

First Contact

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Someone you know and love is dying of addiction. No one, even the addict, knows the extent of the disease that is poisoning his or her body. More than half of Americans drink, and many of them innocently fall victim to this silent killer. Addicts live their lives deeply alone, immersed in self-told lies. They could not tell you the truth if they wanted to because 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 about their pain. 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



Source: Created by Mervin Magus.

of untreated alcoholics die of alcoholism an average of 26 years 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, and resist primitive impulses goes off-line. Clients are obsessed with doing what they hate doing. The addiction is the only way they know how to feel normal. Not to use causes withdrawal, which causes craving, which is too painful to consider. In time, the addict's brain adapts to the point that he or she cannot get high and cannot 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.

In America, 51.1% of the population drinks alcohol, and a little less than a third of them will have a substance use disorder sometime in their lifetime (Substance Abuse and Mental Health Services Administration [SAMHSA], 2009a). In the United States, almost 1 million people die of substance abuse disorders 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 exercising. Heavy drinking or drug use contributes 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 find that 78% of high school seniors have tried alcohol. Fifty-three percent have tried illegal drugs. Fifty-seven percent of high school seniors have tried cigarettes, and 27% are current smokers. Addiction is one of the most horrible plagues to attack the human race. According to the Centers for Disease Control and Prevention (CDC), 25% of Americans die as a direct result of substance abuse (Heron et al., 2009).

Millions of Americans are dying annually of preventable conditions. Drug overdoses are now the leading cause of accidental death in the United States.

- 443,000 die of tobacco products.
- 365,000 die of improper diet and exercise habits.
- 88,000 die of alcohol abuse.
- 75,000 die of microbial agents.
- 55,000 die of toxic agents.
- 47,000 die of adverse reactions to prescription drugs.
- 29,300 die of homicide.
- 29,000 die of firearms.
- 26,000 die of automobile accidents.
- 20,000 die of sexual behavior.
- 19,000 die of prescription pain reliever overdoses.
- 17,000 die of illegal drugs ("Annual Causes of Death in the United States," 2014; Center for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System, Mortality File, 2015).
- 11,000 die of heroin overdoses.

TREATMENT WORKS

Most 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 make the choice that the negative consequences of continued use outweigh the rewards. They go through the same motivational steps that a client needs to make in treatment (DiClemente, 2006b). Some clients 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 a program of recovery stay clean and sober. To get clean, clients have to come out of hiding and use their journey to help others. By sharing our experience, strength, and hope, addicts in recovery give others 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, O'Malley, Bachman, & Schulenberg, 2008; McLellan, 2006).

Your first meeting with a client might be accidental or it might be by appointment. During the interview, you—if you look and listen carefully—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 over time learn to trust. 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. The person might look depressed and anxious. Her face may be red and swollen, his eyes watery and red, or the person may be markedly thin with scabs caused by “meth bugs.” He might have a fine hand tremor or have difficulty sitting still. Sometimes the person’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 to them. One side knows they are in trouble, while the other side 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) (2002a) says this illness is “cunning, baffling and powerful” (pp. 58–59).

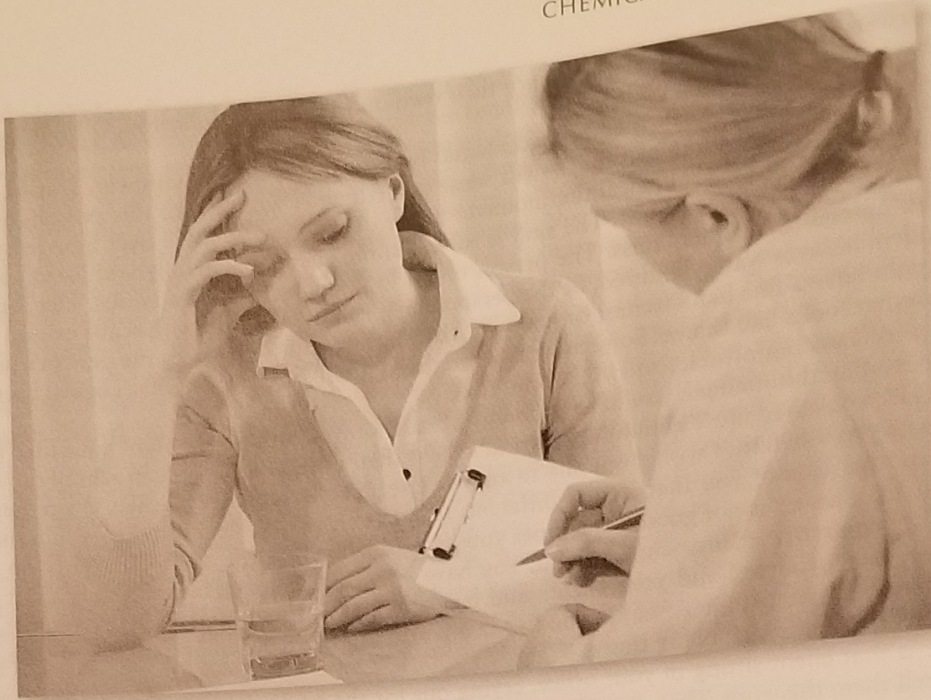
The battle lines are drawn. The illness inside of the client is confident of victory. It thinks that you will take the easy way out. You will handle the acute problem and let the client go home. You will not ask the questions that could lead to the truth. That would be too much trouble; besides, you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

