Alcoholism and Chemical Substance Abuse Dependency Continuing Education Course

(15 Hours/units)

Course Objectives: In addition to the course objectives listed, this course addresses the following content areas related to alcoholism and chemical substance abuse dependency:

- ✓ Counseling theory and practice
- ✓ Social and Cultural Foundations
- ✓ Assessment
- ✓ Professional practice issues
- ✓ Wellness and prevention
- ✓ Human growth and development

Table of Contents:

1. Substance Use and Mental Health Indicators in the United States

Summary

The information below summarizes key findings from the 2018 National Survey on Drug Use and Health (NSDUH) for national indicators of substance use and mental health among people aged 12 or older in the civilian, non-institutionalized population of the United States. Results are provided for the overall category of people aged 12 or older and by age subgroups.

Substance Use

In 2018, an estimated 164.8 million people aged 12 or older in the United States (60.2 percent) were past month substance users (i.e., tobacco, alcohol, or illicit drugs). About 2 out of 5 people aged 12 or older (108.9 million, or 39.8 percent) did not use substances in the past month. The 164.8 million past month substance users in 2018 include 139.8 million people who drank alcohol, 58.8 million people who used a tobacco product, and 31.9 million people who used an illicit drug.

Tobacco Use

In 2018, an estimated 47.0 million people aged 12 or older were past month cigarette smokers, including 27.3 million people who were daily cigarette smokers and 10.8 million daily smokers who smoked approximately a pack or more of cigarettes per day. Fewer than 1 in 6 people aged 12 or older in 2018 were past month cigarette smokers. Cigarette use generally declined between 2002 and 2018 across all age groups. Some of this decline may reflect the use of electronic vaporizing devices ("vaping"), such as e-cigarettes, as a substitute for delivering nicotine. NSDUH does not currently ask separate questions about the vaping of nicotine.

Alcohol Use

In 2018, about 139.8 million Americans aged 12 or older were past month alcohol users, 67.1 million were binge drinkers in the past month, and 16.6 million were heavy drinkers in the past month.1 About 2.2 million adolescents aged 12 to 17 drank alcohol in the past month, and 1.2 million of these adolescents binge drank in that period. Although the percentage of adolescents who drank alcohol decreased between 2002 and 2018, about 1 in 11 adolescents in 2018 were past month alcohol users.

Illicit Drug Use

In 2018, nearly 1 in 5 people aged 12 or older (19.4 percent) used an illicit drug in the past year, which is a higher percentage than in 2015 and 2016. The estimate of past year illicit drug use for 2018 was driven primarily by marijuana use, with 43.5 million past year marijuana users. The percentage of people aged 12 or older in 2018 who used marijuana in the past year (15.9 percent) was higher than the percentages in 2002 to 2017. This increase in past year marijuana use for people aged 12 or older reflects increases in marijuana use among both young adults aged 18 to 25 and adults aged 26 or older.

In contrast, past year marijuana use among adolescents aged 12 to 17 did not increase between 2014 and 2018.

Prescription pain reliever misuse was the second most common form of illicit drug use in the United States in 2018, with 3.6 percent of the population misusing pain relievers. For people aged 12 or older and for young adults aged 18 to 25, the percentages who misused prescription pain relievers in the past year were lower in 2018 than in 2015 to 2017. Similar decreases in pain reliever misuse were observed for adolescents aged 12 to 17 and adults aged 26 or older in 2018 compared with 2015 and 2016 but not when compared with 2017. Among people aged 12 or older in 2018 who misused pain relievers in the past year, the most common main reason for their last misuse of a pain reliever was to relieve physical pain (63.6 percent). More than half (51.3 percent) of people who misused pain relievers in the past year obtained the last pain reliever they misused from a friend or relative.

NSDUH also allows for estimation of opioid misuse, which is defined as the use of heroin or the misuse of prescription pain relievers. In 2018, an estimated 10.3 million people aged 12 or older misused opioids in the past year, including 9.9 million prescription pain reliever misusers and 808,000 heroin users. Approximately 506,000 people misused prescription pain relievers and used heroin in the past year. The percentage of people aged 12 or older in in 2018 who were past year opioid misusers was lower than the percentages between 2015 and 2017, which was largely driven by declines in pain reliever misuse rather than by changes in heroin use.

Substance Use Initiation

In 2018, the substances with the largest number of recent (i.e., past year) initiates of use or misuse were alcohol (4.9 million new users), marijuana (3.1 million new users), prescription pain relievers (1.9 million new misusers), and cigarettes (1.8 million new users). Although the number of marijuana initiates aged 12 or older in 2018 was higher than the numbers in 2002 to 2016, it was similar to that in 2017. The number of people aged 12 or older in 2018 who initiated the misuse of prescription pain relievers was similar to the numbers in 2015 to 2017. In 2018, among adolescents aged 12 to 17 and young adults aged 18 to 25, however, the numbers of new misusers of pain relievers were lower than the numbers in 2015 and 2016.

Perceived Risk from Substance Use

In 2018, more than 4 out of 5 people aged 12 or older perceived great risk of harm from weekly use of cocaine or heroin (86.5 and 94.3 percent, respectively), while less than one third of people (30.6 percent) perceived great risk of harm from weekly marijuana use. About 2 out of 3 people (68.5 percent) perceived great risk from daily binge drinking, and nearly 3 out of 4 people (71.8 percent) perceived great risk from smoking one or more packs of cigarettes per day. Perceptions of risk from this level of daily cigarette use or weekly marijuana and cocaine use among people were lower in 2018 than in 2015. However, the percentages of people in 2018 who perceived great risk from weekly heroin use or daily binge drinking were similar to the corresponding percentages in 2015 to 2017. Among adolescents aged 12 to 17 in 2018, there were declines in the percentages who perceived great risk from this level of daily cigarette use (smoking one or more packs per day) and weekly marijuana use, but the percentages who

perceived great risk from daily binge drinking, weekly cocaine use, or weekly heroin use were similar to prior years.

Substance Use Disorders
In 2018, approximately 20.3 million people aged 12 or older had a substance use disorder (SUD) related to their use of alcohol or illicit drugs in the past year, including 14.8 million people who had an alcohol use disorder and 8.1 million people who had an illicit drug use disorder.2 The most common illicit drug use disorder was marijuana use disorder (4.4 million people). An estimated 2.0 million people had an opioid use disorder, which includes 1.7 million people with a prescription pain reliever use disorder and 0.5 million people with a heroin use disorder. Although the percentage of people with an SUD in 2018 was similar to the percentages in 2015 to 2017, the corresponding percentages of the population with a pain reliever use disorder, opioid use disorder, or alcohol use disorder were lower than in 2015.

Major Depressive Episode
In 2018, about 1 in 7 adolescents aged 12 to 17 (14.4 percent) had a past year major depressive episode (MDE), or 3.5 million adolescents. About 1 in 10 adolescents (10.0 percent) had a past year MDE with severe impairment, or 2.4 million adolescents.3 The percentage of adolescents in 2018 who had a past year MDE was higher than the percentages in 2004 to 2017.

In 2018, approximately 13.8 percent of young adults aged 18 to 25 (4.6 million) had an MDE during the past year, and 8.9 percent (3.0 million) had a past year MDE with severe impairment. The percentage of young adults in 2018 who had a past year MDE was greater than the percentages in 2005 to 2016, but it was similar to the percentage in 2017.

Mental Illness among Adults
In 2018, an estimated 47.6 million adults aged 18 or older (19.1 percent) had any mental illness (AMI) in the past year. An estimated 11.4 million adults in the nation had serious mental illness (SMI) in the past year, corresponding to 4.6 percent of all U.S. adults.4 The percentages of adults aged 18 or older in 2018 with AMI or SMI were similar to the corresponding percentages in 2017, but they were higher than the percentages in most years from 2008 to 2016. Percentages of young adults aged 18 to 25 in 2018 who had AMI or SMI also were greater than the corresponding percentages in each year from 2008 to 2016, but they were similar to the percentages in 2017.

Co-Occurring Mental Health Issues and Substance Use Disorders
Approximately 358,000 adolescents (1.5 percent of all adolescents) had an SUD and an MDE in the past year, including 288,000 adolescents (1.2 percent of all adolescents) who had an SUD and an MDE with severe impairment. The percentages of adolescents who had an SUD and an MDE or who had an SUD and an MDE with severe impairment remained steady from 2015 to 2018.

In 2018, an estimated 9.2 million adults aged 18 or older (3.7 percent of all adults) had both AMI and at least one SUD in the past year, and 3.2 million adults (1.3 percent of all adults) had co−occurring SMI and an SUD in the past year. The 2018 percentages of adults with both AMI and an SUD and adults with

both SMI and an SUD were higher than the corresponding percentages in 2015 and 2016, but they were similar to the percentages in 2017.

Substance Use among People with Mental Health Issues

In 2018, substance use was more common among both adolescents and adults who had a mental health issue than among those who did not have a mental health issue. About 1 in 16 adolescents aged 12 to 17 in 2018 (6.1 percent) with a past year MDE smoked cigarettes in the past month compared with 2.1 percent of those without a past year MDE. In addition, adolescents with an MDE were more likely than those without an MDE to binge drink in the past month (8.5 vs. 4.1 percent) and to use an illicit drug in the past year (32.7 vs. 14.0 percent).

Among adults aged 18 or older in 2018, an estimated 28.1 percent of adults with AMI and 37.2 percent of adults with SMI were cigarette smokers in the past month compared with 16.3 percent of those without any mental illness. In addition, 31.3 percent of adults with AMI and 32.3 percent of adults with SMI were binge drinkers in the past month compared with 25.3 percent of adults with no mental illness. The percentages of adults who used illicit drugs in the past year were higher among those with SMI (49.4 percent) and adults with AMI (36.7 percent) compared with those without any mental illness (15.7 percent).

Suicidal Thoughts and Behavior among Adults

In 2018, an estimated 10.7 million adults aged 18 or older had thought seriously about trying to kill themselves (4.3 percent of adults), 3.3 million had made suicide plans (1.3 percent), and 1.4 million made a nonfatal suicide attempt (0.6 percent). The percentage of adults aged 18 or older in 2018 who had serious thoughts of suicide was higher than the percentages in 2008 to 2014, but it was similar to the percentages in 2015 to 2017. The percentage of young adults aged 18 to 25 in 2018 with serious thoughts of suicide also was higher than in 2008 to 2016. Similarly, the percentage of adults aged 26 to 49 in 2018 who had serious thoughts of suicide was higher than the percentages in most years between 2008 and 2015. In contrast, the percentage of adults aged 50 or older in 2018 with serious thoughts of suicide was similar to the percentages in most years from 2008 to 2017.

Substance Use Treatment

In 2018, an estimated 21.2 million people aged 12 or older needed substance use treatment.5 This number translates to about 1 in 13 people who needed treatment (7.8 percent). About 1 in 26 adolescents aged 12 to 17 (3.8 percent), about 1 in 7 young adults aged 18 to 25 (15.3 percent), and 1 in 14 adults aged 26 or older (7.0 percent) needed treatment. The 2018 percentage of adolescents aged 12 to 17 who needed treatment was lower than in 2015 and 2016, but it was similar to the percentage in 2017. In contrast, percentages of adults in 2018 who needed substance use treatment were similar to the percentages in 2015 to 2017 for young adults aged 18 to 25 and adults aged 26 or older.

In 2018, approximately 1.4 percent of people aged 12 or older (3.7 million people) received any substance use treatment in the past year, and 0.9 percent (2.4 million) received substance use treatment at a specialty facility. The percentages of people aged 12 or older in 2018 who received any substance use treatment and who received substance use treatment at a specialty facility were similar to the

percentages in 2015 to 2017. An estimated 11.1 percent of people aged 12 or older who needed substance use treatment received treatment at a specialty facility in the past year. The percentage of people aged 12 or older in 2018 who needed substance use treatment and received treatment at a specialty facility also was similar to the percentages in 2015 and 2017.

In 2018, among the estimated 18.9 million people aged 12 or older who needed substance use treatment but did not receive specialty treatment in the past year, about 964,000 perceived a need for substance use treatment. About 2 in 5 people who needed and perceived a need for treatment but did not receive treatment at a specialty facility were not ready to stop using, and about 1 in 3 had no health care coverage and were not able to afford the cost.

Treatment for Depression

Among the 3.5 million adolescents aged 12 to 17 and the 4.6 million young adults aged 18 to 25 in 2018 who had a past year MDE, 1.4 million adolescents (41.4 percent) and 2.3 million young adults (49.6 percent) received treatment for depression. The percentages of adolescents and young adults in 2018 with a past year MDE who received treatment for their depression were similar to the percentages in most prior years.

Mental Health Service Use among Adults

In 2018, an estimated 37.1 million adults aged 18 or older (15.0 percent of adults) received mental health care during the past 12 months. Among the 47.6 million adults with AMI, 20.6 million (43.3 percent) received mental health services in the past year. The percentage of adults in 2018 with AMI who received mental health care was higher than the percentages in most years from 2008 to 2012, but it was similar to the percentages in 2013 to 2017. About 7.3 million of the 11.4 million adults with past year SMI (64.1 percent) received mental health services in the past year. The percentage of adults in 2018 with SMI who received mental health care was similar to the percentages in 2008 to 2012 and 2015 to 2017, but it was lower than the percentages in 2013 and 2014. However, about one third of adults with SMI in any given year did not receive mental health services.

In 2018, an estimated 11.2 million adults aged 18 or older with past year AMI and 5.1 million adults with past year SMI had a perceived unmet need for mental health care at any time in the past year. The percentage of adults in 2018 with AMI who perceived an unmet need for mental health care in the past year was higher than the percentages in most years from 2008 to 2017. The percentage of adults in 2018 with SMI who perceived an unmet need for mental health care in the past year was higher than the percentages in 2015 and 2016, but it was similar to the percentages in 2017 and in most years from 2008 to 2014. In 2018, about 2 out of 5 adults with AMI (45.2 percent) and slightly more than half of those with SMI (54.7 percent) who perceived an unmet need for mental health services did not receive services because they could not afford the cost of care.

Receipt of Services among People with Co-Occurring Mental Illness and Substance Use Disorder

In 2018, among adolescents aged 12 to 17 who had a co-occurring MDE and an SUD in the past year, 65.7 percent received either substance use treatment at a specialty facility or mental health services in the past year. An estimated 5.4 percent of adolescents with a co-occurring MDE and an SUD received

both mental health care and specialty substance use treatment, 59.5 percent received only mental health care, and 0.8 percent received only specialty substance use treatment.

In 2018, about half of the adults aged 18 or older with co-occurring AMI and an SUD in the past year (51.4 percent) received either mental health care or specialty substance use treatment, and 48.6 percent received neither type of care. An estimated 69.5 percent of adults with co−occurring SMI and an SUD received either type of care, and about 1 in 3 (30.5 percent) received neither type of care. The percentage of adults in 2018 with co-occurring AMI and an SUD who received mental health care or specialty substance use treatment was similar to the percentages in all years from 2015 to 2017. For adults with SMI and an SUD, the percentage of those who received either type of care was higher than the percentage in 2015, but it was similar to the percentages in 2016 and 2017.

2. DSM-5 Diagnostic Summary

Substance abuse is defined as “the overindulgence in and dependence of a drug or other chemical leading to effects that are detrimental to the individual's physical and mental health, or the welfare of others. It is characterized by a pattern of continued pathological use of a medication, non-medically indicated substance, drug or toxin, that results in repeated adverse social consequences related to drug use, such as failure to meet work, family, or school obligations, interpersonal conflicts, or legal problems.”

Substance-Related Disorders and the DSM-5

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

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

- “Recurrent legal problems” has been deleted
- "Craving or a strong desire or urge to use a substance" was added to the criteria

Severity from mild to severe is based on the number of criteria endorsed. Criteria for cannabis and caffeine withdrawal were added. New specifies were added for early and sustained remission along with

new specifiers for "in a controlled environment" and "on maintenance therapy". According to the APA, “Criteria are provided for substance use disorder, accompanied by criteria for intoxication, withdrawal, substance/medication-induced disorders, and unspecified substance-induced disorders, where relevant”.

