treatment process. They cannot be actively harmful to themselves or to others. They cannot be overtly psychotic. They cannot have such a serious medical or psychiatric problem that they cannot learn.

Diagnostic and Statistical Manual Criteria for Diagnosis

To make a diagnosis, use the criteria listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*-5-TR) published by the American Psychiatric Association (APA, 2022). A new edition comes out every few years, so there will be changes in the criteria from time to time.

DSM-5-TR Diagnosis Criteria for Substance Use Disorders

Substance use disorders span a wide variety of problems arising from substance use and cover 11 different criteria:

1. Taking the substance in larger amounts or for longer than you're meant to
2. Wanting to cut down on or stop using the substance but not managing to
3. Spending a lot of time getting, using, or recovering from use of the substance
4. Cravings and urges to use the substance
5. Not managing to do what you should at work, home, or school because of substance use
6. Continuing to use, even when it causes problems in relationships
7. Giving up important social, occupational, or recreational activities because of substance use
8. Using substances again and again, even when it puts you in danger
9. Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance
10. Needing more of the substance to get the effect you want (tolerance)

11. Development of withdrawal symptoms, which can be relieved by taking more of the substance

The 11 criteria outlined in the *DSM*-5-TR can be grouped into four primary categories: physical dependence, risky use, social problems, and impaired control.

It is important to note that people can experience tolerance and withdrawal in the context of taking prescription drugs to treat a medical or mental health condition. This does not necessarily mean that they have a substance use disorder, however.

DSM-5-TR Severity of Substance Use Disorders

The *DSM*-5-TR allows clinicians to specify how severe or how much of a problem the substance use disorder is, depending on how many symptoms are identified.

- Mild: Two or three symptoms indicate a mild substance use disorder.
- Moderate: Four or five symptoms indicate a moderate substance use disorder.
- Severe: Six or more symptoms indicate a severe substance use disorder.

Questions for You to Ask the Client

1. What are your alcohol and drug use habits?
2. Was there ever a period in your life when you drank alcohol or used drugs too often?
3. Has alcohol or drug use ever caused problems for you?
4. Has anyone ever objected to your alcohol or drug use?

If you are unable to diagnose abuse, then check with the family. The client may be in denial, and you might get more of the truth from someone else. A family member, particularly a spouse or a parent, might give you a more accurate clinical picture of the problems.

Explain to your clients that the diagnosis is your best professional judgment. It is important that clients make up their own mind. Clients need to collect the evidence for themselves and to get accurate in their thinking. Do they have a problem or not? This is a good time to explain about denial and how it keeps clients from seeing the truth.

How to Determine the Level of Care Needed

Once you know that the client has a significant addiction, you must decide the level of care the client needs. There are five levels of care generally offered across the United States:

- Level 0.5: Early intervention. Early intervention is an organized service delivered in a wide variety of settings. Early intervention explores and addresses problems or risk factors related to substance use and assists clients in recognizing the harmful consequences of inappropriate substance use. Clients who need early intervention do not meet the diagnostic criteria, but they have significant problems with substances. The rest of the treatment levels include clients who meet the criteria for psychoactive substance abuse or dependency.
- Level I: Outpatient treatment. Outpatient treatment takes place in a nonresidential facility or in an office run by addiction professionals. Clients come in for individual or group therapy sessions, usually fewer than 9 hours per week.
- Level II: Intensive outpatient/partial hospitalization.
  - Level II.1: Intensive outpatient treatment. This is a structured day or evening program of 9 or more hours of programming per week. The program has the capacity to refer clients for their medical, psychological, or pharmacological needs.

- Level II.5: Partial hospitalization. Partial hospitalization generally includes 20 or more hours of intense programming per week. This program has ready access to psychiatric, medical, and laboratory services.

- Level III: Residential/inpatient services.
  - Level III.1: Clinically managed, low-intensity residential services. This is a halfway house.
  - Level III.3: Clinically managed, medium-intensity residential services. This is an extended care program oriented around long-term management.
  - Level III.5: Clinically managed, high-intensity residential services. This is a therapeutic community designed to maintain recovery.
  - Level III.7: Medically monitored intensive inpatient treatment. This residential facility provides a 24-hour structured treatment. This program is monitored by a physician and is able to manage the psychiatric, physical, and pharmacological needs of its clients.

- Level IV: Medically managed intensive inpatient treatment. This 24-hour program has the resources of a hospital. Physicians provide daily medical management.