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 him or her with change. Your job is to go with the client toward the truth. It does no good to go against the client’s idea of himself or herself. Arguing with the client will not work because the addict is an expert at giving every excuse in the world for abnormal behavior. If you argue, the client will win because he or she will leave your office convinced you are a bad person. Walk *with* the client toward the truth. 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 the client’s world and connect with that gentle voice of reason inside of him or her. That healthy voice is there, and your job is to connect with it, empathize with it, and pull for more. The other voice in the client’s head 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; he or she is a good person with a bad disease. The disease of addiction lives



Source: ©iStockphoto.com/AlexRaths.

in and grows in the self-told lie. The client must lie to himself or herself and believe the lie, or the illness cannot continue. The client will have a long list of excuses for his or her 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 super sensitivity. 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 him or her 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, lethal 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, and if it is very good, it is remembered 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 he or she 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 the client toward a decision he or she finds impossible. You need to help 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 talking to family, friends, court workers, school personnel, and anyone else who can help you until 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; it's 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 his or her 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 them 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 the client that he or she does 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. The client knows things that you do not know. The client knows himself or herself better than anyone else does, and he or she needs to learn how to share his or her life with you. Likewise, you have knowledge that the client does not have. You know the tools of recovery.

The client must trust you. To establish this trust, you must be honest and consistent. You must prove to the client, repeatedly, that you are going to be actively involved in his or her individual growth. You are not going to argue or shame the client; you are going to try to understand him or her. 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, the client must learn that your staff works as a team. You can share with the whole team what the client tells you—even in confidence. The client will occasionally test this. The client will tell you that he or she has something to share but that it can only be shared with you. The client wants 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 the client that if he or she feels too uncomfortable sharing certain information that the client should keep it secret for the time being. Maybe they can share this information later when they feel more comfortable.

The client must understand that you are committed to his or her recovery, but you cannot recover for the client. You cannot do the work by yourself. You must work together, cooperatively. You can only teach the tools of recovery. The client must use the tools to stay clean and sober.

How to Do a Motivational Interview

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 incorporate the following elements (with the client being free of alcohol at the time of the screening) (DiClemente, 2006a; Prochaska, 2003):

- 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 do not 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 a person's expression, you validate his or her worldview.)*

Client: I do not 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 is 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?

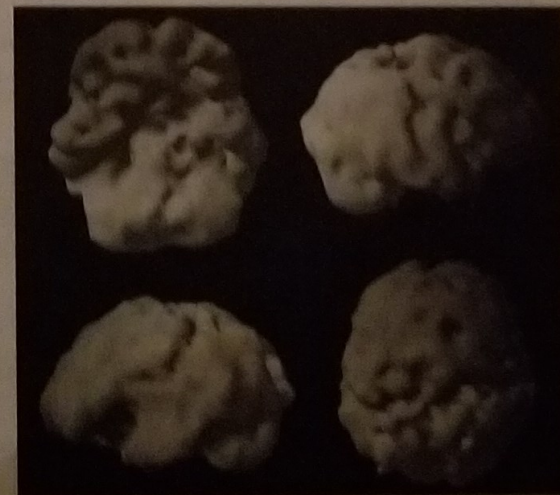
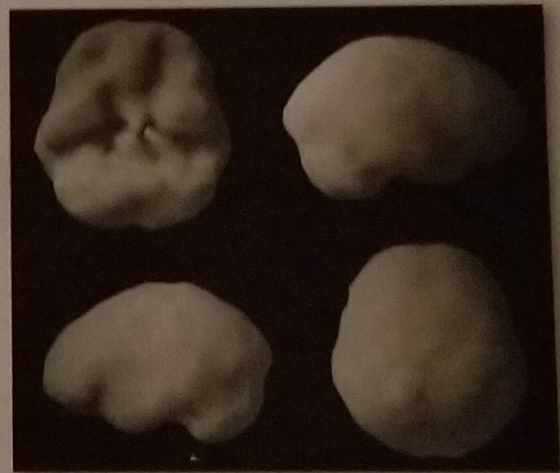
Client: I work hard, and I deserve to relax. *(The client is resisting, and the professional backs off a little. It is important to keep the client's ears open. Be empathic, tender, and understand the client's world and understand his or her point of view. Once you enter the client's world and understand his or her point of view, you will get clues about what will motivate the client to change. This client is mad at his wife, and he 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.
- 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 a single photon emission computed tomography (SPECT) scan 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 did see it, and he could not 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.



More substance abuse pictures are available at www.brainplace.com.

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

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

Client: No, honestly, I have not. *(This comes across as real. When the words and the client's 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, do you not 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? *(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 their alcoholism? And 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 did not 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 or her 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) 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. Surgeon General Releases Advisory on Alcohol Use in Pregnancy," 2005).

We could also add that no person should ingest an illegal substance.