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

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

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

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

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

DSM-5 Substance Related Disorders

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

- Substance Induced Disorder
  - Substance Intoxication and Withdrawn

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

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

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

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

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

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

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

Cannabis Use Disorder: Marijuana is the most used drug after alcohol and tobacco in the United States. Marijuana's immediate effects include distorted perception, difficulty with thinking and problem solving, and loss of motor coordination. Long-term use of the drug can contribute to respiratory

infection, impaired memory, and exposure to cancer-causing compounds. Heavy marijuana use in youth has also been linked to increased risk for developing mental illness and poorer cognitive functioning.

Some symptoms of cannabis use disorder include disruptions in functioning due to cannabis use, the development of tolerance, cravings for cannabis, and the development of withdrawal symptoms, such as the inability to sleep, restlessness, nervousness, anger, or depression within a week of ceasing heavy use. For information about the treatment of cannabis use disorder, visit SAMHSA's Treatments for Substance Use Disorders page.

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

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

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

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

Symptoms of opioid use disorders include strong desire for opioids, inability to control or reduce use, continued use despite interference with major obligations or social functioning, use of larger amounts

over time, development of tolerance, spending a great deal of time to obtain and use opioids, and withdrawal symptoms that occur after stopping or reducing use, such as negative mood, nausea or vomiting, muscle aches, diarrhea, fever, and insomnia.

3. Types of Substance Abuse

- More young Americans die from drugs than suicides, firearms, or school violence;
- The only disease that affects more people than substance abuse in America today is heart disease;
- Substance abuse is the single largest contributor to crime in the United States;
- In the latest year measured, the direct cost of drug abuse was estimated at 52 billion, with indirect costs of 128 billion.

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

➔ Narcotics
➔ Depressants
➔ Stimulants
➔ Hallucinogens
➔ Anabolic steroids

Each class has distinguishing properties, and drugs within each class often produce similar effects. However, all controlled substances, regardless of class, share a number of common features. All controlled substances have abuse potential or are immediate precursors to substances with abuse potential. With the exception of anabolic steroids, controlled substances are abused to alter mood, thought, and feeling through their actions on the central nervous system (brain and spinal cord). Some of these drugs alleviate pain, anxiety, or depression. Some induce sleep and others energize.
Though some controlled substances are therapeutically useful, the “feel good” effects of these drugs contribute to their abuse. The extent to which a substance is reliably capable of producing intensely pleasurable feelings (euphoria) increases the likelihood of that substance being abused.

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

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

Physical Dependence

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

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

Psychological Dependence

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

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

Addiction

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

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

Narcotics

Also known as "opioids," the term "narcotic" comes from the Greek word for "stupor" and originally referred to a variety of substances that dulled the senses and relieved pain. Though some people still

refer to all drugs as “narcotics,” today “narcotic” refers to opium, opium derivatives, and their semi-synthetic substitutes. A more current term for these drugs, with less uncertainty regarding its meaning, is “opioid.” Examples include the illicit drug heroin and pharmaceutical drugs like OxyContin®, Vicodin®, codeine, morphine, methadone, and fentanyl. What is their origin? The poppy papaver somniferum is the source for all natural opioids, whereas synthetic opioids are made entirely in a lab and include meperidine, fentanyl, and methadone. Semi-synthetic opioids are synthesized from naturally occurring opium products, such as morphine and codeine, and include heroin, oxycodone, hydrocodone, and hydromorphone. Teens can obtain narcotics from friends, family members, medicine cabinets, pharmacies, nursing homes, hospitals, hospices, doctors, and the Internet.

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

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

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

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

Caffeine is an odorless, slightly bitter alkaloid found in coffee, tea, kola nuts, ilex plants, and cocoa. It can also be prepared synthetically from uric acid. While relatively harmless, it is the most commonly used mind altering drug in the world. When used in moderation, caffeine acts as a mild stimulant to the nervous system, blocking the neurotransmitter adenosine and resulting in a feeling of well-being and alertness. It increases the heart rate, blood pressure, and urination and stimulates secretion of stomach acids. However, excessive intake can result in restlessness, insomnia, and heart irregularities. The effects of caffeine vary from person to person, as people excrete it at different rates. Physical

dependence and unpleasant symptoms upon withdrawal (headache, fatigue, and depression) are common in regular caffeine users *(B. A Weinberg and B. K. Bealer, The World of Caffeine)*.

Alcohol

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

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

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

Only 5% of individuals with Alcohol Dependence ever experience severe complications of withdrawal such as delirium. However, repeated intake of high doses of alcohol can affect nearly every organ system, especially the gastrointestinal tract, cardiovascular system, and the central and peripheral nervous system. Gastrointestinal effects include gastritis, stomach or duodenal ulcers, and, in about 15% of those who use alcohol heavily, liver cirrhosis and pancreatitis. There is also an increased rate of cancer of the esophagus, stomach, and other parts of the gastrointestinal tract. One of the most common associated general medical conditions is low-grade hypertension. There is an elevated risk of heart disease. Peripheral neuropathy may be evidenced by muscular weakness, paresthesias, and decreased peripheral sensation. Most persistent central nervous system effects include cognitive deficits, severe memory impairment, and degenerative changes in the cerebellum. One devastating central nervous system effect is the relatively rare Alcohol-Induced Persisting Amnesic Disorder (Wernicke-Korsakoff syndrome) in which there is a dramatic impairment in short-term memory. Men may develop erectile dysfunction and decreased testosterone levels. Repeated heavy drinking in women is associated with menstrual irregularities and, during pregnancy, with spontaneous abortion and fetal alcohol syndrome. Alcohol Dependence can suppress immune system mechanisms, predispose individuals to infections, and increase the risk for cancer. Individuals with Alcohol Dependence are at increased risk for Major

Depressive Disorder, other Substance-Related Disorders, and Conduct Disorder in adolescents, Antisocial and Emotionally Unstable (Borderline) Personality Disorders, Schizophrenia, and Bipolar Disorder *(Diagnostic and Statistical Manual of Mental Disorders, 5th ed. Washington, DC: American Psychiatric Association)*.

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

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

Possible warning signs of advanced alcohol dependence include serious injuries sustained while under the influence, multiple blackouts, and multiple DUI's. Alcohol Dependence is frequently characterized by periods of remission and relapse. The first episode of alcohol intoxication is likely to occur in the mid-teens, with the age at onset of Alcohol Dependence peaking in the 20s to mid-30s. The large majority of those who develop Alcohol Dependency do so by their late 30s. Alcohol Dependence often has a familial pattern, and it is estimated that 40%-60% of the variance of risk is explained by genetic influences. The risk for Alcohol Dependence is 3 to 4 times higher in close relatives of people with Alcohol Dependence. Most studies have found a significantly higher risk for Alcohol Dependence in the monozygotic twin than in the dizygotic twin of a person with Alcohol Dependence. Adoption studies have revealed a 3- to 4-fold increase in risk for Alcohol Dependence in the children of individuals with Alcohol Dependence when these children were adopted away at birth and raised by adoptive parents who did not have this disorder. Follow-up studies of the typical person with an Alcohol Use Disorder show a higher than 65% 1-year abstinence rate following treatment. Even among less functional and homeless individuals with Alcohol Dependence who complete a treatment program, as many as 60% are

abstinent at 3 months, and 45% at 1 year. Some individuals (perhaps 20% or more) with Alcohol Dependence achieve long-term sobriety even without treatment *(Source: National Clearinghouse for Drug & Alcohol Information).*

Tranquilizers

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

Amphetamines

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

Inhalants

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

Inhalants fall into the following categories:

Volatile solvents—liquids that vaporize at room temperature

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

Aerosols—sprays that contain propellants and solvents

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

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

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

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

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

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

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

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

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

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

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

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

Benzodiazepines

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

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

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

Barbiturates

Barbiturates are any one of a group of drugs that act as depressants on the central nervous system. High doses depress both nerve and muscle activity and inhibit oxygen consumption in the tissues. In low doses barbiturates act as sedatives, i.e., they have a tranquilizing effect; increased doses have a hypnotic or sleep-inducing effect; still larger doses have anticonvulsant and anesthetic activity. The mechanism of action on the central nervous system is not known. The barbiturates are all derivatives of barbituric acid, which was first prepared in 1864 by the German organic chemist Adolf von Baeyer.

The drugs differ widely in the duration of their action, which depends on the rapidity with which they are distributed in body tissues, degraded, and excreted. Ultrashort-acting barbiturates such as thiopental sodium (Pentothal) are often used as general anesthetics. Secobarbital (Seconal) and pentobarbital sodium (Nembutal) are short-acting barbiturates, amobarbital (Amytal) is intermediate in duration of action, and phenobarbital (Luminal) is a long-acting derivative. Barbiturates are used to relax patients before surgery, as anticonvulsants, and as sleeping pills. They also are commonly abused. Taken

regularly, barbiturates can be psychologically and physically addictive. Barbiturate addicts must be withdrawn from the drug gradually to avoid severe withdrawal symptoms such as convulsions. Overdose can cause coma or death. In the United States the manufacture and distribution of barbiturates were brought under federal control by the 1965 Drug Abuse and Control Act, and they are legally available only by prescription. See publications of the Drugs & Crime Data Center and Clearinghouse, the Bureau of Justice Statistics Clearinghouse, and the National Clearinghouse for Alcohol and Drug Information *(American Psychiatric Association. Substance-related disorders. In Diagnostic and Statistical Manual of Mental Disorders, 5th ed, Washington, DC: American Psychiatric Association).*

Steroids

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

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

Natural or synthetic steroids are used in oral contraceptives and in the treatment of arthritis, Addison's disease, and certain skin ailments. Side effects, related to dosage and length of treatment, can be serious and include high blood pressure, edema, unwanted hair growth, and menstrual cycle disruption. Anabolic steroids, male hormones given to build up strength in seriously ill patients, have been abused by bodybuilders and athletes in an attempt to increase muscle mass and strength *(The Columbia Electronic Encyclopedia, 6th ed., Columbia University Press).*

Analgesics

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

Illegal Substances

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

Opiates

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

Cocaine

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

Modes of Administration; "Crack" Cocaine

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

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

Marijuana

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

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

The primary active component of marijuana is delta-9-tetrahydrocannabinol (THC), although other cannabinol derivatives are also thought to be intoxicating. In 1988 scientists discovered receptors that bind THC on the membranes of nerve cells. They reasoned that the body must make its own THC-like substance. The substance, named anandamide, was isolated from pig brains in 1992 by an American pharmacologist, William A. Devane.

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

Hashish

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

Heroin

Heroin is an opiate drug synthesized from morphine. Originally produced in 1874, it was thought to be not only nonaddictive but useful as a cure for respiratory illness and morphine addiction, and capable of relieving morphine withdrawal symptoms. Later it was discovered to have the same pharmacologic effects as morphine and to be just as addictive. In many parts of the world, it is used as an analgesic (for relief of pain), particularly for the terminally ill. Although in the United States the manufacture and importation of the drug are prohibited and it is not used medically, heroin predominates in illicit narcotics traffic because it Heroin is a central nervous system depressant that relieves pain and induces sleep. It produces a dreamlike state of warmth and well-being. It may also cause constricted pupils, nausea, and respiratory depression, which in its extremes can result in death. Heroin activates brain regions that produce euphoric sensations and brain regions that produce physical dependence. Hence, its notorious ability to produce both psychological and physical addiction. Its addictiveness is characterized by persistent craving for the drug, tolerance, and painful and dangerous withdrawal. Withdrawal symptoms include panic, nausea, muscle cramps, chills, and insomnia. Heroin use during pregnancy increases the risk of miscarriage and stillbirth. Infants exposed to heroin in the womb go through withdrawal at birth and exhibit various developmental problems. Besides the danger of overdose, addicts are susceptible to malnutrition, hepatitis, pneumonia, and AIDS *(Baron; Matrix Center; National Council on Alcoholism; National Clearinghouse for Drug & Alcohol Information; Whitebread).*

Hallucinogens

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

4. Substance Abuse Treatment and Outcomes

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

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

Dual diagnosis is the co-morbid condition of a person considered to be suffering from a mental illness and a substance abuse problem. The concept can be used broadly, for example depression and alcoholism, or it can be restricted to specify severe mental illness (e.g. psychosis, schizophrenia) and substance misuse disorder (e.g. cannabis abuse). Dual diagnosis is also a term used for people with an intellectual disability and diagnosed with a mental illness *(Regier DA; Farmer ME, Rae DS, Locke BZ, Keith SJ, Judd LL, Goodwin FK. "Comorbidity of mental disorders with alcohol and other drug abuse. Results from the Epidemiologic Catchment Area Study". JAMA).*

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

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

Jackson described the following stages and behaviors of an alcoholic family during active drinking and recovery periods:

• ***Denial of the problem:*** In this stage, incidents of excessive drinking occur but the alcoholic explains them away. The spouse tries to avoid the topic believing that drinking is not a problem. If the spouse attempts to exert control, s/he is met with resentment and rebellion from the alcoholic.

• ***Attempts to eliminate the problem***: As drinking episodes increase and last longer, the spouse tries to hide the problem from friends and the alcoholic's employer. Husband and wife try to handle problems themselves. The alcoholic feels that no one understands. The non-alcoholic spouse feels out of control and has a sense of failure. The parents impose conflicting requirements on the children during alternate times of drinking and non-drinking. The non-alcoholic spouse is in conflict about whether to protect the children from the reality of drinking or to depend on and confide in them. The alcoholic may insist on attending functions with the children, and then embarrass them with drinking episodes.

• ***Disorganization:*** This phase is a time of chaos in which the non-alcoholic spouse and children have developed strategies for avoiding or controlling the alcoholic behavior. The non-alcoholic spouse is frustrated and unhappy with his or her own responses to the reorganization may involve getting professional help for the family, a non-working spouse seeking employment, and/or discovering AA and Al-Anon.

• ***Efforts to escape the problems***: At this point, either the alcoholic spouse deserts the family, or the non-alcoholic spouse decides to separate, further affecting the family structure. Children may be divided between parents or sent to live with relatives or older siblings.

• ***Reorganization of part of the family:*** Separated from the alcoholic, the family tries to establish a new life. However, the alcoholic spouse may still affect the family by calling, by attempting violence against family members, or by working on their sympathy to gain reconciliation.

• ***Recovery and reorganization of the whole family:*** Whether or not there has been a separation, if the alcoholic spouse achieves sobriety, the family may attempt to reorganize. This involves dealing with problems long hidden by the alcoholism. It also requires acceptance of the need to change family members' individual survival roles from those that were developed as a means of avoiding the consequences of alcoholism.

Family Systems

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

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

Additional factors that contribute to adolescent drug abuse, especially alcoholism:

- **Biological Risk**: Increasing evidence points to a genetic predisposition to chemical dependency. If a parent is a substance abuser, one study indicates that chances are increased by 25% that his/her child will also be a substance abuser *(Conroy)*.
- **Lack of Supervision**: Parents who travel or who both work all day create an environment that allows for unsupervised activities which may involve drinking.
- **Parental Attitudes**: Children develop perceptions about drugs and alcohol based on what they see at home.
- **Life Crises**: Death in the family, divorce, illness, and moving to a new community are all examples of life stressors. A significant positive correlation exists between the number of problems reported in the family and the number of different types of drugs abused by the adolescent offspring *(National Youth Polydrug Study)*.
- **Peer Pressure**: One study indicates that an adolescent's chance of problem or heavy drinking is five times greater if a best friend is also a drinker.

- **Early Beginnings:** The earlier a child learns to sedate anxiety with a substance, the greater the problem. Proportionately, younger children in drug-abusing families are heavier users and require more treatment than their older counterparts.
- **Parenting Style:** Parents intent on being buddies, rather than functioning from an adult executive position, have problems confronting the child and setting limits around substance use. Alcohol is the drug of first choice of American teenagers. It is considered a gateway drug, one that leads to abuse of other substances. Alcohol abuse is blamed for the dramatic increase in teen traffic fatalities, suicides, and homicides. (*The National Council on Alcoholism and Drug Dependency (NCADD)).*

There is a strong correlation between adolescent substance abuse, unsatisfactory family relationships, and inadequate emotional support by parents. A family systems idea of the adolescent substance abuse problem might be stated as follows: a family experiencing discord, detachment or loss without stabilizing coping mechanisms results in an emotional climate which is conducive to the development of an adolescent substance abuser. In a vicious cycle, this drug-abusing behavior then leads to an intensification of the pre-existing dysfunctional family patterns. This unresolved situation leads to more acting-out behavior and increased use of drugs by the adolescent.