Criteria for Outpatient Treatment (Adults)

Adult clients qualify for outpatient treatment if they meet the diagnostic criteria for psychoactive substance use disorder, as defined by the current *DSM*, and all six of the following criteria:

1. The client is not acutely intoxicated and is at minimal risk for suffering severe withdrawal symptoms.
2. All medical conditions are stable and do not require inpatient management.
3. All of the following conditions exist:
   - **a.** The individual's anxiety, guilt, and/or depression, if present, appear to be related to substance-related problems rather than to a coexisting emotional/cognitive/behavioral condition. If the client has emotional/cognitive/behavioral problems other than those caused by substance use, then the problems are being treated by an appropriate mental health professional.
   - **b.** Mental status does not preclude the client from comprehending and understanding the program or from participating in the treatment process.
   - **c.** The client is not at risk for harming oneself or others.
4. Both of the following conditions exist:
   - **a.** The client expresses a willingness to cooperate with the program and to attend all scheduled activities.
   - **b.** The client may admit to having a problem with alcohol or drugs, but the client requires monitoring and motivating strategies. The client does not need a more structured program.
5. The client can remain abstinent only with support and can do so between appointments.
6. One of the following conditions exists:
   - **a.** The environment is sufficiently supportive to make outpatient treatment feasible. Family or significant others are supportive of recovery.
   - **b.** The client does not have the ideal support system in the current environment, but the client is willing to obtain such support.
   - **c.** Family or significant others are supportive, but they need professional interventions to improve chances of success.

Criteria for Inpatient Treatment (Adults)

Adult clients need inpatient treatment if they meet the current *DSM* diagnostic criteria for substance use disorder and at least two of the following criteria:

1. The client presents a risk of severe withdrawal or has had past failures at entering treatment after detox.
2. The client has medical conditions that present imminent danger of damaging health if use resumes, or concurrent medical illness needs medical monitoring.
3. One of the following conditions exists:
   - **a.** Emotional/cognitive/behavioral problems interfere with abstinence and stability to the degree that there is a need for a structured 24-hour environment.
   - **b.** There is a moderate risk of behaviors endangering self or others. There are current suicidal/homicidal thoughts with no action plan and a history of suicidal gestures or homicidal threats.
   - **c.** The client is manifesting stress behaviors related to losses or anticipated losses that significantly impair daily living. A 24-hour facility is necessary to address the addiction.
   - **d.** There is a history or presence of violent or disruptive behavior during intoxication with imminent danger to self or others.
   - **e.** Concomitant personality disorders are of such severity that the accompanying dysfunctional behaviors require continuous boundary-setting interventions.
4. Despite consequences, the client does not accept the severity of the problem and needs intensive motivating strategies available in a 24-hour structured setting.
5. One of the following conditions exists:
   - **a.** Despite active participation at a less intensive level of care or in a self-help fellowship, the client is experiencing an acute crisis with an intensification of addiction symptoms. Without 24-hour supervision, the client will continue to use alcohol or drugs.
   - **b.** The client cannot control the use so long as alcohol or drugs are present in the environment.
   - **c.** The treatments necessary for the client require this level of care.
6. One of the following conditions exists:
   - **a.** The client lives in an environment where treatment is unlikely to succeed (e.g., chaotic, rife with interpersonal conflict that undermines the client's efforts to change, nonexistent family, other environmental conditions, significant others living with the client who manifest current substance use and are likely to undermine the client's recovery).
   - **b.** Treatment accessibility prevents participation in a less intensive level of care.
   - **c.** There is a danger of physical, sexual, or emotional abuse in the current environment.
   - **d.** The client is engaged in an occupation where continued use of alcohol or drugs constitutes a substantial imminent risk to personal or public safety.

Criteria for Outpatient Treatment (Adolescents)

Adolescent clients qualify for outpatient treatment if they meet current *DSM* criteria for substance use disorder and the following dimensions:

1. The client is not intoxicated and presents no risk of withdrawal.
2. The client has no biomedical conditions that would interfere with outpatient treatment.
3. The client's problem behaviors, moods, feelings, and attitudes are related to addiction rather than to a mental disorder, or the client is being treated by an appropriate mental health

professional. The client's mental status is stable. The client is not at risk for self-harm or harming others.