If a person cannot stop something they want to stop, it is 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) (<http://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 alcohol or drugs ever caused your family problems?
6. Has a physician ever told you to cut down on or quit use of alcohol?
7. When drinking or using drugs, have you ever had a 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 Figures 1.1 through 1.5.)

Figure 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)

Figure 1.2 Laboratory Red Flags for Adult Alcohol/Substance Abuse Disorder

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

Figure 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)

Figure 1.4 Laboratory Red Flags for Adolescent Alcohol/Substance Abuse Disorder

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

Figure 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 at a time and no more than three nights a week. Women should be advised to drink no more than two drinks at a time and no more than three nights per 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 (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.

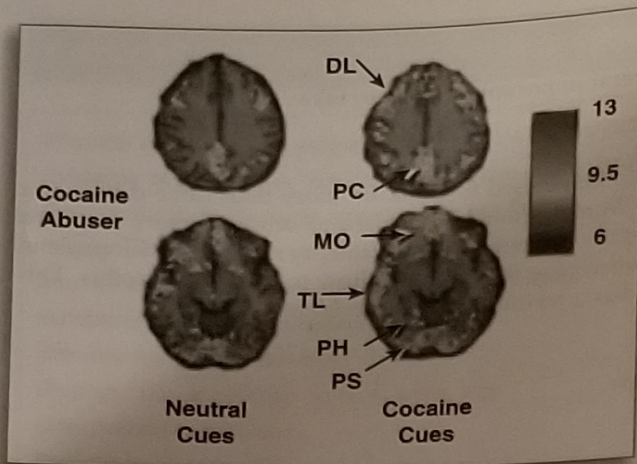
Risk factor 9: There is a genetic predisposition.

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 clients fit into your range of experience and care. Do you have the ability to deal with his or her problem, or do you need to refer to someone else? Does the client have a problem with chemicals or an addictive behavior? Is he or she 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 he or she need treatment? Is he or she motivated for treatment? What kind of treatment does she or he 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.



Source: 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.

provider (SAMHSA, 2007). Two quick screening tests for alcoholism have been developed: the Michigan Alcoholism Screening Test (SMAST) (see Appendix 2) (Selzer, Winokur, & van Rooijen, 1975) and the CAGE questionnaire (Ewing, 1984; Selzer et al., 1975). The Michigan Alcoholism Screening Test (MAST) or SMAST has greater than 90% sensitivity to detect alcoholism. It can be administered to either the client or the spouse.

The Substance Abuse Subtle Screening Inventory (SASSI) (1-800-726-0526; 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 with whom you are still unsure about the diagnosis 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) (1-215-399-0980) 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 administered by a trained technician. The ASI is an excellent tool for delineating the client's case management needs (Kaminer, Bukstein, & Tarter, 1991; McLellan, Luborsky, & Woody, 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 his or her drinking (Mayer & Filstead, 1979; Mee-Lee, 1988; Mee-Lee, Hoffmann, & Smith, 1992) (1-800-755-6299). The 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.

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. A client with a positive family history of addiction should be warned about his or her increased vulnerability to addiction and the need for vigilance.

There are a number of companies that sell inexpensive, disposable Breathalyzers and drug screening instruments, including Prevent (1-800-624-1404); Bi-TechNostix (1-888-339-9964); Random Drug Screens, Inc. (1-803-772-0027); Drug Screens, Inc. (1-800-482-0693); hair screens; Pharmchec Drugs of Abuse Patch, which lasts 2 weeks; a new GGT alcohol screen that will test for alcohol injection for 80 hours after use; and ankle bracelets that measure alcohol in the sweat of probationers 24 hours, 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

- **Problem With Addiction:** The client who has had recurrent problems due to addiction should be encouraged to abstain from, or at least reduce, his or her addictive behavior. A client such as this should be strongly encouraged to abstain from all illegal drugs and addictive behaviors. You should discuss the biopsychosocial complications of addiction (see Appendix 8). A client who is encouraged to cut down on his or her addictive behavior should be provided with the brochure from NIAAA (see Appendix 9). 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 or made worse by the client's continued addictive behavior. The client needs to hear that this illness is not his or her fault and that there is excellent treatment available that will help the individual to stay clean and sober. The client needs 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 AA 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). The client should also be told about the potential benefits of naltrexone, accamprosate, and disulfiram when used along with formal treatment programs. Carefully discuss the ASAM client placement criteria to help you and the client negotiate the best treatment plan possible to bring the addiction under control. (See Figure 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, or 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?

Figure 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)

- 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?

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 the client see the inaccuracies in his or her thinking and move away from the lies toward the truth.

The Stages of Motivation

Precontemplation

The individual is not intending to take action in regard to his or her 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, 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 & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992; Prochaska, Norcross, & DiClemente, 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).

A client in the preparation stage has a plan of action to cut down or quit his or her 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 his or her 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, the client is still changing his or her behavior to be better and is 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 continuing 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,

Figure 1.7 Processes of Change for the Client in 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.

constantly trying to raise the client's consciousness about the causes, consequences, and possible treatments for a particular problem. Denial is unconscious, and one 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 the client to reevaluate his or her self-image, and explain how this is negatively affected by the addictive behavior. Encourage the client to learn the new skills of being honest, helping others, and seeking a relationship with a higher power (DiClemente, 2006a).