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

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

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

Treatment

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

Cocaine Treatment

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

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

Amphetamines Treatment

The person addicted to amphetamines may need medically supervised detoxification. Inpatient treatment may also be necessary. Outpatient treatment for amphetamine abuse often includes a combination of individual and/or group therapies, as well as, participation in a peer support group such as Cocaine Anonymous. Family therapy would be recommended once the substance abuser is stabilized in his or her recovery. Individual therapy for family members could be utilized until family therapy is recommended. This previously described treatment approach could be utilized for most substance abusers and their family members *(Baron; National Clearinghouse for Drug & Alcohol Information; Galanter Kleber)*.

Opiod Treatment

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

Sedative, Hypnotic or Anxiolytic Treatment

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

Marijuana Treatment

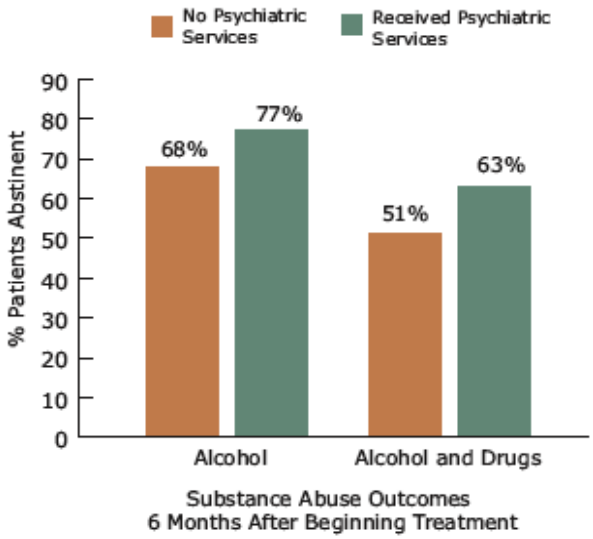
Modern therapy for marijuana addiction embraces a multi-disciplinary approach. Education, group and individual counseling, and peer support groups are often used to facilitate recovery. Community based self-help groups such as Marijuana Anonymous or Narcotics Anonymous should be utilized for continuing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

Hallucinogen Treatment

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

Inhalants Treatment

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



Cognitive Behavioral Therapy (CBT) of Substance Abuse

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

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

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

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

might as well go on a binge"), resulting in a vicious cycle *(Beck et al.)*.

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

12 Step

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

- admitting that one cannot control one's addiction or compulsion;
- recognizing a greater power that can give strength;
- examining past errors with the help of a sponsor (experienced member);
- making amends for these errors;
- learning to live a new life with a new code of behavior;

- helping others that suffer from the same addictions or compulsions.

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

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

Twelve Steps

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

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

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

Twelve Traditions

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

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

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

AA Effectiveness

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

5. Substance Abuse Treatment for Clinicians

Common Treatment Modalities

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

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

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

Short-term Residential

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

Short Term Inpatient Treatment (SIT)

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

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

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

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

Long-term Residential Treatment (or therapeutic community)

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

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

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

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

Outpatient Treatment

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

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

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

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

Understanding 12 Step Self Help Programs

Family therapists would benefit from attendance at 12 Step programs to understand the concepts and to see in action the principles that might be helpful to their clients. Anyone can attend an open 12 Step meeting (see a local telephone directory or AA's Web site at www.aa.org, and click on "contact local

AA"), and therapists who attend meetings and process the information with knowledgeable supervisors or colleagues are able to converse with clients about meeting attendance, problems, benefits, and methods of utilizing 12 Step meetings in conjunction with the therapeutic process. Experience with attendance at 12 Step meetings helps therapists to address issues of resistance when clients say that the meetings are not appropriate for them (e.g., "everyone is different from me," or "they make me tell things I don't want to talk about.") Another benefit of therapists' attendance at meetings is the ability to prepare a client for attendance. The therapist can give an overview of what to expect; for example, it is not necessary to put a donation in the basket as it is passed; it is okay to say "pass" if people are taking turns talking by going around the room, seat by seat; how people use sponsors, and so on.

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

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

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

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

Summary Points from a Family Counselor Point of View

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

6. Engaging Adolescents in Treatment

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

Adolescents with both traumatic stress and substance abuse problems often have complex histories (See section II: Complex Trauma) and numerous additional problems that make this population particularly difficult to treat. Empirically based treatment interventions offer adolescents a good chance of success in overcoming a variety of psychological problems; however, many youth fail to obtain treatment, and those who enter treatment of ten terminate prematurely. Clinicians who work with adolescents encounter a series of challenges when trying to engage youth who have histories of traumatic stress and substance abuse. Most adolescents do not enter treatment voluntarily and are often apprehensive about the process. Furthermore, substance abusing adolescents, much like their adult counterparts, often have a hard time making positive changes in their use patterns. To provide effective services, these challenges and barriers must be addressed.

This fact sheet offers an introduction to many important issues regarding engaging adolescents in treatment that providers must consider when treating adolescents with symptoms of both traumatic stress and substance use. Topics include identifying and encouraging youth to seek help, getting adolescents into initial treatment sessions, addressing practical barriers to care, getting families involved, building alliances, and enhancing community awareness.

As you read through the pages that follow, think about adolescents like Brenda, and consider the following questions:

- What are some specific challenges related to Brenda's history that might make engaging her in treatment difficult?
- How can we identify youth in need early?
- Are there ways to encourage adolescents to seek help?
- How can we get youth to give therapy a chance?

- What are the practical barriers that might keep adolescents out of treatment?
- How can we best get families and other caregivers involved in treatment?
- What are some ways to build alliances with these youth and their families?
- What steps can we take to educate the greater community about the link between substance abuse and traumatic stress?

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

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

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

Identifying & Encouraging Youth to Seek Help

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

Offer multiple types of assistance

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

Identify youth in schools

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

1. Via peer networks: School-based support programs offer a promising pathway to reach at-risk youth. Programs that identify and train student leaders to provide peer assistance can help clinicians recognize at-risk students and provide needed support and referrals. By utilizing in-school student support resources, clinicians are more likely to be able to identify youth who would otherwise not have approached an adult for treatment. Programs that employ peer support networks to identify youth at risk should provide close adult supervision to peer supporters and have counselors readily available to provide assistance to the youth identified by the peer supporters.
2. Via standardized screening: Youth at risk can be identified by screenings and evaluations conducted in school or after-school settings. Clinicians administering annual or semiannual mental health or substance abuse screenings at a school can help identify youth who would not have sought treatment or otherwise been identified, thus facilitating youths' engagement in treatment or services. Multiple schools have screened their adolescent students for substance abuse problems using the CRAFFT (C*hildren's Hospital Boston*), a brief and adolescent-appropriate instrument. Programs that employ the Cognitive-Behavioral Intervention for Trauma in Schools (CBITS), Stein et al., have successfully screened large numbers of students for traumatic stress within high-school populations. (See also Section 4: CBITS).*Getting Adolescents in the Door*

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

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

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

they receive training in cultural competence; this will greatly contribute to successful treatment engagement and delivery.

Reach out to the family

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

Engaging Homeless Youth

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

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

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

Addressing Practical Barriers to Care

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

- **Transportation:** Discuss with the youth and family potential obstacles to getting to appointments regularly. Whenever possible, offer to provide bus or transit passes if your center is near public transportation.
- **Scheduling:** Both parents and adolescents may have difficulty with scheduling appointments. If a family is working with other treatment team members, try to coordinate with these members to schedule as many appointments as possible on the same day, so that the family has to make only one trip to your location. Discuss the possibility of holding sessions before or after usual business hours to enable families to schedule appointments around work and school commitments.
- **Address child care limitations:** Families may have young children to care for and may not be able to afford child care during family sessions or parent sessions. If your agency has access to volunteers, ask them to assist with child care while parents are in session.
- **Address caregivers' treatment issues:** Caregivers may need referrals for treatment themselves. Providing independent referrals for caregiver treatment may help to alleviate stress on a family.

Getting Families Involved

Adolescents whose caregivers are involved and engaged in treatment are more likely to have better outcomes than those whose caregivers do not believe that treatment will help and/or are unwilling to work with treatment providers (Dakof, Tejeda, & Liddle). Specific strategies for family involvement in treatment (See section 4: Family-Based Therapies) include:

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

involved in an adolescent's care day to day including close friends and mentors who might support the adolescent's successful engagement in treatment. Be particularly sensitive to situations in which an adolescent does not live with a biological parent.

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

Building Alliances

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

- Establishing rapport, setting clear boundaries, and allowing for autonomy: Many adolescents do not respond to an intervention that they perceive as being imposed upon them, whether by a clinician, parents, or other authority figures. Regardless of the specific treatment approach, it is essential that clinicians get to know an adolescent in the beginning of treatment and develop a solid working relationship. It is also essential that clinicians outline a framework for the therapeutic relationship that establishes clear boundaries but allows for the adolescent to make autonomous decisions.
- Finding out what the adolescent wants to talk about: Although adolescents may be reluctant to disclose details about their risky behavior, there are several ways to encourage meaningful conversations that will lead to open discussion about what is going on in their lives. These strategies include the following.
    - Discovering and displaying both genuine interest in and respect for his/her unique interests, concerns, and worldview
    - Showing some understanding of the culture the adolescent is surrounded by.

- Offering wisdom and guidance that can help the adolescent solve his/her life problems as he/she sees them.
- Informing youth about normal behavior

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

Using appropriate assessment tools

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

Discussing the limits of confidentiality thoroughly

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

Employing Motivational Interviewing (discussed in section 4)

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

- Taking an empathic, nonjudgmental stance and listening reflectively. This involves attempting to understand the teenager's perspective and helping them feel understood, so that they can be more open and honest with others.
- Identifying how the adolescent's current behavior may affect their goals. This involves working with adolescents to identify personally meaningful goals, and helping youth evaluate whether what they are doing now will interfere with where they want to be in the future.
- Rolling with resistance. Rather than arguing with youth when they hit a roadblock, help them develop their own solutions to the problems that they have identified. Thus, youth are not reinforced when being a devil's advocate for the clinician's suggestions or recommendations about discontinuing use.

- Supporting self-efficacy for change. The belief that change is possible is an important motivator for successful change. Help adolescents be hopeful and confident about their ability to impact their own future in a positive way.
- Leaving the door open :When an adolescent wants to terminate treatment, make sure you leave the door open for them
- Rolling with resistance. Rather than arguing with youth when they hit a roadblock, help them develop their own solutions to the problems that they have identified. Thus, youth are not reinforced when being a devil's advocate for the clinician's suggestions or recommendations about discontinuing use.
- Supporting self-efficacy for change. The belief that change is possible is an important motivator for successful change. Help adolescents be hopeful and confident about their ability to impact their own future in a positive way.

Leaving the door open

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

Provide information about symptoms of substance abuse

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

Provide information about risk and protective factors

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

Community Awareness

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

7. Brief Strategic Family Therapy for Adolescent Drug Abuse

Brief Strategic Family Therapy: An Overview

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

BSFT is based on three basic principles. The first is that BSFT is a family systems approach. Family systems means that family members are interdependent: What affects one family member affects other family members. According to family systems theory, the drug-using adolescent is a family member who displays symptoms, including drug use and related co-occurring problem behaviors. These symptoms are indicative, at least in part, of what else is going on in the family system (Szapocznik and Kurtines). Just as important, research shows that families are the strongest and most enduring force in the development of children and adolescents (Szapocznik and Coatsworth). For this reason, family-based interventions have been studied as treatments for drug-abusing adolescents and have been found to be efficacious in treating both the drug abuse and related co-occurring problem behaviors *(for reviews, see Liddle and Dakof 1995; Robbins et al. 1998; Ozechowski and Liddle 2000)*.

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

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

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

Why Brief Strategic Family Therapy?

The scientific literature describes various treatment approaches for adolescents with drug addictions, including behavioral therapy, multisystemic therapy, and several family therapy approaches. Each of these approaches has strengths.

BSFT's strengths include the following:

Basic Concepts of Brief Strategic Family Therapy

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

- ✓ Context
- ✓ Systems
- ✓ Structure
- ✓ Strategy
- ✓ Content versus process

Context

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

Family as Context

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

Peers as Context

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

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

Neighborhood as Context

The interactions between the family and the context in which the family lives may also be important to consider. A family functions within a neighborhood context, family members live in a particular neighborhood, and the children in the family are students at a particular school. For instance, to effectively manage a troubled 15- year-old's behavioral problems in a particular neighborhood, families may have to work against high drug availability, crime, and social isolation. In contrast, a small town in a semi-rural community may have a community network that includes parents, teachers, grandparents, and civic leaders, all of whom collaborate in raising the town's children. Neighborhood context, then, can introduce additional challenges to parenting or resources that should be considered when working with families.

Culture as Context

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

Counseling as Context

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

Systems

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

A Whole Organism

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

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

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

Family Systemic Influences

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

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

The Principle of Complementarity

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

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

Structure: Patterns of Family Interaction

An exchange among family members, either through actions or conversations, is called an interaction. In time, interactions become habitual and repetitive, and thus are referred to as patterns of interaction *(source: Minuchin)*. Patterns of family interaction are the habitual and repeated behaviors family members engage in with each other. More specifically, the patterns of family interaction are comprised of linked chains of behavior that occur among family members. A simple example can be illustrated by

observing that family members choose to sit at the same place at the dinner table every day. Where people sit may make it easier for them to speak with each other and not with others. Consequently, a repetitive pattern of interaction reflected in a "sitting" pattern is likely to predict the "talking" pattern. A large number of these patterns of interaction will develop in any system. In families, this constellation of repetitive patterns of interaction is called the family "structure."

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

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

Strategy

The Three Ps of Effective Strategy

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

Practical

BSFT uses strategies that work quickly and effectively, even though they might seem unconventional. BSFT may use any technique, approach, or strategy that will help change the maladaptive interactions that contribute to or maintain the family's presenting problem. Some interventions used in BSFT may seem "outside the theory" because they may be borrowed from other treatment modalities, such as behavior modification. For example, behavioral contracting, in which patients sign a contract agreeing to do or not to do certain things, is used frequently as part of BSFT because it is one way to re-establish the parent figures as the family leaders. Frequently, the counselor's greatest challenge is to get the parent(s) to behave in a measured and predictable fashion. Behavioral contracting may be an ideal tool to use to accomplish this. The BSFT counselor uses whatever strategies are most likely to achieve the desired structural (i.e., interactional) changes with maximum speed, effectiveness, and permanence. Often, rather than trying to capture every problematic aspect of a family, the BSFT counselor might emphasize one aspect because it serves to move the counseling in a particular direction. For example, a counselor might emphasize a mother's permissiveness because it is related to her daughter's drug abuse and not emphasize the mother's relationship with her own parents, which may also be problematic.

Problem-Focused

The BSFT counselor works to change maladaptive interactions or to augment existing adaptive interactions (i.e., when family members interact effectively with one another) that are directly related to the presenting problem (e.g., adolescent drug use). This is a way of limiting the scope of treatment to those family dynamics that directly influence the adolescent's symptoms. The counselor may realize that the family has other problems. However, if they do not directly affect the adolescent's problem

behaviors, these other family problems may not become a part of the BSFT treatment. It is not that BSFT cannot focus on these other problems. Rather, the counselor makes a choice about what problems to focus on as part of a time-limited counseling program. For example, the absence of clear family rules about appropriate and inappropriate behavior may directly affect the adolescent's drug-using behavior, but marital problems might not need to be modified to help the parents increase their involvement, control, monitoring and supervision, rule setting, and enforcement of rules in the adolescent's life.

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

Planned

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

Content versus Process: A Critical Distinction

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

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

Process and content can send contradictory messages. For example, while an adolescent may say, "Sure Mom, I'll come home early," her sarcastic gesture and intonation may indicate that she has no intention of following her mother's request that she be home early. Generally, the process is more reliable than the content because behaviors or interactions (e.g., disobeying family rules) tend to repeat over time, while

the specific topic involved may change from interaction to interaction (e.g., coming home late, not doing chores, etc.).