4. The client is willing to cooperate and attend all scheduled outpatient activities. The client is responsive to parents, school authorities, and staff.
5. The client is willing to consider maintaining abstinence and recovery goals.
6. A sufficiently supportive recovery environment exists to make outpatient treatment feasible:
   a. Parents or significant others are supportive of treatment, and the program is accessible.
   b. The client currently does not have a supportive recovery environment but is willing to obtain such support.
   c. The family or significant others are supportive but require professional intervention to improve chances of success.

Criteria for Inpatient Treatment (Adolescents)

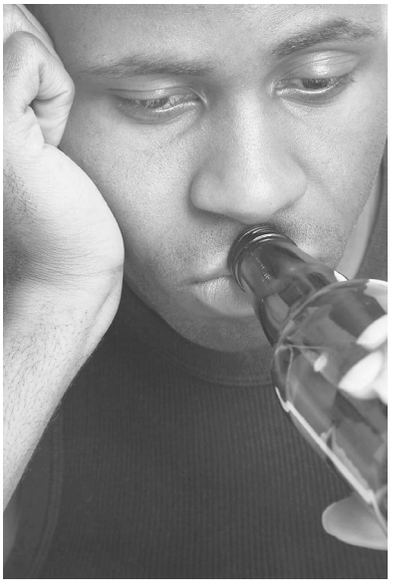
To qualify for inpatient treatment, adolescents must meet the current *DSM* criteria for substance use disorder, all of the dimensions for outpatient treatment, and at least two of the following dimensions:

1. The risk of withdrawal is present.
2. Continued use of alcohol or drugs places the client at imminent risk of serious damage to health, or a biomedical condition requires medical management.
3. History reflects cognitive development of at least 11 years of age and significant impairment in social, interpersonal, occupational, or educational functioning, as evidenced by one of the following:
   a. There is a current inability to maintain behavioral stability for more than a 48-hour period.
   b. There is a mild to moderate risk to self or others. There are current suicidal/homicidal thoughts with no active plan and a history of suicidal/homicidal gestures.
   c. Behaviors are sufficiently chronic and/or disruptive to require separation from the current environment.
4. The client is having difficulty in acknowledging an alcohol or drug problem and is not able to follow through with treatment in a less intense environment.
5. The client is experiencing an intensification of addiction symptoms despite interventions in a less intense level of care; the client has been unable to control use so long as alcohol or drugs are present in the environment; or the client, if abstinent, is in crisis and appears to be in imminent danger of using alcohol or drugs.
6. One of the following conditions exists:
   a. The environment is not conducive to successful treatment at a less intense level of care.
   b. The parents or legal guardians are unable to provide consistent participation necessary to support treatment at a less intense level of care.
   c. Accessibility to treatment precludes participation at a less intense level of care.
   d. There is a danger of physical, sexual, or emotional abuse in the client's current environment.

The Client's Reaction to Intoxication

Clients in an acute organic brain syndrome state can seem to be relatively normal or extremely bizarre. They can be actively psychotic, relaxed and comfortable, or in a panic. They can experience intense flashbacks. High doses of amphetamines, cocaine, or phencyclidine (PCP) may produce organic delirium. Disorganized thinking characterizes delirium in the ability to maintain attention. The client

will not be able to follow a conversation. The disorganized thinking is manifested by rambling, irrelevant, or incoherent speech. This delirium usually is brief (less than 6 hours) after amphetamine or cocaine use, but it can last for up to a week after PCP use (Schuckit, 1984; Spitzer, 1987).



iStockPhoto/keeweeboy

Acute use of amphetamines, cocaine, or PCP may result in a delusional state. Delusions are false beliefs that are intractable to logic. Clients may feel that someone or some group is out to get them. Clients may think that they have strange or unusual powers. These delusions usually are brief, lasting from several hours to several days, but in some clients, they can last for up to a year or more, even in the absence of further drug use. Hallucinogen use can result in the development of delusions (Vardy & Kay, 1983). Brief psychotic states also have been reported following cannabis use (Hollister, 1986).

During acute intoxication and withdrawal, it is not unusual to see clients complaining of hallucinations. These hallucinations usually are visual or tactile and rarely are auditory. Lights may seem too bright, or sounds may seem too loud and startling. This is a transient psychotic state. The clients may see trailing of objects (e.g., when the clients move a hand, they see a brief image extend behind the solid object like a jet contrail). The walls or floor might seem to move, or the clients might see bugs or other things that are not there. The clients may feel something unusual on or under their skin. These hallucinations usually are brief, but the clients will need to be reassured and supported. The clients' brains are chemically correcting. These negative experiences are used to give the clients evidence that they need to stop abusing chemicals.