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; Prochaska & DiClemente, 1983; Prochaska et al., 1992; Prochaska et al., 1994).

The following process should be applied to clients in the precontemplation stage (see Figure 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.

The Clinical Staff



Source: ©iStockphoto.com/LivingImages.

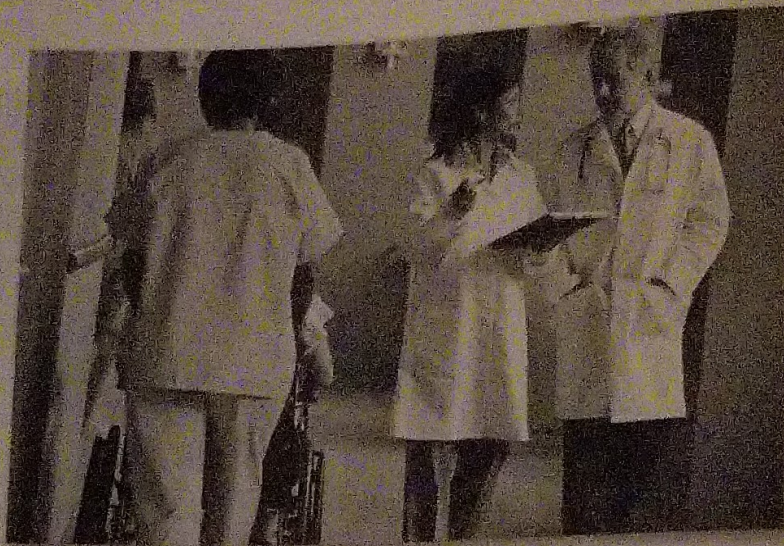
The staff of any treatment center is the lifeblood of treatment. A good staff can do effective treatment anywhere. The clinical staff has a great deal of respect for each individual member of the staff and listens carefully to each other. No one staff member is more important than another is. All are equal and essential for recovery. They work together like a symphony all playing the same masterpiece.

A good staff is fun. The staff members enjoy working together and supporting each other in the war against addiction. A good staff laughs a lot. Sometimes you have to laugh to keep the disease from getting you down.

Everyone has input into the clients' treatment plans, but everyone has his or her own area of specialization. Professional boundaries are important and should be respected and guarded. To question another person's skills or decisions when you do not know their profession is silly. Let them do what they are trained to do and trust that they have you and the client's best interest at heart. If you stay within your own boundaries—the boundaries of the chemical dependency counselor—then you will be a lot better off, you will feel better, and you will give better quality treatment. All staff members are experts in their chosen fields. They are licensed or certified by their respective boards, and you have to believe that they know what they are doing.

THE PHYSICIAN/ADDICTIONOLOGIST

The medical doctor is in charge of all medical treatment. This physician has the most training in the total disease process. A physician completes a premedical bachelor's degree, 3 or 4 years of advanced medical training, and at least 1 year of interning. Many physicians go on to specialize in one or more areas of medicine. Physicians can have a specialty in addiction called addictionology.



Source: Comstock Images/Thinkstock.

All clients must have a complete history and physical examination given by a physician. If you have any questions about any type of physical disease or medical treatment, then the physician is the person to rely on. It is important to establish a professional working relationship with the physician. He or she is a wealth of information. Do not be intimidated by professionals with advanced degrees. They are just people like you—fallible and human. Discuss your client's case with them, and respect their judgment. Good physicians are easy to talk to and readily admit that they do not know everything. They often need you to tell them how the client is responding to treatment.

The physician will be in close contact with you, particularly if your client has a medical condition that requires treatment. Close consultation with the physician will prevent you from assuming that behavior is caused by an organic disease or is a psychological problem.

The physician is in charge of any medication order. If you believe that your client needs pharmacological treatment, then you need to tell the physician or nurse. Once you have discussed this issue carefully with the medical staff, your job is over. The physician will examine the client and make the determination based on his or her own clinical judgment. Do not argue with the physician or the nurse about what they are doing. They know more about it than you do. Trust them to do their job. You must keep the medical staff advised about your client's condition if they are not doing well or might be having side effects to the medication. Let them know your concerns, and leave it to them to treat the medical condition.

THE PSYCHOLOGIST/PSYCHIATRIST

All treatment centers should have a consulting psychologist or psychiatrist. The psychologist or psychiatrist has advanced training in the diagnosis and treatment of mental disorders. A psychiatrist is a medical doctor with 3 years of residency in psychiatry. A psychologist has a 2-year master's degree and a 4-year

doctorate degree with 1 year of internship during the doctoral training and 1 year postdoctorate. These two professionals are the best-trained mental health professionals. Only psychiatrists can order medications, and usually only psychologists are heavily trained in psychotherapy, particularly evidence-based cognitive behavioral therapy and psychological testing.