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

Diagnosing Family System Problems

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

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

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

Organization

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

Leadership

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

Counselors look at the hierarchy, or the way a family is ranked, to see who is in charge of leading the family and who holds the family's positions of authority. BSFT assumes that the leadership should be with the parent figures, with supporting roles assigned to older family members. Some leadership responsibilities can be delegated to older children, as long as those responsibilities are not overly burdensome, are age-appropriate, and are delegated by parent figures rather than usurped by the children. BSFT counselors look at behavior control in the family to see who, if anyone, keeps order and doles out discipline in the family. Effective behavior control typically means that the parents are in charge and the children are acting in accordance with parental rules. Guidance refers to the teaching and mentoring functions in the family. BSFT assesses whether these roles are filled by appropriate family members and whether the youngsters' needs for guidance are being met.

Subsystem Organization

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

Subsystem Membership

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

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

Triangulation

Sometimes when two parental authority figures have a disagreement, rather than resolving the disagreement between themselves, they involve a third, less powerful person to diffuse the conflict. This process is called "triangulation." Invariably this triangulated third party, usually a child or an adolescent, experiences stress and develops symptoms of this stress, such as behavior problems. Triangles always spell trouble because they prevent the resolution of a conflict between two authority figures. The triangulated child typically receives the brunt of much of his or her parents' unhappiness and begins to develop behavior problems that should be understood as a call for help.

Communication Flow

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

Resonance

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

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

Enmeshment and Disengagement

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

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

Resonance and Culture

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

Enmeshment (high resonance) and Disengagement (low resonance)

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

BSFT counselors look for certain behaviors in a family that are telltale signs of either enmeshment or disengagement. Obviously, some of these behaviors may happen in any family. However, when a large number of these behaviors occur or when some occur in an extreme form, they are likely to reflect problems in the family's patterns of interaction. Easily observable symptoms of enmeshment include one person answering for another, one person finishing another's statements, and people interrupting each other. Observable symptoms of disengagement include one family member who wants to be separated from another or a family member who rarely speaks or is spoken about.

Developmental Stages

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

Each time a developmental transition is reached, the family is confronted by a new set of circumstances. As the family attempts to adapt to the new circumstances, it experiences stress. Failure to adapt, to make the transition, to give up behaviors that were used successfully at a previous developmental stage, and to establish new behaviors that are adaptive to the new stage will cause some family members to develop new behavior problems. Perhaps one of the most stressful developmental changes occurs when children reach adolescence. This is the stage at which a large number of families are not able to adapt to developmental changes (e.g., from direct guidance to leadership and negotiation). Parents must be able

to continue to be involved and monitor their adolescent's life, but now they must do it from a distinctly different perspective that allows their daughter or son to gain autonomy.

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

Developmental transitions may be stressful. They are likely to cause family shake-ups because families may continue to approach new situations in old ways, thus making it possible for conflict to develop. Most often, families come to the attention of counselors precisely at these times. Of all of these developmental milestones, reaching adolescence appears to be one of the most risky and critical stages in which drug abuse can occur in most ethnic groups *(Vega and Gil)*. Although the adolescent is the family member who is most likely to behave in problematic ways, often other members of the family, such as parents, also exhibit signs of troublesome or maladaptive behaviors and feelings *(Silverberg)*.

Assessing Appropriate Developmental Functioning

Careful judgments are needed to determine what is developmentally appropriate and/or inappropriate for each family member. It is particularly difficult to make these judgments when assessing the tasks and roles of children and extended family members. In every instance, the BSFT counselor should take into account the family's cultural heritage when making these judgments. For example, it is useful to know that some traditional African-American and Hispanic families tend to protect their children longer than non-Hispanic whites do. Thus, it would not be unusual for children to have a longer period of dependence among traditional Hispanic groups than among non-Hispanic white families. Similarly, it would not be unusual for the African-American caretaker of a 12-year-old to continue to behave in an authoritarian manner without the child rebelling or considering it odd. In fact, researchers have suggested that African-American inner city youths experience an authoritarian command as caring, while a child from another cultural group might experience it as rejecting. However, as suggested earlier, as an adolescent in the United States grows older, his or her parent, who may be from any culture and in any setting, may have to moderate his or her level of control and increase his or her authoritative parenting, or the youth may rebel.

Common Problems in Assessing Appropriateness of Developmental Stage

It is often difficult for parents to determine what is developmentally appropriate for children of different ages; for example, how much or how little responsibility should a child 6, 10, or 16 years old have in a household? In families of drug-abusing and conduct-disordered adolescents, parents and their children often have a difficult time determining what is developmentally appropriate for a child's age.

One of the main problems family members encounter is how to determine the degree of supervision and autonomy that children should have at each age level. This is a highly complex and conflictive area, even for the best of parents, because as children grow older, they experience considerable pressure from their peers to demonstrate increasing independence. It is also complex because many parents are not aware of what might be the norm in today's society. Therefore, they may allow too little or too much autonomy, based either on their own comfort or discomfort level, their own experience, and/or their culture. Moreover, children's peer groups may vary considerably in the level of autonomy they expect from parents. In working with the notion of "developmental appropriateness," a BSFT counselor needs to examine issues such as roles and functions, rights and responsibilities, limits and consequences, as they are applied to the adolescents in the family. Examples of these standards are available from adolescent development research.

Life Context

While the dimensions of family functioning discussed up to now are all within the family, life context refers to what happens in the family's relationship to its social context. The life context of the family includes the extended family, the community, the work situation, adolescent peers, schools, courts, and other groups that may have an impact on the family, either as stressors or as support systems.

Antisocial Peers

A careful analysis of the life context is useful in many situations involving the treatment of substance abuse. For example, a youngster who uses drugs may be involved with a deviant or antisocial peer group. These friendships affect the youth and family in an adverse way and will certainly need to be modified to successfully eliminate the youth's drug use. Parents need help to identify less acceptable and more acceptable adolescent peers so that they can encourage their teens to associate with more desirable peers and discourage them from associating with less desirable peers.

Parent Support Systems and Social Resources

Parenting is a difficult task. Parents often lack adequate support systems for parenting. Parents need support from friends, extended family members, and other parents *(Henricson and Roker 2000)*. The availability of support systems needs to be assessed, particularly in the case of single-parent families. The availability of social resources needs to be assessed, both in terms of what is already being used or what could potentially be used.

Juvenile Justice System

Increasingly, probation officers and the courts have become critical players in the families of drug-abusing adolescents. It is the BSFT counselor's job to assess how juvenile justice representatives such as probation officers interact with the family to determine whether they are supporting or undermining the family. One way to assess the probation officer's role, for example, is to invite him or her to participate in a family therapy session.

Identified Patient

The "identified patient" is the family member who has been branded by the family as the problem. The family blames this person, usually the drug-abusing adolescent, for much of its troubles. However, as

discussed earlier, the BSFT view of the family is that the symptom is only that: a symptom of the family's problems. The more that family members insist that their entire problem is embodied in a single person, the more difficult it will be for them to accept that it is the entire family that needs to change. On the other hand, the family that recognizes that several of its members may have problems is far healthier and more flexible and will have a relatively easier time of making changes through BSFT. The BSFT counselor believes that the problem is in the family's repetitive (habitual, rigid) patterns of interaction. Thus, the counselor not only will try to change the person who exhibits the problem but also to change the way all members of the family behave with each other.

The other aspect to understanding a family's identified patient is that usually families with problematic behaviors identify only one aspect of the identified patient as the source of all the pain and worry. For example, families of drug-abusing youths tend to focus only on the drug use and possibly on accompanying school and legal troubles that are directly and overtly related to the drug abuse. These families usually overlook the fact that the youngster may have other symptoms or problems, such as depression, attention deficit disorder, and learning deficits.

Conflict Resolution

While solving differences of opinion is always challenging, it is much more challenging when it is done in the context of a conflictive relationship that is high in negativity. The following are five different ways in which families can approach or manage conflicts. Some are adaptive and some are not. In the case of drug-abusing adolescents, with few exceptions, the first four tend to be ineffective, whereas the fifth tends to be effective in most situations:

- Denial
- Avoidance
- Diffusion
- Conflict emergence without resolution
- Conflict emergence with resolution

Denial

"Denial" refers to a situation in which conflict is not allowed to emerge. Sometimes this is done by adopting the attitude that everything is all right. At other times, conflict is denied by arranging situations to avoid confrontation or establishing unwritten rules with which no one dares to disagree outwardly, regardless of how they feel. The classic denial case is the one in which the family says: "We have no problems."

Avoidance

"Avoidance" refers to a situation in which conflict begins to emerge but is stopped, covered up, or inhibited in some way that prevents it from emerging. Examples of avoidance include postponing ("Let's not have a fight now."), humor ("You're so cute when you're mad."), minimizing ("That's not really important."), and inhibiting ("Let's not argue; you know what can happen.").

Diffusion

"Diffusion" refers to situations in which conflict begins to emerge, but discussion about the conflict is diverted in another direction. This diversion prevents conflict resolution by distracting the family's attention away from the original conflict. This change of subject is often framed as a personal attack against the person who raised the original issue. For example, a mother says to her husband, "I don't like it when you get home late," but the husband changes the topic by responding: "What kind of mother are you anyway, letting your son stay home from school today when he is not even sick!"

Conflict Emergence without Resolution

"Conflict emergence" without resolution occurs when different opinions are clearly expressed, but no final solution is accepted. Everyone knows exactly where everyone else stands, but little is done to reach a negotiated agreement. Sometimes this occurs because the family, while willing to discuss the problem, simply does not know how to negotiate a compromise.

Conflict Emergence with Resolution

Emergence of the conflict and its resolution is generally considered to be the best outcome. Separate accounts and opinions regarding a particular conflict are clearly expressed and confronted. Then, the family is able to negotiate a solution that is acceptable to all family members involved.

A Caveat

In some cases, conflicts need to be postponed for more appropriate times. For example, if a family member is very angry, tired, or sick, it may be reasonable to table the conflict until he or she is ready to have a meaningful discussion. However, in such instances, it is critical that the family set a specific time to address the conflict. Indefinitely postponing conflict resolution is a sign of avoidance. A postponement for a definite amount of time is adaptive.

In other instances, a person may decide that the issue at hand is not worth having an argument about. For example, one person may want to stay home while his or her partner wants to go dancing. Either partner may opt to compromise by agreeing to the other's preference. So long as partners take turns compromising, this is adaptive and balanced. However, if the same person is always the one to give in, this may reflect the use of denial by one partner to avoid conflict with the other.

Orchestrating Change

This chapter describes the BSFT approach to orchestrating change in the family. The first section describes how BSFT counselors establish a therapeutic relationship, including the importance of joining with the family, the role of tracking family interactions, and what is involved in building a treatment plan. The second section describes strategies for producing change in the family, including focusing on the present, reframing negativity in the family, shifting patterns of interaction through reversals of usual behavior, changing family boundaries and alliances, "detriangulating" family members caught in the middle of others' conflicts, and opening up closed family systems or subsystems by directing new interactions.

Establishing a Therapeutic Relationship

The counselor's first step in working with a family is to establish a therapeutic relationship with the family, beginning with the very first contact with family members. The quality of the relationship between the counselor and the family is a strong predictor of whether families will come to, stay in, and

improve in treatment *(Robbins et al.)*. In general, studies have found that the therapeutic relationship is a strong predictor of success in many forms of therapy. Validating and supporting the family as a system and attending to each individual family member's experience are particularly important aspects of developing and maintaining a good therapeutic relationship *(Diamond et al)*

Establishing a therapeutic relationship means that the BSFT counselor needs to form a new system--a therapeutic system--made up of the counselor and the family. In this therapeutic system, the counselor is both a member and its leader. One challenge for the BSFT counselor is to establish relationships with all family members, some of whom are likely to be in conflict with each other. For example, drug-abusing adolescents generally begin treatment in conflict with their parent(s) or guardian(s). Both parties approach counseling needing support from the counselor. The counselor's job is to find ways to support the individuals on either side of the conflict. For example, the counselor might say to the adolescent, "I am here to help you explain to your something he or she would like to achieve, the counselor is able to establish a therapeutic alliance with the whole family.

The BSFT approach is based on the view that building a good therapeutic relationship is necessary to bring about change in the family. Several strategies for building a therapeutic relationship, joining, tracking, and building a treatment plan, are discussed below.

Joining

A number of techniques can be used to establish a therapeutic relationship. Some of these techniques fall into the category of "joining," or becoming a temporary member of the family.

Definition of Joining

In BSFT, joining has two aspects. Joining it is the steps a counselor takes to prepare the family for change. Joining also occurs when a therapist gains a position of leadership within the family. Counselors use a number of techniques to prepare the family to accept therapy and to accept the therapist as a leader of change. Some techniques that the therapist can use to facilitate the family's readiness for therapy include presenting oneself as an ally, appealing to family members with the greatest dominance over the family unit, and attempting to fit in with the family by adopting the family's manner of speaking and behaving. A counselor has joined a family when he or she has been accepted as a "special temporary member" of the family for the purpose of treatment. Joining occurs when the therapist has gained the family's trust and has blended with family members. To prepare the family for change and earn a position of leadership, the counselor must show respect and support for each family member and, in turn, earn each one's trust.

One of the most useful strategies a counselor can employ in joining is to support the existing family power structure. The BSFT counselor supports those family members who are in power by showing respect for them. This is done because they are the ones with the power to accept the counselor into the family; they have the power to place the counselor in a leadership role, and they have the power to take the family out of counseling. In most families, the most powerful member needs to agree to a change in the family, including changing himself or herself. For that reason, the counselor's strongest alliance must initially be with the most powerful family member. BSFT counselors must be careful not to defy those in power too early in the process of establishing a therapeutic relationship. Inexperienced family counselors often take the side of one family member against another, behaving as though one were right

and the other were obviously wrong. In establishing relationships with the family, the counselor must join all family members, not just those with whom he or she agrees. In fact, frequently, the person with whom it is most critical to establish an alliance or bond is the most powerful and unlikable family member.

Many counselors in the drug abuse field feel somewhat hopeless about helping the families of drug-abusing youths because these families have many serious problems. Counselors who feel this way may find a discussion about becoming a member of the family unhelpful because their previous efforts to change families have been unsuccessful. BSFT teaches counselors how to succeed by approaching families as insiders, not as outsiders. As outsiders, counselors typically attempt to force change on the family, often through confrontation. However, the counselor who has learned how to become part of the system and to work with families from the inside should seldom need to be confrontational. Confrontation erodes the rapport and trust that the counselor has worked hard to earn. Confrontation can change the family's perception of the counselor as being an integral part of the therapeutic system to being an outsider.

The Price of Failed Joining

An example may help illustrate what is meant by powerful family members. The court system referred a family to counseling because its oldest child had behavior problems. The mother was willing to come to counseling with her son, but the mother's live-in boyfriend did not want the family to be in counseling. The counselor advised the mother to come to therapy with the adolescent anyway. The boyfriend felt that his position of power had been threatened by the potential alliance between the mother and the counselor. As a result, the boyfriend reasserted himself, demanding that she stop participating in counseling. She then dropped out of counseling. This is clearly a case in which the counselor's early challenge of the family's way of "operating" caused the entire family to drop out of treatment. The counselor could and should have been more aware and respectful of the family's existing power structure. Respect, in this case, does not mean that the counselor approves of or agrees with the boyfriend's behavior. Rather, it means that the counselor understands how this family is organized and works his or her way into the family through the existing structure.

A more adaptive counseling strategy might be to call the mother's boyfriend, with the mother's permission, to recognize his position of power in the family and request his help with his girlfriend's son.

A Cautionary Note: Family Secrets

As was already stated, joining is about establishing a relationship with every member of the family. Sometimes a family member will try to sabotage the joining process by using family secrets. Some secrets can cause the counselor such serious problems that he or she is forced to refer the family he or she had intended to help to another counselor. Secrets are best dealt with up front. The counselor should not allow himself or herself to get trapped in a special relationship with one family member that is based on sharing a secret that the other family members do not know. A counselor who keeps a secret is caught between family members. The counselor has formed an alliance with one family member to the exclusion of others. In some cases, it is not just an alliance with one family member but also an alliance with one family member against another family member. It means that the family member with the secret can blackmail the counselor with the threat of revealing that the counselor knows this secret and

didn't address it with the family. Consequently, a family secret is a very effective strategy that family members can use to sabotage the treatment, if counselors let them.