What to Do With an Intoxicated Client

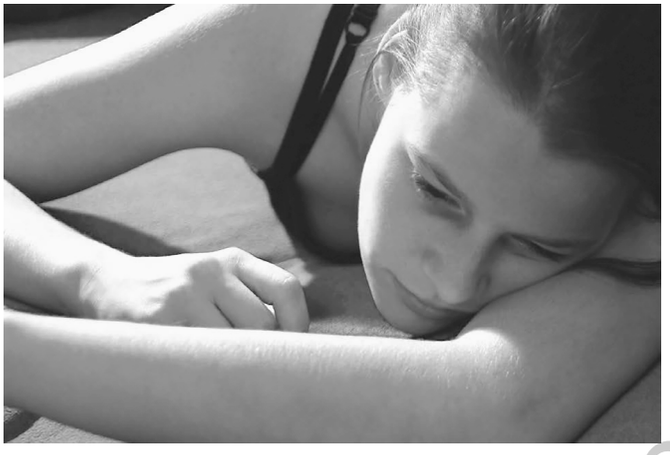
Never argue with intoxicated clients. This will get you nowhere. They probably are not going to remember the conversation anyway. Briefly introduce yourself, let the medical staff examine and treat these clients, and let the clients sleep. Intoxicated clients and clients in withdrawal will mainly be the responsibility of the medical staff. These staff members will be watching the clients carefully and monitoring their vital signs.

There is an old idea that has been floating around the field for years that clients should hurt in withdrawal. The theory goes that this will help clients to learn that they have a problem. To do this would be a medically unsound practice. It is inappropriate to subject clients to severe withdrawal symptoms just to teach them a lesson. Some of them would die. Clients should be medicated to a point where they stay in mild withdrawal. This hurts enough.

Intoxicated clients who want to talk will have to be reassured and educated. They are not bad people. They are sick. If they want to talk a lot, then let some of the other clients do the talking. Join in if you must. The clients will definitely need to trade off. This is very tiring work, but it is beneficial for them to see the intoxicated clients so messed up. It reinforces for the other clients that they never want to go through this again.

Clients need to be educated about withdrawal. What can they expect? The main thing that clients need to hear is that things are going to get better. With every hour that passes, things are going to improve. The staff is not going to let the clients feel too uncomfortable. Things are going to feel uncomfortable sometimes, but the staff is not going to allow the pain to reach intolerable levels.

Many of the clients' thoughts and feelings now are chemically induced. The clients need to understand that they are going to have some wide mood swings in acute withdrawal. Most clients will be feeling depressed, agitated, irritable, and crabby at various times. They need to have their fears and concerns put to rest. Let them talk. Answer their questions. Listen. These clients need a lot of attention.



iStockPhoto/Scrofula

Detoxification

Except for the hallucinogens, PCP, and the inhalants, prolonged drug or alcohol use is accompanied by the development of drug tolerance and physical dependence. In the case of withdrawal from the central nervous system (CNS) depressants (alcohol, barbiturates, and benzodiazepines), tremulousness, sweating, anxiety, and irritability may give way to life-threatening seizures and delirium. Opioid withdrawal is not life-threatening, although these clients feel very uncomfortable, like they have a bad case of the flu (Group for the Advancement of Psychiatry Committee on Alcoholism and the Addictions, 1991). Withdrawal from CNS stimulants may be accompanied by a "crash" characterized by depression, fatigue, increased need for sleep, and increased appetite (Gawin & Ellinwood, 1988; Kasser et al., 1998).

Detoxification is the gradual safe elimination of the drug from the body. Some drugs, such as alcohol, are detoxified quickly, usually within a few days, but the benzodiazepines, opioids, and amphetamines may take weeks or months (Burant, 1990; Schuckit, 1984). Many clients are suffering from polysubstance withdrawal, and this can complicate the clinical picture. The drugs most likely to cause serious physical problems are the depressants. These clients can deteriorate rapidly.