Two thirds of chemically dependent clients have a concomitant psychiatric diagnosis. They have problems such as depression, anxiety, and/or personality disorders in conjunction with their addiction. Clients will not do well in recovery unless these disorders are treated effectively (Frances & Franklin, 1988; Ries & Miller, 2009; Talbott et al., 1988; Woody et al., 1984). It is important to have a professional in your center who can deal with these coexisting problems.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Commission on Accreditation of Rehabilitation Facilities (CARF) require that all clients in inpatient substance abuse treatment receive a psychiatric or psychological evaluation. This examination includes a mental status examination, a determination of current and past psychiatric or psychological abnormality, a determination of the degree of danger to self or others, and a brief neuropsychological assessment. It is from this examination that you will learn about any secondary diagnosis and will develop a treatment plan. The psychiatrist or psychologist will tell you what to do. Follow his or her directions as precisely as you can. Use this professional as a valuable information source. This professional understands the development of personality and the forces that motivate behavior. If you are confused by a client, talk the situation over carefully with the psychiatrist or psychologist.

THE SOCIAL WORKER/MENTAL HEALTH COUNSELOR

Social workers and mental health counselors are wonderful mental health professionals. They usually have been through a 2- to 3-year graduate program and are licensed by the state. These mental health professionals have many fine qualities. They are excellent therapists and group leaders. They understand the community of mental health professionals and are often charged with testing and treating co-occurring disorders and arranging for continuing care placements, including referrals to other professionals, halfway houses, and group homes. These professionals are good at just about anything and can handle almost any mental health task except ordering medication. They are a lot like mental health professionals or professional counselors who have a master's degree in counseling and have many things to offer you and your clients.

THE NURSE

There are two types of nurses: (1) registered nurses and (2) licensed practical nurses. Registered nurses complete a registered nurse's degree from an accredited institution. Most go on for a bachelor's degree. Licensed practical nurses complete a 1-year vocational-technical program in nursing.

Nurses are frontline medical personnel. They take responsibility for the client in the absence of the physician. In an inpatient setting, they usually are guiding the ship and are available 24 hours a day. There is a tendency in some centers for there to be some conflict between the nursing staff and the counseling staff. This is a big mistake for all concerned. A good clinical staff has few of these turf battles. Each staff member should feel comfortable with his or her unique function in the treatment setting.

Nurses are second in command in medical treatment. Only the doctor has more medical authority. The physician writes the orders, and the nurses carry them out. In many facilities, there are standing orders that allow nurses to make medical decisions. This is necessary to reduce response time and to prevent the physician from being called every time a decision is made. If a nurse tells you to do something, then you should carry out this order as if it came from the physician.

Nurses will listen to you and help you. You will find them to be supportive. They tend to be caring people who are willing to go the extra mile to provide good quality care. They are used to charting and usually are wonderfully self-disciplined.

THE CLINICAL DIRECTOR

The clinical director has the primary responsibility for making sure that the clinical team provides the best possible treatment. This individual develops and implements the whole treatment program. He or she has advanced training and experience in treating addiction and co-occurring disorders. The clinical director decides makes sure that the team is working well together and is accomplishing its goals. The clinical director decides who does what, when, how, and with whom. This person leads the clinical team and the client population. The clinical director has administrative experience. This individual usually sees the clients and the staff who are having more severe problems. All program and policy changes go through the clinical director.

THE CLINICAL SUPERVISOR

The clinical supervisor is an addiction counselor with several years of experience in counseling and supervision. This individual's primary responsibility is to supervise the counseling staff. The clinical supervisor will be doing some hands-on work with the clients and will be sitting in on some of your individual sessions and groups. He or she makes up the work schedule. You should use this person often. The clinical director and clinical supervisor are your mentors. This person will set a good example for how to take a client through treatment effectively. If you have any questions about treatment planning, charting, or therapy, then these are the first people to ask. You should receive continuing education from the supervisory personnel. If you feel as though you have any weak points in your training, then ask them for in-service training sessions to build your expertise.

The clinical supervisor will be going over your charts to be sure that you are treating the clients according to JCAHO or CARF. JCAHO and CARF require specific standards of care to be met before it will allow a facility to receive accreditation. (You can order a copy of the standards by contacting JCAHO, 875 North Michigan Avenue, Chicago, IL 60611 or CARF International, 4891 E. Grant Road, Tucson, AZ 85712 USA, 520-325-1044 or 888-28106531 voice/TTY, 520-318-1129 fax.)

THE CHEMICAL DEPENDENCY COUNSELOR

Chemical dependency counselors must meet state standards set by a certification board. They take specialized college courses and work for at least 1 year in a treatment setting under a qualified supervisor. In most states, they have to pass a national examination and are state certified or licensed. Counselors must show competency in 12 core function areas: (1) screening, (2) intake, (3) orientation, (4) assessment, (5) treatment planning, (6) counseling, (7) case management, (8) crisis intervention, (9) client education, (10) referral, (11) reports and record keeping, and (12) consultation. Many counselors are involved in their own recovery programs, but many are not. It does not seem to matter. It is the on-the-job training in addictions and personal experience that gives addictions counselors their unique professional character. They are excellent, highly qualified health care professionals.