For these reasons, counselors should make it a rule to announce to each family at the onset of counseling that he or she will not keep secrets. The counselor should also say that if anyone shares special information with the counselor, the counselor will help them share it with the appropriate people in the family. For example, if a wife calls and tells the counselor that she is having an affair, her spouse will need to know, although the children do not need to know the parents' marital issues. In this case, the counselor would say, "This affair is indicative of a problem in your marriage. Let me help you share it with your husband." The counselor must do whatever is needed to continue to help the wife see that affairs are symptoms of marital problems. The affair can be reframed as a cry for help, a call for action, or a basic discontent. If so, these marital issues or problems need to be discussed.

It is possible that despite all the counselor's efforts, the wife will respond with an absolute, "No, I don't want to tell him. He would leave me. Besides, this affair doesn't mean all that much." Typically BSFT therapy only gets into marital issues to the extent that the marital problems are interfering with the parents' abilities to function effectively as parents. However, the counselor has no choice but to help the wife tell her husband about the affair. If the wife absolutely refuses, then the counselor has lost his or her bid for leadership in the counseling process. The wife now has control over the counseling process. For that reason, the counselor must refer the family to another counselor.

Tracking

In the example about the mother's powerful boyfriend, it was recommended that the counselor use the way in which the family is organized, or interacts, with the father figure in a position of power, as a vehicle for getting the family into treatment. This strategy in which the counselor learns how the family interacts and then uses this information to establish a therapeutic plan of action is called "tracking." Tracking is a technique in which the counselor respects how the family interacts but, at the same time, takes advantage of those family interactions for therapeutic purposes. Sometimes families interact spontaneously, permitting the counselor to observe the family dynamics. When this does not happen spontaneously, the counselor must encourage the family to interact.

Encouraging the Family to Interact

When a family is in counseling, family members like to tell the counselor stories about each other. For example, a mother might say to the counselor, "My son did so and so." In contrast to the way in which the counselor functions in other therapy models, the BSFT counselor is not interested in the content of the family members' stories. Instead, the counselor is interested in observing (and correcting) problematic interactions. To observe the family's patterns of interaction, the counselor must ask family members to talk directly to each other about the problem. When this occurs, the counselor can observe or track what happens when the family members discuss the issue. The counselor can then watch the family's interactions: fighting, disagreeing, and struggling with their issues. By tracking, the counselor will not only be able to identify the interactive patterns in the family, but also will be able to determine which of these patterns may be causing the family's problems or symptoms. The added benefit of this kind of tracking is that the counselor shows respect for the family's ways of interacting.

Tracking Content and Process

The difference between "content" and "process" was discussed in Chapter 2 (see p. 13). Content is the subject matter that is being discussed. Process refers to the interactions that underlie the communication. By observing the process, the counselor learns who is dominant, who is submissive, what emotions are expressed in the interaction, and the unwritten rules that appear to guide the family's communication and organization. For example, a mother may mention that her son's drug problem is a concern. The grandmother responds by shouting that the mother is overreacting and needs to back off. The content of the interaction--the son's drug problem--is not nearly as important as the process being displayed--the grandmother undermining the mother and shutting her down. Often the counselor will track or use the family's content because it represents a topic that is important to the family. In this example, the counselor might keep the focus of the counseling session on the son's drug problem because it is an important topic in this family. However, the focus of BSFT is entirely on changing process. What needs to be changed here, as a first step, is the parent figures' inability to agree on the existence of a problem, and, more generally, the grandmother's tendency to invalidate the mother's concerns.

Mimesis

"Mimesis" is a form of tracking for the purpose of joining. It refers to mimicking the family's behavior in an effort to join with the family. Mimesis can be used to join with the whole family. For example, a counselor can act jovial with a jovial family. Mimesis also can be used to join with one family member. Mimesis is used in everyday social situations. For example, by attending to how others dress for a particular activity so that one can dress appropriately, one is attempting to gain and demonstrate acceptance by mimicking the type of dress that is worn by others (e.g., casual). People mimic other people's moods when they act like the other people do in certain situations. For example, at a funeral they would act sad as others do and at a celebration they would act joyful. When the counselor validates a family by mimicking its behavior, family members are more likely to accept the counselor as one of their own.

Mimesis also refers to using a family's own ways of speaking to join with the family. Each family and each family member has its, his, or her own vocabulary and perspective. For instance, if a family member is a carpenter, it might be useful to use the language of carpentry. The therapist might say, "Dealing with your son requires lots of different tools, just like jobs at work do. Sometimes you need to use a hammer and use a lot of force, and sometimes you need to use a soft cloth for a more gentle job." If a family member is an accountant, it may be helpful to speak in terms of assets and liabilities. If a person is religious, it may be helpful to speak of God's will.

Whatever language a family uses should be the language the counselor uses to converse with that family. The counselor should not talk to a family using vocabulary that is found in this manual--words such as "interactions," "restructuring," and "systems." Instead, the BSFT counselor should use the "pots and pans" language that each of the family members uses in his or her everyday life. For example, if families are uncomfortable with the term "counseling," the term "meetings" might be used.

Much of the work the counselor does to establish the therapeutic relationship involves learning how the family interacts to better blend with the family. However, the counselor cannot learn the ways in which the family interacts unless he or she sees family members interacting as they would when the counselor is not present. Getting family members to interact can be difficult because families often come into counseling thinking that their job is to tell the counselor what happened. Therefore, it is essential that

counselors decentralize themselves by discouraging communications that are directed at them, and instead encouraging family members to interact so that they can be observed behaving in their usual way.

Building a Treatment Plan

BSFT diagnoses are made to identify adaptive and maladaptive patterns of family interaction so that the counselor can plan practical, strategically efficient interventions. The purpose of the intervention is to improve the family interactions most closely linked to the adolescent's symptoms. This, in turn, will help the family to manage those symptoms.

Enactment: Identifying Maladaptive Interactions

In BSFT, the counselor assesses and diagnoses the family's interactions by allowing the family to interact in the counseling session as it normally does at home. To begin, the counselor asks the family to discuss something. When a family member speaks to the counselor about another family member who is present, the counselor asks the family member who is speaking to repeat what was said directly to the family member about whom it was said. Family interactions that occur as they would at home and that show the family's typical interactional patterns are called "enactments." An enactment can either occur spontaneously, or the counselor can initiate it by asking family members to discuss something among themselves. Creating enactments of family interactions is like placing the counselor on the viewing side of a one-way mirror and letting the family "do its thing" while the counselor observes.

Different therapy models have different explanations for why a family or adolescent is having difficulty, and so they have different targets of intervention. BSFT targets interactional patterns. Because BSFT is a problem-focused therapy approach, it targets those interactional patterns that are most directly related to the symptom for which the family is seeking treatment. Targeting patterns most directly related to the symptom allows BSFT to be brief and strengthens a therapist's relationship with a family by demonstrating that the therapist will help the family solve the problems family members have identified.

Families that develop symptoms tend to be organized or to function around those symptoms. That's because a symptom works like a magnet, organizing the family around it. This is especially true if the symptom is a serious, life-threatening one, such as drug abuse. Therefore, it is most efficient to work with the family by focusing on the symptom around which the family has already organized itself.

Family Crises as Enactments

Enactments are used to observe family interactions in the present and to identify family interactional problems. Family crises are particularly opportune types of enactments because they are highly charged, and family members are emotionally available to try new behaviors. Therefore, families in crisis should be seen immediately. In addition to gaining valuable information about problematic family interactions, the counselor gains considerable rapport with families because he or she is willing to be of service at a time of great need.

A Cautionary Note: Adolescents Attending Therapy Sessions on Drugs

Counselors usually refuse to work with a client who comes into the therapy session on drugs because the client is viewed as "not being all there" to do the treatment work. However, in the case of a family therapy such as BSFT, determining whether to conduct the session is a strategic decision the counselor

must make. One possibility in BSFT is to view the adolescent on drugs as an enactment of what the family confronts at home all the time. Thus, when an adolescent comes to therapy on drugs, it can be viewed as an opportunity for the counselor to teach the family how to respond to the adolescent when he or she takes drugs. The BSFT counselor can see how each family member responds to this situation and look for the maladaptive interactions that allow the adolescent to continue this behavior. The counselor can then work with the non-drug-using family members to change their usual way of responding to the adolescent on drugs. Hence, the work in this session is not with the adolescent but with the other family members.

From Diagnosis to Planning

Once a therapeutic relationship has been established and a diagnosis has been formulated, the counselor is ready to develop a treatment plan. The treatment plan lays out the interventions that will be necessary to change those family maladaptive interactional patterns that have been identified as related to the presenting symptom. Problematic patterns of family interaction are diagnosed using the six dimensions of family interaction discussed in Chapter 3 (organization, resonance, developmental stages, life context, identified patient, and conflict resolution). Often some dimensions are more problematic than others. The interventions need to focus more on the most problematic interactions than on the others.

The six dimensions of the family's interactions operate in an interdependent fashion. For this reason, it may not be necessary to plan a separate intervention to address each problem that has been diagnosed. For example, addressing a family's tendency to blame its problems on the adolescent (i.e., the identified patient) may bring the family's ineffective conflict resolution strategies to light. In a similar fashion, addressing a son's role as his mother's confidant (i.e., inappropriate developmental stage) may bring out the rigid and inflexible boundary between the parent figures.

Producing Change

As was stated earlier, the focus of BSFT is to shift the family from maladaptive patterns of interaction to adaptive ones. Counselors can use a number of techniques to facilitate this shift. These techniques, all of which are used to encourage family members to behave differently, fall under the heading of "restructuring." In restructuring, the counselor orchestrates and directs change in the family's patterns of interaction (i.e., structure). Some of the most frequently used restructuring techniques are described in this chapter.

When the family's structure has been shifted from maladaptive toward adaptive, the family develops a mastery of communication and management skills. In turn, this mastery will help them solve both present and future problems. To help family members master these skills, the BSFT counselor works with them to develop new behaviors and use these new behaviors to interact more constructively with one another. After these more adaptive behaviors and interactions occur, the BSFT counselor validates them with positive reinforcements. Subsequently, the counselor gives the family the task of practicing these new behaviors/interactions in naturally occurring situations (e.g., when setting a curfew or when eating meals together) so that family members can practice mastering these skills at home.

Mastering more adaptive interactions provides families with the tools they need to manage the adolescent's drug abuse and related problem behaviors. Some adaptive behaviors/interactions that validate individual family members are self-reinforcing. However, the counselor needs to reinforce those

behaviors/interactions that initially are not strongly self-reinforcing (i.e., validated) to better ensure their sustainability. As family members reinforce each other's more adaptive skills, they master the skills needed to behave in adaptive ways. It is very important to note that mastery of adaptive skills is not achieved by criticizing, interpreting, or belittling the individual. Rather, it is achieved by incrementally shaping positive behavior.

The rest of this chapter describes seven frequently used restructuring techniques (i.e., to change families' patterns of interaction). These techniques will give a counselor the basic tools needed to help a family change its patterns of interaction. The seven restructuring techniques are:

- ➢ Working in the present
- ➢ Reframing negativity
- ➢ Reversals
- ➢ Working with boundaries and alliances
- ➢ Detriangulation
- ➢ Opening up closed systems
- ➢ Tasks

Working in the Present

Although some types of counseling focus on the past (Bergin and Garfield 1994), BSFT focuses strictly on the present. In BSFT, families do not simply talk about their problems, because talking about problems usually involves telling a story about the past. Working in the present with family interactional processes that are maintaining the family's symptoms is necessary to bring about change in BSFT. Consequently, the BSFT counselor wants the family to engage in interactions within the therapy session--in the same way that it would at home. When this happens and family members enact the way in which they interact routinely, the counselor can respond to help the family members reshape their behavior. Several techniques that require working in the present with family processes are found in subsequent sections within this chapter.

Does BSFT Ever Work in the Past?

Counselors work with the past less than 5 percent of the counseling time. One important example of working in the past can be illustrated by an early counseling session in which the parent and adolescent are in adversarial roles. The parent may be angry or deeply hurt by the youth's behavior. One strategy to overcome this impasse in which neither family member is willing to bend is to ask the parent, "Can you remember when Felix was born? How did you feel?" The parent may say nostalgically: "He was such a beautiful child. The minute I saw him, I was enchanted. I loved him so much I thought my heart would burst."

This kind of intervention is called "reconnection" *(cf. Liddle).* When the parent is hardened by the very difficult experiences he or she has had with a troublesome adolescent, counselors sometimes use the strategy of reconnection to overcome the impasse in which neither the parent nor the youth is willing to bend first. Reconnection is an intervention that helps the parent recall the positive feeling (love) that he or she once had for the child. After the parent expresses his or her early love for the child, the counselor

turns to the youth and says: "Did you know your mother loves you so very much? Look at the expression of bliss on her face."

As can be seen, the counseling session digressed into the past for a very short time to reconnect the parent. This was necessary to change the here-and-now interaction between two family members. The reconnection allowed the counselor to transform an interaction characterized by resentment into an interaction characterized by affection. Because the feelings of affection and bonding do not last long, the counselor must move quickly to use reconnection as a bridge that moves the counseling to a more positive interactional terrain.

Reframing: Systemic Cognitive Restructuring

To "reframe," a counselor creates a different perspective or "frame" of reality than the one within which the family has been operating. He or she presents this new frame to the family in a convincing manner -- that is, "selling" it to the family and then using this new frame to facilitate change. The purpose of systems-oriented, cognitive restructuring (reframing) is to change perceptions and/or meaning in ways that will enable family members to change their interactions. Most of the time, in families of adolescent drug abusers, negativity needs to be reframed. Negativity is usually exhibited as blaming, pejorative, and invalidating statements ("You are no good." "I can't trust you."), and, in general, "angry fighting." Reframing negativity might involve describing a mother's criticism of her teenage son as her desire that he be successful, or reframing fighting as an attempt to have some sort of connection with another family member.

It has been suggested that "... high levels of negativity interfere with effective problem-solving and communication within the family" *(Robbins et al. 1998, p. 174)*. Robbins and colleagues report that negativity in family therapy sessions is linked to dropping out of family therapy. For those who remain in therapy, negativity is linked to poor family therapy outcomes. Because negativity is bad for the family and for the therapy, most contemporary family therapies target negativity. The best-known strategy for transforming negative interactions into positive ones is reframing *(Robbins et al. 2000)*.

While the counselor is encouraged to permit family members to interact with each other in their usual way and to join before orchestrating change, a caveat is necessary when intense negative feelings accompany conflictive interactions. If the family is to remain in counseling, family members must experience some relief from the negative feelings soon after counseling begins. Therefore, counselors are encouraged to use reframing abundantly, if necessary, in the first and perhaps the first few sessions to alleviate the family's intensive negative feelings. Such reframes also may allow family members to discuss their pain and grievances in a meaningful way.

An example will help illustrate the use of reframing negative feelings to create more positive feelings among family members. Anger is a fairly common emotion among families with an adolescent who is involved in antisocial activities. The parents may feel angry that their attempts to guide their child down the "right" path have failed and that the child disrespects their guidance. The adolescent is likely to interpret this anger as uncaring and rejecting. Both parties may feel that the other is an adversary, which severely diminishes the possibility that they can have a genuine dialogue.

The particular reframe that needs to be used is one that changes the emotions from anger, hurt, and fighting (negative) to caring and concern (positive). The counselor must create a more positive reality or

frame. The counselor, for example, might say to the parent, "I can see how terribly worried you are about your son. I know you care an awful lot about him, and that is why you are so frustrated about what he is doing to himself."

With this intervention, the counselor helps move both the parent's and the child's perceptions from anger to concern. Typically, most parents would respond by saying, "I am very worried. I want my child to do well and to be successful in life." When the youth hears the parent's concern, he or she may begin to feel less rejected. Instead of rejecting, the parent is now communicating concern, care, and support for the child. Hence, by creating a more positive sense of reality, the counselor transforms an adversarial relationship between the parent(s) and the adolescent, orchestrating opportunities for new channels of communication to emerge and for new interactions to take place between them.

Reframing is among the safest interventions in BSFT, and, consequently, the beginning counselor is encouraged to use it abundantly. Reframing is an intervention that usually does not cause the counselor any loss of rapport. For that reason, the counselor should feel free to use it abundantly, particularly in the most explosive situations.