How Clients React in Detoxification

Most any physical or mental symptom can present itself in withdrawal. No heavy confrontation is necessary. These clients are sick and irritable. They are sleeping poorly. They have powerful cravings. This is where many clients walk out of treatment. They feel as though they cannot stand the symptoms anymore. These clients need medication, reassurance, and support. You must be gentle. Keep telling them repeatedly that it will get better. If they stay clean and sober, then they never will have to go through this misery again. The correct detox medication should keep the client in a mild withdrawal that is easily tolerated, but some clients can't seem to stand even mild withdrawal symptoms.

In withdrawal, clients are restless and have strong cravings. This physiological and psychological need for the substance is the primary motivating force behind drug addiction. The clients' bodies are driving them to return to their drugs of choice. The cells are screaming for relief. The clients have been in withdrawal hundreds of times before, but they always have treated it by getting intoxicated again. Now they are going to stick it out, striving for recovery. All of these clients think about leaving treatment, but when they get to feeling a little better, they reach the greatest chance of actually going out the door. You must be on top of this by constantly assessing where the clients are both physically and psychologically.

- The clients need to keep a journal of each day they are in treatment. What happened? What did they learn? What do they need to work on? As they journal, they need to think about their recovery skills and how they need to use them.
- The clients need to rate their cravings and try to uncover the situations, feelings, or thoughts that trigger the craving. Clients need to keep up with their Daily Craving Record (see Appendix 9) for at least the first 90 days of recovery. Check this record often throughout treatment to see how the client is doing in recovery. Identify situations, thoughts, and feelings that trigger craving, and make a plan to cope with each trigger. Watch for triggers that happen repeatedly because they are driven by inaccurate thoughts. For example, clients may have a trigger that they call feeling angry. "When I get angry, I want to drink." You know that all anger comes from hurt, so you try to answer the questions of why other people hurt the client so often and why the client feels other people are too aggressive. Once you pull for the thinking that comes before the feeling, you will get more and more data about how to help the client see these situations and cope with each situation appropriately.

Detoxification should be managed in a room that is reduced of excessive stimulation. The area needs to be quiet and without bright lights. Familiar people, pictures, a clock, and clothes are helpful. Soft conversation that reassures clients and keeps them oriented is best. The staff should display a positive attitude of mutual respect. Reassuring touches, such as taking a pulse and putting a hand on a shoulder, are helpful (Baum & Iber, 1980).

Once the acute withdrawal syndrome has passed, clients remain in a protracted abstinence syndrome for weeks or even years. Meth addicts seem unable to feel normal pleasure for 2 years. Opioid addicts can feel sick and in pain for months. Relapse is higher during this period of physiological adjustment. The protracted abstinence syndrome varies depending on the drug of dependency. Typically, it is a symptom constellation opposite of that which the client was using the drug to produce (e.g., the client who used stimulants to increase energy will experience lethargy) (Geller, 1990).

The AMA Threat

Clients in an inpatient or outpatient setting can present an AMA threat (leave treatment against medical advice). They usually isolate themselves first from the treatment peers and staff. Addictive thinkers must lie to themselves and believe that the lies are the truth for the illness to work. The addiction cannot exist in the light of the truth. The disease has a much better chance of working in isolation. That is why clients must not be left alone in early treatment until they have stabilized.

The illness cooks a stew of inaccurate information—minimization ("My use is not that bad"), rationalization ("I have a good reason to use"), projection ("It is not my problem; it is their problem"), and denial (a stubborn refusal to see the truth). All of these defenses are used to distort reality.

You may first get wind of an AMA threat as you assess a client, or you may learn of it from another client or from a staff member. Clients may share that they are thinking about leaving treatment. You must intervene when you see this problem developing. As the clients tell more and more lies to themselves, they become convinced that the lies are the truth. Such clients keep collecting information that proves that the illness is right.

For the most part, clients' reasons will be inaccurate. They are distortions of reality. Clients might not be aware that the real reason they are leaving treatment is to use their drugs of choice. Clients delude themselves. They are craving, but many of them do not know it. They believe the inaccurate thinking.

Example of an AMA Intervention

The intervention desperately needed here is the truth. Every time clients bring up a reason for leaving treatment, you challenge them with the truth. Be gentle. The truth is on your side, and a big part of every client wants to know the facts. Do not talk to the illness side of the client. Talk to the side that wants to get well.