THE REHABILITATION TECHNICIAN OR AIDE

Rehabilitation technicians, sometimes called aides, usually are individuals with no formal training in addiction. Sometimes they are people who are getting their degrees in addiction and need experience. These people do a variety of work assigned by supervisory personnel. They work with the clients, sometimes individually and sometimes in groups. They work under the direct supervision of the counseling staff. It is your responsibility to help them to function effectively around the client population. Many times, the tech

or aid says just the right thing at just the right time to turn a client toward recovery. Never forget that they are smart, willing, and able to go the extra mile for you and your clients.

There often is some conflict about how far these people should go in treating clients. For the most part, the care they offer should be highly structured and supervised by someone on the clinical staff. You will find that much of the real work in treatment is offered by these individuals. You must see to it that they offer quality care. The only way of doing this is to listen to them, talk to them, and educate them. They might be in recovery and know the 12-step program well, but you can still improve their skills by extending yourself to support, educate, and encourage them. They are working harder than you often think and are having more effect than you can possibly imagine.

THE RECREATIONAL THERAPIST

The recreational therapist is a certified coordinator in charge of getting the clients involved in fun, constructive exercise, and leisure time activities. This individual will be doing an activities assessment to see what the clients are doing for entertainment, play, or fun. The activities coordinator will develop an exercise program for each client. Most addiction clients have lost the capacity to have fun in sobriety. They need to be encouraged to develop healthy recreational activities and hobbies. They need to learn how to have fun clean and sober. It is important that you encourage your clients to become active in pleasure-oriented activities in recovery. The clients who enjoy sobriety will be more likely to stay sober. One of the most important things that clients can do in their recovery program is to establish regular exercise habits. All clients should be encouraged to exercise on a daily basis. The recreational therapist needs to be a lot of fun to be with and very encouraging. Most addicts have not exercised or enjoyed recreational activities in a long time, so they need someone fun to encourage them to try new activities.



Source: Paul Sutherland/Thinkstock.

CLINICAL STAFFING

The clinical staff makes up the treatment team. The staff usually meets once a day, usually at each shift change, to discuss the clients' status. Once a week, the staff meets for a more formal clinical staffing. Here the clients will be discussed in more detail, and each problem on the problem list will be evaluated.

The staff must be constantly kept informed about how the clients are doing in treatment. In these meetings, treatment plans will be updated. A multidisciplinary staff can take clients through treatment much more effectively. More expertise comes into play, and many heads are much better than one.

Clinical staffing is your opportunity to discuss a client with the whole team. You can get advice and help from everyone at the same time. The client is reassessed throughout treatment to determine current clinical problems, needs, and responses to treatment. The assessment includes major changes in the client, family, or life events that could complicate or alter treatment. A client could have just learned that his wife is divorcing him or that he is being prosecuted for a crime. Someone in the client's immediate family could die or become ill. All changes in treatment need to be documented in the client record.

The atmosphere of clinical staffing is a professional one. The principal matter of concern is the clients. You must assume that all members of the professional staff are willing and able to help. The staff members should be supportive of each other. Treating addiction is emotionally draining, and everyone occasionally will make mistakes. The atmosphere in clinical staffing should be one of mutual respect. You should enjoy clinical staff meetings. They should be educational, and they should help you to develop your professional skills.

How to Present a Client

You will present each of your clients to the clinical staff and will discuss how treatment generally is going. If you have any questions, now is the time to ask them. The first time that you present a client, you need to be thorough. As the client remains in treatment, you need to cover just the pertinent issues. An outline for case presentation is handy to use your first few times. The outline might look something like this:

1. Identifying data
2. Present illness
3. Past history
4. Family history
5. Social history
6. Medical history
7. Mental status examination
8. Most likely diagnosis
9. Formulation
 - a. Predisposing factors
 - b. Psychosocial stressors
 - c. Stress that precipitated treatment
10. Further assessment you propose
11. Treatment plan
12. Prognosis

Your presentation should sound something like this:

Jason Roberts is a 43-year-old black male who just got his third DWI. He has been drinking heavily for the past 20 years. He is divorced with two children. He lives alone. He came to treatment after spending the night in jail. He is working on his chemical use history and problem assessment form. He is doing well around the unit so far. He is in good physical health except for some mild withdrawal symptoms. His CWIA scores have averaged around 8 to 14. He seems to be getting along well with his treatment peers. In group, he did admit to a drinking problem. He seems committed to treatment. He says he

does not want to go on living this way anymore. I talked to his oldest son this morning, and the family is supportive of treatment. He is in some withdrawal, but he seems to be handling that okay. He needs to visit with the psychologist to rule out other psychiatric disorders. He is depressed and reports he is not sleeping well. His diagnosis is alcohol dependence—severe—with a possible substance-induced depression or a major depression. He will be working through the steps, and we will probably address his depression depending on the psychologist's report.

The case presentation globally advises the treatment team of the client's condition and describes how the client is doing in treatment. After you present the client, each member of the treatment team can comment. The physician or the nursing staff may have something to share about withdrawal or the medical condition for which the client is being treated. The dietitian may make a report on the client's diet. The recreational therapist may have a comment on how the client has been using his or her leisure time. The other counselors may have something to say about what they see. As the primary counselor, you collate this material and enter the staff's input into the client record. These progress notes do not have to be very long, but they do have to show that the treatment team is reassessing the client and changing the treatment plan where necessary.