Affect: Creating Opportunities for New Ways of Behaving

In BSFT, counselors are interested in affect (a feeling or an emotion) as it is reflected in interactions. In BSFT, the counseling strategy is to use emotion as an opportunity to "move" the family to a new, more adaptive set of interactions. One of many possible ways of working with emotion is found in the following example. When a mother cries, the counselor might suggest to the drug-abusing youngster, "Ask your mom to tell you about her tears." An alternative would be, "What do you think your mom's tears are trying to say?" If the youth responds, "I think it is...," the counselor would follow with a directive to the youth, "Ask your mother if what you think her tears mean is why she is crying." In this way, the crying is used to initiate an interaction among family members that acknowledges not only the emotion in crying but also the experience underlying the crying. In other words, the crying is used to promote interactions that show respect for the emotion as well as promote a deeper level of understanding among family members.

In another example, a drug-abusing adolescent and her family come to their first BSFT counseling session. The parents proceed to describe their daughter as disobedient, rebellious, and disrespectful-- a girl who is ruining her life and going nowhere. They are angry and reject this young girl, and they blame her for all the pain in the family. In this instance, the BSFT counselor recognizes that the family is "stuck" about what to do with this girl and that their inability to decide what to do is based on the view they have developed about her and her behavior. To "open up" the family to try new ways to reach the youngster, the BSFT counselor must present a new "frame" or perspective that will enable the family to react differently toward the girl. The BSFT counselor might tell the family that, although she realizes how frustrated and exasperated they must feel about their daughter's behavior, "it is my professional opinion that the main problem with this girl is that she is very depressed and is in a lot of pain that she does not know how to handle." Reframing is a practical tool used to stimulate a change in family interactions. With this new frame, the family may now be able to behave in new ways toward the adolescent, which can include communicating in a caring and nurturing manner. A more collaborative set of relationships within the family will make it easier for the parents to discuss the daughter's drug

abuse, to address the issues that may be driving her to abuse drugs, and to develop a family strategy to help the adolescent reduce her drug use.

Reversals

When using the technique called "reversal," the counselor changes a habitual pattern of interacting by coaching one member of the family to do or say the opposite of what he or she usually would. Reversing the established interactional pattern breaks up previously rigid patterns of interacting that give rise to and maintain symptoms, while allowing alternatives to emerge. If an adolescent gets angry because her father nagged her, she yells at her father, and the father and daughter begin to fight, a reversal would entail coaching the father to respond differently to his daughter by saying, "Rachel, I love you when you get angry like that," or "Rachel, I get very frightened when you get angry like that." Reversals make family members interact differently than they did when the family got into trouble.

Working With Boundaries and Alliances

Certain alliances are likely to be adaptive. For example, when the authority or parent figures in the family are allied with each other, they will be in a better position to manage the adolescent's problem behaviors. However, when an alliance forms between a parent figure and one of the children against another parent figure, the family is likely to experience trouble, especially with antisocial adolescent behavior. An adolescent who is allied with an authority figure has a great deal of power and authority within the family system. Therefore, it would be difficult to place limits on this adolescent's problem behavior. One goal of BSFT is to realign maladaptive alliances.

One important determinant of alliances between family members is the psychological barrier between them, or the metaphorical fence that distinguishes one member from another. BSFT counselors call this barrier or fence a "boundary." Counselors aim to have clear boundaries between family members so that there is some privacy and some independence from other family members. However, these should not be rigid boundaries, with which family members would have few shared experiences. By shifting boundaries, BSFT counselors change maladaptive alliances across the generations (e.g., between parent figures and child). For example, in a family in which the mother and the daughter are allied and support each other on almost all issues while excluding the father, the mother may no longer be powerful enough to control her daughter when she becomes an adolescent and may need help. In this case, an alliance between the mother and the father needs to be re-established, while the cross-generational coalition between mother and daughter needs to be eliminated.

It is the BSFT counselor's job to shift the alliances that exist in the family. This means restoring the balance of power to the parents or parent figures so that they can effectively exercise their leadership in the family and control their daughter's behavior. The counselor attempts to achieve these alliance shifts in a very smooth, subtle, and perhaps even sly fashion. Rather than directly confronting the alliance of the mother and daughter, for example, the counselor may begin by encouraging the father to establish some form of interaction with his daughter.

Boundary shifting is accomplished in two ways. Some boundaries need to be loosened, while others need to be strengthened. Loosening boundaries brings disengaged family members (e.g., father and daughter) closer together. This may involve finding areas of common interest between them and encouraging them to pursue these interests together. For instance, in the case of a teenage son enmeshed

with his mother and disengaged from his father, the counselor may direct the father to involve his son in a project or to take his son on regular outings. The counselor also may arrange the seating in counseling sessions to help strengthen some alliances and loosen others.

In addition to bringing family members closer together, the counselor may need to strengthen the boundaries between enmeshed family members to create more separation. One example is the mother grandmother parenting system in which the grandmother enables her grandson's drug use by protecting him from his mother's attempts to set limits. Rather than confronting the grandmother-adolescent alliance directly, the counselor may first encourage the mother and grandmother to sit down together and design a set of rules and responsibilities for the adolescent. This process of designing rules often requires the parent figures to work out some of the unresolved conflict(s) in their relationship, without the counselor having to address that relationship directly. This brings the mother closer to the grandmother and distances the grandmother from the adolescent, thereby rearranging the family's maladaptive hierarchy and subsystem composition.

It should be noted that, in this case, the counselor tracks the family's content (grandmother hiding adolescent's drug use from mother) as a maneuver to change the nature of the interaction between the mother and the grandmother from an adversarial relationship to one in which they agree on something. The adolescent's drug use provides the content necessary to strengthen the boundaries between the generations and to loosen the boundaries between the parent figures.

Clearly, bringing the mother and grandmother together to the negotiating table is only an intermediate step. After that, the tough work of helping mother and grandmother negotiate their deep-seated resentments and grievances against each other begins. Because the counselor follows a problem-focused approach, he or she does not attempt to resolve all of the problems the parent figures encounter. Instead, the counselor tries to resolve only those aspects of their difficulties with each other that interfere with their ability to resolve the problems they have with the adolescent in the family.

Behavioral Contracting as a Strategy for Setting Limits for Both Parent and Adolescent

From a process perspective, setting clear rules and consequences helps develop the demarcation of boundaries between parent(s) and child(ren). Sometimes when a parent and an adolescent have a very intense conflictive relationship in which there is a constant battle over the violation of rules, the rules and their consequences are vague, and there is considerable lack of consistency in their application. In these cases, it is recommended that the counselor use behavioral contracting to help the parent(s) and the adolescent agree on a set of rules and the resulting consequences if he or she fails to follow these rules. The counselor encourages the parent(s) and the adolescent to negotiate a set of clearly stated and enforceable rules, and encourages both parties to commit to maintaining and following these rules.

Helping parents use behavioral contracting to establish boundaries for themselves in relationship to their adolescent is of tremendous therapeutic value. Parents who have established boundaries can no longer respond to the adolescent's behavior/misbehavior according to how they feel at the time (lax, tired, frustrated, angry). The parents have committed themselves to respond according to agreed-upon rules. From a BSFT point of view, it is very important for the counselor to begin to help the parents develop adequate boundaries with their adolescent children who have behavior problems.

In families that have problems with boundaries, the counselor's most difficult task is to get the parents to stick to their part of the contract. Counselors expect that the adolescent will not keep his or her part of the contract and instead will try to test whether his or her parents will try to stick to their part of the contract. When the adolescent misbehaves, parents tend to behave in their usual way, which may be a reaction to the way they feel at the moment. The counselor's job is to make the parents uphold their side of the agreement. Once parents have set effective boundaries with their adolescent children, most misbehavior quickly diminishes. (Of course, sometimes rules and consequences need to be renegotiated as parents and adolescents begin to acquire experience with the notion of enforceable rules and consequences.)

Boundaries Between the Family and the Outside World

It is important not only to understand the nature of the alliances and boundaries that occur within the family but also to understand the boundaries that exist between the family and the outside world.

Some families have very rigid boundaries around themselves, prohibiting their members from interacting with the outside world. Other families have very weak boundaries around themselves that allow outsiders to have an undue influence on family members. Either of these extremes can be problematic and is fair ground for BSFT intervention. For example, if parents are uninvolved with their children's school or friends (rigid boundaries), the BSFT counselor works to get the parents to participate more fully in their child's school life and to interact more with their child's friends.

Detriangulation

As was said earlier, triangles occur when a third, usually less powerful, person gets involved in a conflict between two others. It is a basic assumption of BSFT that the only way conflict between two people (called a "dyad") can be resolved is by keeping the conflict between them. Bringing in a third person and forming a triangle becomes an obstacle to resolving the conflict. The third person usually is drawn into a coalition with one of the parties in conflict and against the other. This coalition results in an imbalance within the original dyad. The issues involved in the conflict are detoured through the third person rather than dealt with directly. For example, when parent A has a fight with parent B, parent B may attack the adolescent in retaliation for parent A's behavior (or attempt to enlist the youth's support for his or her side of the argument) rather than expressing his or her anger directly to parent A. Such triangulated adolescents are often blamed for the family's problems, and they may become identified patients and develop symptoms such as drug abuse.

Because triangulation prevents the involved parties from resolving their conflicts, the goal of counseling is to break up the triangle. Detriangulation permits the parents in conflict to discuss issues and feelings directly and more effectively. Detriangulation also frees the third party, the adolescent, from being used as the escape valve for the parents' problems.

One of the ways in which a BSFT counselor achieves detriangulation is by keeping the third party (i.e., the adolescent) from participating in the discussions between the dyad. Another way to set boundaries to detriangulate is to ask the third party not to attend a therapy session so that the two conflicting parties can work on their issues directly. For example, when working with a family in which the son begins to act disrespectfully whenever his parents begin to argue, the counselor might instruct the parents to ignore the son and continue their discussion. If the son's misbehavior becomes unmanageable, the

counselor may ask the son to leave the room so that the parents can argue without the son's interference. Eventually, the counselor will ask the parents to collaborate in controlling the son.

Attempts by the Family to Triangulate the Counselor

Triangulation does not necessarily have to involve only family members. Sometimes a counselor can become part of a triangle as well. One of the most common strategies used by family members is to attempt to get the counselor to ally himself or herself with one family member against another. For example, one family member might say to the counselor, "Isn't it true that I am right and he is wrong?" "You know best, you tell him." "We were having this argument last night, and I told her that you had said that...."

Triangulation is always a form of conflict avoidance. Regardless of whether it is the counselor or a family member who is being triangulated, triangulation prevents two family members in conflict from reaching a resolution. The only way two family members can resolve their conflicts is on a one-to-one basis.

An important reason why the counselor does not want to be triangulated is that the person in the middle of a triangle is either rendered powerless or symptomatic. In the case of the counselor, the "symptom" he or she would develop would be ineffectiveness as a therapist, that is an inability to do his or her job well because his or her freedom of movement (e.g., changing alliances, choosing whom to address, etc.) has been restricted. A triangulated counselor is defeated. If the counselor is unable to get out of the triangle, he or she has no hope of being effective, regardless of what else he or she does or says.

When a family member attempts to triangulate the counselor, the counselor has to bring the conflict back to the people who are involved in it. For example, the counselor might say, "Ultimately, it doesn't matter what I think. What matters is what the two of you agree to, together. I am here to help you talk, negotiate, hear each other clearly, and come to an agreement." In this way, the counselor places the focus of the interaction back on the family. The counselor also might respond, "I understand how difficult this is for you, but this is your son, and you have to come to terms with each other, not with me."

Opening up Closed Systems

Families in which conflicts are not openly expressed need help in discussing the conflict so that it can be a target for change. Sometimes a counselor can work with a family member who has an unexpressed or implicit conflict and help that person discuss the problem so that it can be resolved. This brings conflicts out into the open and facilitates their resolution by intensifying and focusing on covert emotional issues. In families of drug-abusing adolescents, a typical example of unexpressed or suppressed conflict involves disengaged fathers who tend to deny or avoid any discussion of the youth's problems. Asking a surly or sulking adolescent to express what is on his or her mind whenever the father is addressed may help the father break through his denial.

Tasks

Central Role

The use of "tasks" or assignments is central to all work with families. The counselor uses tasks both inside and outside the counseling sessions as the basic tool for orchestrating change. Because the emphasis in BSFT is in promoting new skills among family members, at both the level of individual

behaviors and in family interactional relations, tasks serve as the vehicle through which counselors choreograph opportunities for the family to behave differently.

In the example in which mother and son were initially allied and the father was left outside of this alliance, father and son were first assigned the task of doing something together that would interest them both. Later on, the mother and father were assigned the collaborative task of working together to define rules regarding the types of behaviors they would permit in their son and the consequences that they would assign to their son's behavior and misbehavior.

General Rule

It is a general rule that the BSFT counselor must first assign a task for the family to perform in the therapy session so that the counselor has an opportunity to observe and help the family successfully carry out the task. Only after a task has been accomplished successfully in the therapy session can a similar follow up task be assigned to the family to be completed outside of therapy.

Moreover, the counselor's aim is to provide the family with a successful experience. Thus, the counselor should try to assign tasks that are sufficiently doable at each step of the counseling process. The counselor should start with easy tasks and work up to more difficult ones, slowly building a foundation of successes with the family before attempting truly difficult restructuring moves.

Hope for the Best; Be Prepared for the Worst

Counselors should never expect the family to accomplish the assigned tasks flawlessly. In fact, if family members were skillful enough to accomplish all assigned tasks successfully, they would not need to be in counseling. When tasks are assigned, counselors should always hope for the best but be prepared for the worst. After all, a task represents a new way of behaving for the family and one that may be difficult given that they have had years of practice engaging in the old ways of behaving.

As the family attempts to carry out a task, the counselor should help the family overcome obstacles it may encounter. However, in spite of the counselor's best efforts, the task is not always accomplished. The counselor's job is to observe and/or uncover what happened and identify the obstacles that prevented the family from achieving the task. When a task fails, the counselor starts over and works to overcome the newly identified obstacles. Unsuccessful attempts to complete tasks are a great source of new and important information regarding the interactions that prevent a family from functioning optimally.

The first task that family counselors give to all of their cases is to bring everyone into the counseling session. Every counselor who works with problem youths and their families knows very well that most of the families who need counseling never reach the first counseling session. Therefore, these families can be described as having failed the first task given them, to come in for counseling. This task, called engagement, is so important that we have devoted the next chapter to it.

Engaging the Family into Treatment

This section defines, in systems terms, the nature of the problem of resistance to treatment and redefines the nature of BSFT joining, diagnosing, and restructuring interventions in ways that take into account those patterns of interaction that prevent families from entering treatment.

The Problem

Regardless of their professional orientation and where or how they practice, all counselors have had the disappointing and frustrating experience of encountering "resistance to counseling" in the form of missed or cancelled first appointments. For BSFT counselors, this becomes an even more common and complex issue because more than one individual needs to be engaged to come to treatment.

Unfortunately, some counselors handle engagement problems by accepting the resistance of some family members. In effect, the counselor agrees with the family's assessment that only one member is sick and needs treatment. Consequently, the initially well-intentioned counselor agrees to see only one or two family members for treatment. This usually results in the adolescent and an overburdened mother following through with counseling visits. Therefore, the counselor has been co-opted into the family's dysfunctional process.

Not only has the counselor "bought" the family's definition of the problem, but he or she also has accepted the family's ideas about who is the identified patient. When the counselor agrees to see only one or two family members, instead of challenging the maladaptive family interaction patterns that kept the other members away, he or she is reinforcing those family patterns. In the example in which a mother and son are allied against the father, if the counselor accepts the mother and son into counseling, he or she is reinforcing the father figure's disengagement.

At a more complex level, there are serious clinical implications for the counselor who accepts the family's version of the problem. In doing this, the counselor surrenders his or her position as the expert and leader. If the counselor agrees with the family's assessment of "who's got the problem," the family will perceive his or her expertise and ability to understand the issues as no greater than its own. The counselor's credibility as a helper and the family's perception of his or her competence will be at stake. Some family members may perceive the counselor as unable to challenge the status quo in the family because, in fact, he or she has failed to achieve the first and defining reframe of the problem.

When the counselor agrees to see only part of the family, he or she may have surrendered his or her authority too early and may be unable to direct change and to move freely from one family member to another. Thus, by beginning counseling with only part of the family, excluded family members may see the counselor as being in a coalition with the family members who originally participated in therapy. Therefore, the family members who didn't attend the initial sessions may never come to trust the counselor. This means that the counselor will not be able to observe the system as a whole as it usually operates at home because the family members who were not involved in therapy from the beginning will not trust the counselor sufficiently to behave as they would at home. The counselor, then, will be working with the family knowing only one aspect of how the family typically interacts.