Client: I have to get out of here. I can quit on my own.
Counselor: You have tried that before, and you have always failed.
Client: This time I can do it.
Counselor: Your meth addiction is worse now than it has ever been. It is not better. It's worse.
Client: I will go to meetings. That is all I need. I know how to stay off drugs.
Counselor: You may do that for a while, but it is very likely that you will begin using again.
Client: I think I can do it this time.
Counselor: You have had that thought a hundred times before. Give the disease some credit. It is stronger than you are. The 12-step program says that no human power can remove our addiction. It is unlikely that you will lick this problem on your own.
Client: I will go to church.
Counselor: I believe you need treatment.
Client: I have some marital problems that I need to work out. I cannot do that in here.
Counselor: The best thing you can do for your marriage is to stay in treatment and get into a stable recovery. Why don't we call your partner and see if they want you to leave?
Client: I have to get out of here. I do not fit in.
Counselor: Why don't you try to help someone else?
Client: I am not like these people. Their problems are much worse than mine are. Some of them are criminals.
Counselor: Weren't you arrested twice?
Client: Yes.
Counselor: But you are not like these people?
Client: No.

This conversation can go on for quite some time. The longer you expose the lies that clients are telling themselves, the better the chance of keeping these clients in treatment. If you have to, see whether the clients will agree to stay in treatment for 1 more day or even 1 more hour. The longer they stay, the more opportunity you have to help them see the truth.

How to Develop and Use the AMA Team

The AMA team is a group of three or more treatment peers selected by the staff to help other clients who are at risk of leaving treatment early. Have them share their experiences, strengths, and hopes with the client. Often, this group will be more effective than you are.

It is easier for a client to trust people who are in treatment. In an outpatient setting, if you do not have an AMA group, then maybe one of the clients further along in the program will agree to encourage the client to stay.

If there are any consequences that clients will face if they leave treatment, this is the time to bring these things out. A client may have been court ordered into treatment. The client's employment may be in jeopardy. A spouse or parent may have given the client an ultimatum—get treatment or else. Use every angle you can so long as it is based in the truth. The family may even have to involuntarily commit the client into treatment.

Clients must be gently told the truth until they hear it. There is a healthy side of every client—the side that is sick of this problem and wants to recover. The truth is a very powerful tool. It is even more powerful when delivered in an atmosphere of encouragement and support.

Some counselors believe that they have to hammer away at a client's denial aggressively until they literally "break through it," but it cannot be like a war. The therapeutic alliance builds on mutual acceptance, trust, and unconditional positive regard. It is impossible to trust someone who is verbally beating on you. This behavior harms your relationship and makes your job even harder than it already is. You will get angry with clients. That is normal; everyone does. Try to treat clients the same way in which you would want to be treated.

How to Use the In-House Intervention

If all else fails, then you might have to arrange an in-house intervention. Here you gather the client's family and concerned others together and have them share why they want the client to stay in treatment.

Have each of the participants write a letter stating how the client's addiction has adversely affected the participant. The participants need to give specific examples of how they were hurt. They share how they are feeling now and ask for what they want. They write down exactly what they are going to do if the client does not agree to stay in treatment. The client's spouse could state that they have been humiliated in front of friends. If the client does not stay in treatment, then they will be facing divorce. An employer could say that they are weary of the client calling in sick. If the client does not stay in treatment, then they will be fired. The kids could say that they are embarrassed by the client and want out of the home. Parents could talk about the lies and mistrust in the home and say that they are going to withdraw their financial support.

In an intervention, the family members are going to need a lot of encouragement. You need to help them with their letters and practice the intervention without the client present. Once the group is gathered, bring the client in and have each member share a letter. If the client is still unwilling to stay in treatment, then you can open the group up for discussion. Again, every time the client gives the family a good reason for leaving, you and the family will tell the client the truth.

How to Respond to Clients Who Leave AMA

Do everything in your power to keep your clients in treatment, but if they decide to leave early, then wish them well and invite them to come back if they have further problems. Many clients will leave for a time and then return. Whatever happens, remember that when the clients were in treatment, you told them the truth. Clients leaving treatment are no reflection on you or your skills. You did not lose. You planted the seed of the truth that will grow later.

Programs that are more genuinely caring will keep more clients than will programs that are harsh and confrontational. The key balance is to confront the clients in an atmosphere of support. An encouraging and supportive environment is attractive, and everyone wants more. You will know that you have struck the right balance when many of your clients are reluctant to leave treatment at the end of their stays. They have felt so accepted, loved, and supported that they do not want to leave an environment in which they have made major progress.