TEAM BUILDING

A good staff is constantly building the team. These staff members are actively encouraging each other and reinforcing each other's work. When you see someone do a good job, you say so: "You did a good job with Mark this morning. I was impressed with how you handled yourself." These comments are very reinforcing to fellow staff members. The staff members often put so much energy into the clients that they forget that they have needs, too. This is emotionally difficult work, and everyone needs support. A good team knows this. Each member goes out of his or her way to treat each other well.

New team members are welcomed and are assisted in adjusting to the flow of treatment. Every treatment center is different, and new staff members need orientation on both an intellectual and an emotional level. A good team's members constantly talk each other up to insiders as well as outsiders. They never talk someone on the staff down. You can share the truth about someone without damaging his or her reputation. The members of a good staff communicate well together. They share openly how they feel and what they think. They work together as a group. If a personal problem develops between staff members, then the problem is handled by a supervisor.

A good staff's members never gossip about each other. Gossip is one of the most harmful things that can occur in any staff organization. Gossip will cause a team to fail. Everyone's life outside of the center should be private. Unless someone decides to confide in you, keep out of the issue. Do not spread damaging rumors about anyone. A good way of checking yourself is to refuse to repeat anything unless you have the permission of the person in question.

Good staff members get support, not treatment, from their fellow staff members. It is a mistake for someone in recovery to think they no longer need their 12-step meetings because they have the support of the clinical team. The clinical staff does not exist to treat you; it exists to treat the clients. If you want to see someone on the staff for a brief consultation about a problem, that is fine, but keep it short. Do not be afraid to seek outside help for your problems. Your mental and physical health directly affects your job performance. If your problems are bogging you down, then you cannot be effective. Becoming involved in a good program of recovery will make you a better counselor and a better person. One of the best ways of learning about good therapy is to go to a good therapist. Make sure that this therapist is highly qualified in his or her field.

A good clinical staff does not "subgroup" against each other. This is where a smaller group of staff members gets together and talks about the other members. This is very common, and it is a disaster for the clinical team. If you are having problems with a staff member, then go to that staff member first and try to work the issue through. If you are unable to resolve the problem, then go to your supervisor and get him or her to help you. If you and the supervisor cannot handle the problem, then it needs to be addressed before the clinical staff as a whole. Do not let problems fester. The only way of resolving problems is to

get everyone together and have each person share how he or she feels. Any problem can be solved in an atmosphere of love and truth. The staff needs to practice what it preaches to the clients.

The following guidelines are excellent for maintaining productive staff interaction.

COMMITMENT TO COWORKERS

As your coworker with a shared goal of providing excellent care to our clients, I commit myself to the following:

1. I will accept responsibility for establishing and maintaining healthy interpersonal relationships with you and every member of this staff. I will talk to you promptly if I am having a problem with you. The only time I will discuss it with another person is when I need advice or help in deciding how to communicate to you appropriately.
2. I will establish and maintain a relationship of functional trust with you and every member of this staff. My relationships with each of you will be equally respectful, regardless of job titles or levels of educational preparation.
3. I will not engage in the "3 Bs" (bickering, back-stabbing, and bitching) and will ask you not to do [so] as well.
4. I will not complain about another team member and ask you not to do [so] as well. If I hear you doing so, I will ask you to talk to that person.
5. I will accept you as you are today, forgiving past problems, and ask you to do the same with me.
6. I will be committed to finding solutions to problems, rather than complaining about them, and ask you to do the same.
7. I will affirm your contribution to quality client care.
8. I will remember that neither of us is perfect and that human errors are opportunities, not for shame or guilt but rather for forgiveness and growth. (Manthey, 1991)

Signature and date

BOUNDARIES

Everyone on the clinical team needs to know and respect each other's professional boundaries. You need to know what each person's function is in treatment. Once you know that a part of treatment is not in your area of expertise, stay out of that area. Everyone on the staff wants to hear what you think—that is helpful—but do not concern yourself with client care outside of your area of specialization. You are an addiction counselor, not a physician or a nurse. You should not concern yourself with who gets certain medications, but you should express your concern about your client's signs and symptoms. Many counselors spend long hours worrying about whether or not their clients are being properly treated by the medical staff. If you worry that your medical staff is inadequate, then work somewhere else. Never accept a job in an institution that gives substandard care. Once you decide to accept a position, act as if your staff is the greatest. Be grateful for all of the good work the staff is doing.

Most staff problems are attitude problems, and attitudes can change. You need to keep a positive attitude about you and your coworkers. This will go a long way toward making your day more pleasant and enjoyable. If you see your attitude slipping, then talk about this with your supervisor. Check your own life.

How are you doing? Many times, a negative attitude flags personal problems that need to be addressed outside of the treatment center. Remember that if you do not take good care of yourself, you are not going to be very helpful to others. If you are suffering, your staff and clients will suffer. Do not hesitate to get help from your supervisor or an outside counselor. Most treatment centers have an employment assistant professional (EAP) who will see you a few times and, if you need it, will help you get a referral to the right professional.