Some counselors respond to the resistance of some family members to attend counseling by agreeing to see only those who wish to come. Other family counselors have resolved the dilemma of what to do when only some family members want to go to counseling by taking a more alienated stance saying: "There are too many motivated families waiting for help; the resistant families will call back when they finally feel the need; there is no need to get involved in a power struggle." The reality is that these resistant families will most likely never come to counseling by themselves. Ironically, the families who most need counseling are those families whose patterns and habits interfere with their ability to get help for themselves.

Dealing With Resistance to Engagement

When some family members do not want to participate in treatment, has called the counselor asking for help, that parent is not powerful enough to bring the adolescent into counseling. If the counselor wants the family to be in counseling, he or she will have to recognize that the youth (or a noncooperative parent figure) is the most powerful person in the family. Once the reason the family is not in treatment is understood, the counselor can draw upon the concept of tracking to find a way to reach this powerful person directly and negotiate a treatment contract to which the person will agree.

Counselors should not become discouraged at this stage. Their mission now is to identify the obstacles the family faces and help it surmount them. It is essential to keep in mind that a family seeks counseling because it is unable to overcome an obstacle without help. Failed tasks, such as not getting the family to come in for treatment, tend to be a great source of new and important information regarding the reasons why a family cannot do what is best for them. The most important question in counseling is, "What has happened that will not allow some families to do what may be best for them?"

In trying to engage the family in treatment, the counselor should apply the concept of repetitive patterns of maladaptive interaction, which give rise to and maintain symptoms, to the problem of resistance to entering treatment. The very same principles that apply to understanding family functioning and treatment also apply to understanding and treating the family's resistance to entering counseling. When the family wishes to get rid of the youth's drug abuse symptom by seeking professional help, the same interactive patterns that prevented it from getting rid of the adolescent's symptom also prevent the family from getting help. The term "resistance" is used to refer to the maladaptive interactive patterns that keep families from entering treatment. From a family-systems perspective, resistance is nothing more than the family's display of its inability to adapt effectively to the situation at hand and to collaborate with one another to seek help. Thus, the key to eliminating the resistance to counseling lies within the family's patterns of interaction; overcome the resistance in the interactional patterns and the family will come to counseling.

In working to overcome resistant patterns of family interaction, tasks play a particularly vital role because they are the only BSFT intervention used outside the therapy session. For this reason, tasks are particularly well-suited for use during the engagement period, when crucial aspects of the family's work in overcoming resistance to counseling need to take place outside the office--obviously--because the family has not yet come in.

The central task around which engagement is organized is getting the family to come to therapy together. Thus, in engagement, the counselor assigns tasks that involve doing whatever is needed to get the family into treatment. For example, a father calls a BSFT counselor and asks for help with his drug-abusing son. The counselor responds by suggesting that the father bring his entire family to a session so that he or she can involve the whole family in fixing the problem. The father responds that his son would never come to treatment and that he doesn't know what to do. The first task that the counselor might assign the father is to talk with his wife and involve her in the effort to bring their son into treatment.

The Task of Coming to Treatment

The simple case. The counselor gives the task of bringing the whole family into counseling to the family member who calls for help. The counselor explains why this task is a good idea and promises to support

the family as it works at this task. Occasionally, this is all that is needed. Often people do not request family counseling simply because family counseling is not well known, and thus it does not occur to them to take such action.

Fear, an obstacle that might easily be overcome. Sometimes, family members are afraid of what will happen in family therapy. Some of these fears may be real; others may be simply imagined. In some instances, families just need some reassuring advice to overcome their fears. Such fears might include, "They are going to gang up on me," or "Everyone will know what a failure I am." Once these family members have been helped to overcome their fears, they will be ready to enter counseling.

Tasks to change how family members act with each other. Very often, however, simple clarification and reassurance is not sufficient to mobilize a family. It is at this point that tasks that apply joining, diagnostic, and restructuring strategies are useful in engaging the family. The counselor needs to prescribe tasks for the family members who are willing to come to therapy. These need to be tasks that attempt to change the ways in which family members interact when discussing coming to therapy. In the process of carrying out these tasks, the family's resistance will come to light. When that happens, the counselor will have the diagnostic information needed to get around the family's patterns of interaction that are maintaining the symptom of resistance. Once these patterns are changed, the family will come to therapy.

It should not be a surprise that families fail to accomplish the task of getting all of their members to counseling. In fact, the therapist's job is to help the families accomplish tasks that they are not able to accomplish on their own. As discussed earlier, when assigning any task, the counselor must expect that the task may not be performed as requested. This is certainly the case when the family is asked to perform the task of coming together to counseling.

The application of joining, diagnosing, and restructuring techniques to the engagement of resistant families is discussed separately below. However, these techniques are used simultaneously during engagement, as they are during counseling.

Joining

Joining the resistant family begins with the first contact with the family member who calls for help and continues throughout the entire relationship with the family.

With resistant families, the joining techniques described earlier have to be adapted to match the goal of this phase of therapy. For example, in tracking the resistant family members to engage them, it is necessary to track through the caller or initial help seeker and any other family members who may be involved in the process of bringing the family to counseling. The counselor tracks by "following" from the first family member to the next available family member to the next one and so on. This following, or tracking, is done without challenging the family patterns of interaction. Rather, tracking is accomplished by gaining the permission of one family member to reach the others.

Establishing a Therapeutic Alliance

An effective way for the counselor to establish a therapeutic alliance they want to solve their problems and that the counselor wants the same thing. It must be recognized, however, that each family member may view the problem differently. For example, the mother may want to get her son to quit using drugs, while the son may want peace at home.

A therapeutic alliance is built around individual goals that family members can reach in therapy. Ideally, the counselor and the family members agree on a goal, and therapy is offered in the framework of achieving that goal. However, in families in which members are in conflict over their goals, it is necessary to find something for each of them to achieve in therapy. For example, the counselor can say to the mother that therapy can help her son stop using drugs, to the son that therapy can help him get his mother off his back and stop her nagging, and to the father that therapy can help stop his being called in constantly to play the "bad guy." In each case, the counselor can offer counseling as a means for each family member to achieve his or her own personal goal.

In engaging resistant families, the counselor initially works with and through only one or a few family members. Because the entire family is not initially available, the counselor will need to form a bond with the person who called for help and any other family members that make themselves available. However, the focus of this early engagement phase is strictly to work with these people to bring about the changes necessary to engage the entire family in counseling. The focus is not to talk about the problem but rather to talk about getting everyone to help solve the problem by coming to therapy. By using the contact person as a vehicle (via tracking) for joining with other members of the family, the counselor can eventually establish a therapeutic alliance with each family member and thereby elicit the cooperation of the entire family in the engagement effort.

Diagnosing the Interactions That Keep the Family from Coming Into Treatment

In engagement, the purpose of diagnosis is to identify those particular patterns of interaction that permit the resistant behavior to continue. However, because it isn't possible to observe the entire family, the BSFT counselor works with limited information to diagnose those patterns of interaction that are supporting the resistance.

To identify the maladaptive patterns responsible for the resistance, diagnosis begins prior to therapy, when a family member first calls the counselor. Because it is not possible to encourage and observe enactments of family members interacting before they enter counseling, engagement diagnosis has been modified so that it can be used during engagement to collect the diagnostic information in other ways.

First, the counselor asks the contact person interpersonal systems questions that allow him or her to infer what the family's interactional patterns may be. For example, the counselor may ask, "How do you ask your husband to come to treatment?" "What happens when you ask your husband to come to treatment?" "When he gets angry at you for asking him to come to treatment, what do you do next?" Through these questions, the counselor tries to identify the interplay between these spouses that contributes to the resistance. For example, is it possible that the wife is asking the husband to come to treatment in an accusatory way, which causes him to get angry? An example might be, "It is your fault that your son is in trouble because you are sick. You have to go to treatment."

As was indicated earlier, counselors do not like to rely on what family members tell them because each family member is very invested in his or her own viewpoints and probably cannot provide a systemic or objective account of family functioning. However, when counselors have access to only one person, they work with the person they have, strictly for the purpose of engaging that person in treatment.

Second, counselors explore the family system for resistances to the task of coming to therapy. This is done by assigning exploratory tasks to uncover resistances that cause the family to fail at the task of

coming to therapy. For example, in the case above, the counselor might suggest to the wife that she ask her husband to come for her sake and not because there is anything wrong with him. At that point, the wife may say to the counselor, "I can't really ask him for my sake because I know he's too busy to come to the family meetings." This statement suggests that the wife is not completely committed to getting the husband to come to treatment. On the one hand, she claims to want him to come to treatment, but on the other, she gives excuses for why he cannot. The purpose of exploring the resistance, beginning with the first phone call, is to identify as early as possible the obstacles that may prevent the family from coming to therapy, with the aim of intervening in a way that gets around these obstacles.

Complementarity: Understanding How the Family "Pieces" Fit Together to Create Resistance

What makes this type of early diagnostic work possible is an understanding of the Principle of Complementarity, which was described in Chapter 2. As noted earlier, for a family to work as a unit (even maladaptively), the behaviors of each family member must "fit with" the behaviors of every other family member. Thus, for each action within the family, there is a complementary action or reaction. For example, in the case of resistance, the husband doesn't want to come to treatment (the action), and the wife excuses him for not coming to treatment (the complementary action). Similarly, a caller tells the counselor that whenever she says anything to her husband about counseling (the action), he becomes angry (the complementary reaction). The counselor needs to know exactly what the wife's contribution is to this circular transaction, that is, what her part is in maintaining this pattern of resistance.

Restructuring the Resistance

In the process of engaging resistant families, the counselor initially sees only one or a few of the family members. It is still possible, through these individuals, to bring about short-term changes in interactional patterns that will allow the family to come for therapy. A variety of change-producing interventions have already been described in Chapter 4: reframing, reversals, detriangulation, opening up closed systems, shifting alliances, and task setting. The counselor can use all of these techniques to overcome the family's resistance to counseling. In the process of engaging resistant families, task setting is particularly useful in restructuring.

The next section discusses the types of resistant families that have been identified, the process of getting the family into counseling, and the central role that tasks may play in achieving this goal. Much of counseling work with resistant families has been done with families in which the parents knew or believed the adolescent was using drugs and engaging in associated problem behaviors such as truancy, delinquency, fighting, and breaking curfew. These types of families are typically difficult to engage in therapy. However, the examples are not intended to represent all possible types of configurations of family patterns of interaction that work to resist counseling. Counselors working with other types of problems and families are encouraged to review their caseload of difficult-to-engage families and to carefully diagnose the systemic resistances to therapy. Some counselors may find that the resistant families they work with are similar to those described here, and some may find different patterns of resistance. In any case, counselors will be better equipped to work with these families if they have some understanding of the more common types of resistances in families of adolescent drug abusers.

Types of Resistant Families

There are four general types of family patterns of interaction that emerge repeatedly in work with families of drug-abusing adolescents who resist engagement to therapy. These four patterns are discussed below in terms of how the resistant patterns of interaction are manifested, how they come to the attention of the counselor, and how the resistance can be restructured to get the family into therapy.

Powerful Identified Patient

The most frequently observed type of family resistance to entering treatment is characterized by an identified patient who has a powerful position in the family and whose parents are unable to influence him or her. This is a problem, particularly in cases that are not court referred and in which the adolescent identified patient is not required to engage in counseling. Very often, the parent of a powerful identified patient will admit that he or she is weak or ineffective and will say that his or her son or daughter flatly refuses to come to counseling. Counselors can assume that the identified patient resists counseling for two reasons: It threatens his or her position of power, and counseling is on the parent's agenda and compliance would strengthen the parent's power.

As a first step in joining and tracking the rules of the family, the counselor shows respect for and allies with the adolescent. The counselor contacts the drug-abusing adolescent by phone or in person (perhaps on his or her own turf, such as after school at the park). The counselor listens to the powerful adolescent's complaints about his or her parents and then offers to help the youth change the situation at home so that the parents will stop harassing him or her. This does not threaten the adolescent's power within the family and, thus, is likely to be accepted. The counselor offers respect and concern for the youth and brings an agenda of change that the adolescent will share by virtue of the alliance.

To bring these families who resist entering treatment into treatment, the counselor does not directly challenge the youth's power in the family. Instead, the counselor accepts and tracks the adolescent's power. The counselor allies himself or herself with the adolescent so that he or she may later be in a position to influence the adolescent to change his or her behavior. Initially, in forming an alliance with the powerful adolescent, the counselor reframes the need for counseling in a manner that strengthens the powerful adolescent in a positive way. This is an example of tracking--using the power of the adolescent to bring him or her into therapy. The kind of reframing that is most useful with powerful adolescents is one that transfers the symptom from the powerful adolescent/identified patient to the family. For example, the counselor may say, "I want you to come into counseling to help me change some of the things that are going on in your family." Later, once the adolescent is in counseling, the counselor will challenge the adolescent's position of power.

It should be noted that in cases in which powerful adolescents have less powerful parents, forming the initial alliance with the parents is likely to be ineffective because the parents are not strong enough to bring their adolescent into counseling. Their failed attempts to bring the adolescent into counseling would render the parents even weaker, and the family would fail to enter counseling. Furthermore, the youth is likely to perceive the counselor as being the parents' ally, which would immediately make the adolescent distrust the weak counselor.

Contact Person Protecting Structure

The second most common type of resistance to entering treatment is characterized by a parent who protects the family's maladaptive patterns of interaction. In these families, the person (usually the

mother) who contacts the counselor to request help is also the person who is-- without realizing it-- maintaining the resistance in the family. The way in which the identified patient is maintained in the family is also the way in which counseling is resisted. The mother, for example, might give conflicting messages to the counselor, such as, "I want to take my family to counseling, but my son couldn't come to the session because he forgot and fell asleep, and my husband has so much work he doesn't have the time."

The mother is expressing a desire for the counselor's help while protecting and allying herself with the family's resistance to being involved in solving the problem. The mother protects this resistance by agreeing that the excuses for noninvolvement are valid. In other words, she is supporting the arguments the other family members are using to maintain the status quo. It is worthwhile to note that ordinarily this same conflicting message that occurs in the family maintains the symptomatic structure. In other words, someone complains about the problem behavior, yet supports the maintenance of the behaviors that nurture the problem. This pattern is typical of families in which the caller (e.g., the mother) and the identified patient are enmeshed.

To bring these families into treatment, the counselor must first form an alliance with the mother by acknowledging her frustration in wanting to get help and not getting any cooperation from the other family members to get it. Through this alliance, the counselor asks the mother's permission to contact the other family members "even though they are busy and the counselor recognizes how difficult it is for them to become involved." With the mother's permission, the counselor calls the other family members and separates them from the mother in regard to the issue of coming to counseling. The counselor develops his or her own relationship with other family members in discussing the importance of coming to counseling. In doing so, he or she circumvents the mother's protective behaviors. Once the family is in counseling, the mother's overprotection of the adolescent's misbehavior and of the father's uninvolvement (and the adolescent's and father's eagerness that she continue to protect them) will be addressed because it also may be related to the adolescent's problem behaviors.

Disengaged Parent

These family structures in which one parent protects the family's maladaptive patterns of behavior are characterized by little or no cohesiveness and lack of an alliance between the parents or parent figures as a subsystem. One of the parents, usually the father, refuses to come into therapy. This is typically a father who has remained disengaged from the problems at home. The father's disengagement not only protects him from having to address his adolescent's problems but also protects him from having to deal with the marital relationship, which is most likely the more troublesome of the two relationships he is avoiding. Typically, the mother is over-involved (enmeshed) with the identified patient and either lacks the skills to manage the youth or is supporting the identified patient in a covert fashion.

For example, if the father tries to control the adolescent's behavior, the mother complains that he is too tough or makes her afraid that he may become violent.2 The father does not challenge this portrayal of himself. He is then rendered useless and again distances himself, re-establishing the disengagement between husband and son and between husband and wife. In this family, the dimension of resonance is of foremost importance in planning how to change the family and bring it into therapy. The counselor must use tasks to bring the mother closer to the father and distance her from the son. That is, the

boundary between the parents needs to be loosened to bring them closer together, and the boundary between mother and son needs to be strengthened to create distance between them.