STAFF-CLIENT PROBLEMS

The staff and the clients will constantly have problems with each other. It is the nature of transference and countertransference that there will be conflict. As the clients' maladaptive attitudes and behaviors come into play, the staff can teach new methods of dealing with problems.

Never agree that a client has been treated unfairly by a staff member until you first talk with the staff member. Clients will attempt to use you in a manipulative way against someone else. Remember the staff comes first. You must not subgroup with clients against staff. This decreases the effectiveness of the entire facility. You must prevent clients from using their old manipulative skills. If a client is having a problem with a staff member, then arrange for the staff member and the client to meet to see whether they can resolve the issue together. You are teaching the client how to resolve interpersonal problems. If the client has a problem with someone, then he or she has to go to that person to resolve the issue.

Certain clients will try to pit the staff members against each other. This is common for borderline and anti-social clients. This must be resolved by the staff as a whole. A client usually attempts this by telling different staff members different things. The only way of making this manipulation stop is to call everyone together at the same time. This way, the client cannot continue to manipulate. Any other means of trying to solve this problem will not work because the lies will continue to operate. Once everyone gets together with the client at the same time, you will have a more accurate picture of what the problem is and how to resolve it.

WHAT TO DO WHEN A CLIENT DOES NOT LIKE A COUNSELOR

Sometimes a client will want to change counselors. This client needs to share how he or she feels with the current counselor often with a supervisor present. Something might be going wrong with the therapeutic alliance. This matter needs to be discussed with the counselor and the client who are having the problem. It should be rare for a client to change primary counselors while in treatment. Most of these problems revolve around lack of trust, and this is a common problem for chemically dependent persons.

Many staff-client problems result from miscommunication. It is common for two people to misinterpret each other's behavior. Only by bringing the parties together and having them check out their interpretations will the problems be resolved. Each person needs to ask for—and listen to—the other person's thoughts and feelings.

Sometimes clients will want the counselor to do too much. It is as though the clients want the counselor to do all of the work for them. When the counselor balks at this, the clients feel resentful. These clients need to accept the responsibility for their own behavior. They cannot count on someone else to work the program for them. They must work it for themselves.

A client who is having a problem with a staff member might need more time in individual sessions. The client needs to get his or her thinking accurate. Trust issues are of paramount importance in recovery. Trust is essential for the development of a good therapeutic alliance. If a client is having trust problems with the staff, you can bet that the client has this same problem outside of the treatment setting. The client might need to track his or her lack of trust to earlier situations, perhaps during childhood. Things that happened early can convince a client to trust no one. Keep asking the client if he or she ever felt these feelings at an earlier time. These situations will have to be explored in depth and worked through. The client needs to see that the situation has changed. The client is not in the original situation anymore. He or she is in a



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new situation that demands a new level of trust. What about the new situation makes the client feel that he or she cannot trust someone? What is the most rational decision for the client to make? Trust issues must be resolved for the client to move forward in treatment. The client will remain stuck until he or she can trust someone. Once the client trusts one person, the client can transfer the trust to someone else, the group, and then the higher power.

WHAT TO DO WHEN A CLIENT COMPLAINS ABOUT A RULE

Many staff–client problems revolve around rule violations. Clients will say that they did not break the rule, and they may have a very good story to tell about the situation. You must support other staff members in the things they direct the clients to do. Support their consequences. They were there, and you were not there. Talk about how to do it next time if you need to, but do not change the consequence. If you do this, your staff members will be unable to discipline the clients. If the clients learn that the rules can be manipulated, then all of the rules become meaningless. Bring all members involved in the situation together, and talk the issue through. In very rare instances, the person who leveled the consequence may remove the consequence or change it to something more appropriate. This should be done only by the person who leveled the consequence.

No chemically dependent persons want to obey the rules, but the rules exist to protect them from harm. Once they understand that the rules are for them rather than against them, they will be more likely to obey the rules. Clients who are breaking the rules need to see how this tendency feeds into their addiction. If they learn how to follow the rules—particularly the rule of the 12-step program—then this is recovery.

THE WORK ENVIRONMENT

A treatment center should be a fun place to work. People who come into recovery at their worst are at their best in a few short weeks. This is an extremely rewarding environment. It is a place full of great joy. Real

love abounds in a good treatment center. Clients and staff alike enjoy their days. If you do not genuinely enjoy your work, then you are at the wrong place or you are in the wrong business. Chemically dependent persons are a lot of fun to work with. They laugh and have a good time. They have been the life of the party. The staff can learn how to have fun at work. If the staff members work together and love each other, then they can grow from each work day.

Good treatment must be done in an atmosphere of love and trust. Staff members must support each other through the good times as well as the bad times. The old saying applies: "When the going gets tough, the tough get going." Even during periods of stress, the well-functioning staff pulls together and works things out. Humor often saves the day, and a genuine caring for each other smooths the rough spots for staff members. Remember that you are in this field not only for your clients but also for yourself. You are actively involved in your own individual growth.