To engage these families into treatment, the counselor must form an alliance with the person who called for help (usually the mother). The counselor then must begin to direct the mother to change her patterns of interaction with the father to improve their cooperation, at least temporarily, in bringing the family into treatment. The counselor should give the mother tasks to do with her husband that pertain only to getting the family into treatment and taking care of their son's problems. The counselor should assign tasks in a way that is least likely to spark the broader marital conflict. To set up the task, the counselor may ask the mother what she believes is the real reason her husband does not want to come to counseling. Once this reason is ascertained, the counselor coaches the mother to present the issue of coming to treatment in a way that the husband can accept. For example, if he doesn't want to come because he has given up on his son, she may be coached to suggest to him that coming to treatment will help her cope with the situation.

Although the pattern of resistance is similar to that of the contact person protecting the structure, in this instance, the resistance emerges differently. In this case, the mother does not excuse the father's distance. To the contrary, she complains about her spouse's disinterest; this mother is usually eager to do something to involve her husband; she just needs some direction to be able to do it.

Families with Secrets

Sometimes counseling is threatening to one or more individuals in the family. Sometimes the person who resists coming to counseling is either afraid of being made a scapegoat or afraid that dangerous secrets (e.g., infidelity) will be revealed. These individuals' beliefs or frames about counseling are usually an extension of the frame within which the family is functioning. That is, it is a family of secrets. The counselor must reframe the idea or goal of counseling in a way that eliminates its potential negative consequences and replaces them with positive aims. One example of how to do this is to meet with the person who rejects counseling the most and assure him or her that counseling does not have to go where he or she does not want it to go. The counselor needs to make it clear that he or she will make every effort to focus on the adolescent's problems instead of the issues that might concern the unwilling family member. The counselor also should assure this individual that in the counseling session, "We will deal only with those issues that you want to deal with. You'll be the boss. I am here only to help you to the extent that you say."

Clinical Research Supporting Brief Strategic Family Therapy

This chapter describes past research on the effectiveness of BSFT with drug-abusing adolescents with behavioral problems. BSFT has been found to be effective in reducing adolescents' conduct problems, drug use, and association with antisocial peers and in improving family functioning. In addition, BSFT engagement has been found to increase engagement and retention in therapy. Additional studies testing an ecological version of BSFT with this population are currently underway.

As presented in this manual, BSFT's primary emphasis is on identifying and modifying maladaptive patterns of family interaction that are linked to the adolescent's symptoms. The ecological version of BSFT, BSFT-ecological (Robbins et al. in press) applies this principle of identifying and modifying maladaptive patterns of interaction to the multiple social contexts in which the adolescent is embedded

(cf. Bronfenbrenner). The principal social contexts that are targeted in BSFT-ecological are family, family-peer relations, family-school relations, family-juvenile justice relations, and parent support systems. Joining, diagnosing, and restructuring, as developed in BSFT to use within the family system, are applied to these other social contexts or systems that influence the adolescent's behaviors. For instance, the BSFT counselor assesses the maladaptive, repetitive patterns of interaction that occur in each of these systems or domains. As an example, the BSFT counselor would diagnose the family-school system in the same way that he or she would diagnose the family system. In diagnosing structure, the counselor would ask, "Do parents provide effective leadership in their relationship with their child's teachers?" In diagnosing resonance, the counselor would ask, "Are parents and teachers disengaged?" In diagnosing conflict resolution, the counselor's questions would be, "What is the conflict resolution style in the parent teacher relationship? Might parents and teachers avoid conflict with each other (by remaining disengaged) or diffuse conflicts by blaming each other?" In BSFT-ecological, joining the teacher in the parent teacher relationship employs the same joining techniques developed for BSFT. Similarly, in BSFT-ecological, BSFT restructuring techniques are used to modify the nature of the relationship between a parent and his or her child's teacher.

Outpatient Brief Strategic Family Therapy versus Outpatient Group Counseling

A recent study (Santisteban et al. in press) examined the efficacy of BSFT in reducing an adolescent's behavioral problems, association with antisocial peers, and marijuana use, and in improving family functioning. In this study, outpatient BSFT was compared to an outpatient group counseling control treatment. Participants were 79 Hispanic families with a 12- to 18-year-old adolescent who was referred to counseling for conduct and antisocial problems by either a school counselor or a parent. Families were randomly assigned to either BSFT or group counseling. Analyses of treatment integrity revealed that interventions in both therapies adhered to treatment guidelines and that the two therapies were clearly distinguishable.

Conduct disorder and association with antisocial peers were assessed using the Revised Behavior Problem Checklist (RBPC) (*Quay and Peterson*), which is a measure of adolescent behavior problems reported by parents. Conduct disorder was measured using 22 items, and association with antisocial peers was measured using 17 items. Each item asks the parent(s) to rate whether a specific aspect of the adolescent's behavior (e.g., fighting, spending time with "bad" friends) is no problem (0), a mild problem (1), or a severe problem (2). Ratings for all items on each scale are then added together to derive a total score.

The effects of BSFT on conduct disorder, association with antisocial peers, and marijuana use were evaluated in two ways. First, analyses of variance were conducted to examine whether BSFT reduced conduct disorder, association with antisocial peers, and marijuana use to a significantly greater extent than did group counseling. Second, exploratory analyses were conducted on clinically significant changes in conduct problems and association with antisocial peers. These exploratory analyses used the twofold clinical significance criteria recommended by Jacobson and Truax, et al. To be able to classify a change in symptoms for a given participant as clinically significant, two conditions have to occur. First, the magnitude of the change must be large enough to be reliable--that is, to rule out random fluctuation as a plausible explanation. Second, the participant must "recover" from clinical to nonclinical levels, i.e., cross the diagnostic threshold.

Conduct Disorder

Analyses of variance indicated that conduct disorder scores for adolescents in BSFT compared to those for adolescents in group counseling were significantly reduced between pre- and post treatment. In the clinical significance analyses, a substantially larger proportion of adolescents in BSFT than in group counseling demonstrated clinically significant improvement. At intake, 70 percent of adolescents in BSFT had conduct disorder scores that were above clinical cutoffs. That is, they scored above the empirically established threshold for clinical diagnoses of conduct disorder. At the end of treatment, 46 percent of these adolescents showed reliable improvement, and 5 percent showed reliable deterioration. Among the 46 percent who showed reliable improvement, 59 percent recovered to nonclinical levels of conduct disorder. In contrast, at intake, 64 percent of adolescents in group counseling had conduct disorder scores above the clinical cutoff. Of these, none showed reliable improvement, and 11 percent showed reliable deterioration. Therefore, while adolescents in BSFT who entered treatment at clinical levels of conduct disorder had a 66 percent likelihood of improving, none of the adolescents in group counseling reliably improved.

Association with Antisocial Peers

Analyses of variance indicated that, for adolescents in BSFT, scores for association with antisocial peers were significantly reduced between pre- and post-treatment, compared to those for adolescents in group counseling. In the clinical significance analyses, 79 percent of adolescents in BSFT were above clinical cutoffs for association with antisocial peers at intake. Among adolescents in BSFT meeting clinical criteria for association with antisocial peers, 36 percent showed reliable improvement, and 2 percent showed reliable deterioration. Of the 36 percent of adolescents in BSFT with reliable improvement, 50 percent were classified as recovered. Among adolescents in group counseling, 64 percent were above clinical cutoffs for association with antisocial peers at intake. Among adolescents in group counseling meeting these clinical criteria at intake, 11 percent reliably improved, and none reliably deteriorated. Of the 11 percent of adolescents in group counseling evidencing reliable improvement in association with antisocial peers, 50 percent recovered to nonclinical levels. Hence, adolescents in BSFT who entered treatment at clinical levels of association with antisocial peers were 2.5 times more likely to reliable improve than were adolescents in group treatment.

Marijuana Use

Analyses of variance revealed that BSFT was associated with significantly greater reductions in self-reported marijuana use than was group counseling. To investigate whether clinically meaningful 3 changes in marijuana use occurred, four use categories from the substance use literature (e.g., Brooks et al.1998) were employed. These categories are based on the number of days an individual uses marijuana in the 30 days before the intake and termination assessments:

- abstainer - 0 days
- weekly user - 1 to 8 days
- frequent user - 9 to 16 days
- daily user - 17 or more days

In BSFT, 40 percent of participants reported using marijuana at intake and/or termination. Of these, 25 percent did not show change, 60 percent showed improvement in drug use, and 15 percent showed

deterioration. Of the individuals in BSFT who shifted into less severe categories, 75 percent were no longer using marijuana at termination. In group counseling, 26 percent of participants reported using marijuana at intake and/or termination. Of these, 33 percent showed no change, 17 percent showed improvement, and 50 percent deteriorated. The 17 percent of adolescents in group counseling cases that showed improvement were no longer using marijuana at termination. Hence, adolescents in BSFT were 3.5 times more likely than were adolescents in group counseling to show improvement in marijuana use.

Treatments also were compared in terms of their influence on family functioning. Family functioning was measured using the Structural Family Systems Ratings *(Szapocznik et al)*. This measure was constructed to assess family functioning as defined in Chapter 3. Based on their scores when they entered therapy, families were separated by a median split into those who had good and those who had poor family functioning. Within each group (i.e., those with good and those with poor family functioning), a statistical test that compares group means (analysis of variance) tested changes in family functioning from before to after the intervention.

Among families who were admitted with poor family functioning, the results showed that those assigned to BSFT had a significant improvement in family functioning, while those families assigned to group counseling did not improve significantly.

Among families who were admitted with good family functioning, the results showed that those assigned to BSFT retained their good levels of family functioning, while families assigned to group counseling showed significant deterioration. These findings suggest that not all families of drug-abusing youths begin counseling with poor family functioning, but if the family is not given adequate help to cope with the youth's problems, the family's functioning may deteriorate.

One Person Brief Strategic Family Therapy

With the advent of the adolescent drug epidemic of the 1970s, the vast majority of counselors who worked with drug-using youths reported that, although they preferred to use family therapy, they were not able to bring whole families into treatment. In response, a procedure was developed that would achieve the goals of BSFT (to change maladaptive family interactions and symptomatic adolescent behavior) without requiring the whole family to attend treatment sessions. The procedure is an adaptation of BSFT called "One Person" BSFT. One Person BSFT capitalizes on the systemic concept of complementarity, which suggests that when one family member changes, the rest of the system responds by either restoring the family process to its old ways or adapting to the new changes *(Minuchin and Fishman).* The goal of One Person BSFT is to change the drug-abusing adolescent's participation in maladaptive family interactions that include him or her. Occasionally, these changes create a family crisis as the family attempts to return to its old ways. The counselor uses the opportunity created by these crises to engage reluctant family members.

A clinical trial was conducted to compare the efficacy of One Person BSFT to Conjoint (full family) BSFT. Hispanic families with a drug-abusing 12- to 17-year-old adolescent were randomly assigned to the One Person or Conjoint BSFT modalities. Both therapies were designed to use exactly the same BSFT theory so that only one variable (one person vs. conjoint meetings) would differ between the treatments. Analyses of treatment integrity revealed that interventions in both therapies adhered to guidelines and that the two therapies were clearly distinguishable. The results showed that One Person

was as efficacious as Conjoint BSFT in significantly reducing adolescent drug use and behavior problems as well as in improving family functioning at the end of therapy. These results were maintained at the 6-month follow up.

One Person BSFT is not discussed in this manual because it is considered a very advanced clinical technique. More information on One Person BSFT is available in Szapocznik and Kurtines.

Brief Strategic Family Therapy Engagement

As discussed in Chapter 5, in response to the problem of engaging resistant families, a set of engagement procedures based on BSFT principles was developed. These procedures are based on the premise that resistance to entering treatment can be understood in family interactional terms.

One Person BSFT techniques are useful in this initial phase. That's because the person who contacts the counselor to request help may become the one person through whom work is initially done to restructure the maladaptive family interactions that are maintaining the symptom of resistance. The success of the engagement process is measured by the family's and the symptomatic youth's attendance in family therapy. In part, success in engagement permits the counselor to redefine the problem as a family problem in which all family members have something to gain. Once the family is engaged in treatment, the focus of the intervention is shifted from engagement to removing the adolescent's presenting symptoms.

The efficacy of BSFT engagement has been tested in three studies with Hispanic youths *(Coatsworth et al.)*. The first study included mostly Cuban families with adolescents who had behavior problems and who were suspected of or observed using drugs by their parents or school counselors. Of those engaged, 93 percent actually reported drug use. Families were randomly assigned to one of two therapies: BSFT engagement or engagement as usual (the control therapy). The engagement-as-usual therapy consisted of the typical engagement methods used by community treatment agencies, which were identified prior to the study using a community survey of outpatient agencies serving drug-abusing adolescents. All families who were successfully engaged received BSFT. In the experimental therapy, families were engaged and retained using BSFT engagement techniques. Successful engagement was defined as the conjoint family (minimally the identified patient and his or her parents and siblings living in the same household) attending the first BSFT session, which was usually to assess the drug-using adolescent and his or her family. Treatment integrity analyses revealed that interventions in both engagement therapies adhered to prescribed guidelines using six levels of engagement effort that were operationally defined and that the therapies were clearly distinguishable by level of engagement effort applied.

The six levels of engagement effort, as enumerated in *Szapocznik et al*. are:

- ➢Level 0 - expressing polite concern, scheduling an intake appointment, establishing that cases met criteria for inclusion in the study, and making clear who must attend the intake assessment;
- ➢Level 1 - attempting minimal joining, encouraging the caller to involve the family, asking about the depth and breadth of adolescent problems, and asking about family members;
- ➢Level 2 - attempting more thorough joining; asking about family interactions; seeking information about the problems, values, and interests of family members; supporting and

establishing an alliance with the caller; beginning to establish leadership; and asking whether all family members would be willing to attend the intake appointment;

- ➢Level 3 - restructuring for engagement through the caller, advising the caller about negotiating and reframing, and following up with family members (either over the phone or personally with the caller at the therapist's office) to be sure that intake appointments would be kept;
- ➢Level 4 - conducting lower level ecological engagement interventions, joining family members or conducting intrapersonal restructuring (with family members other than the original caller) over the phone or in the therapist's office, and contacting significant others (by phone) to gather more information; and
- ➢Level 5 - conducting higher level ecological interventions, making out-of-office visits to family members or significant others, and using significant others to help conduct restructuring.

Level 0-1 behaviors were permitted for both the BSFT engagement and engagement-as-usual conditions. Level 2-5 behaviors were permitted only for the BSFT engagement condition. Efficacy was measured in rates of both family treatment entry as well as retention to treatment completion.

The efficacy of the two methods of engagement was measured by the percentage of families who entered treatment and the percentage of families who completed the treatment. The results revealed that 42 percent of the families in the engagement-as-usual therapy and 93 percent of the families in the BSFT engagement therapy were successfully engaged. In addition, 25 percent of engaged cases in the engagement-as-usual treatment and 77 percent of engaged cases in the BSFT engagement treatment successfully completed treatment. These differences in engagement and retention between the two methods of engagement were both statistically significant. Improvements in adolescent symptoms occurred but were not significantly different between the two methods of engagement. Thus, the critical distinction between the treatments was in their different rates of engagement and retention. Therefore, BSFT engagement had a positive impact on more families than did engagement as usual.

In addition to replicating the previous engagement study, the second study also explored factors that might moderate the efficacy of the engagement interventions. In contrast to the previous engagement study, Santisteban et al. more stringently defined the success of engagement as a minimum of two office visits: the intake session and the first therapy session. The researchers randomly assigned 193 Hispanic families to one experimental and two control treatments. The experimental therapy was BSFT plus BSFT engagement. The first control therapy was BSFT plus engagement as usual, and the second was group counseling plus engagement as usual. In both control treatments, engagement as usual involved no specialized engagement strategies.

Results showed that 81 percent of families were successfully engaged in the BSFT plus BSFT engagement experimental treatment. In contrast, 60 percent of the families in the two control therapies were successfully engaged. These differences in engagement were statistically significant. However, the efficacy of the experimental therapy procedures was moderated by the cultural/ethnic identity of the Hispanic families in the study. Among families assigned to BSFT engagement, 93 percent of the non-Cuban Hispanics (composed primarily of Nicaraguan, Colombian, Puerto Rican, Peruvian, and Mexican families) and 64 percent of the Cuban Hispanics were engaged. These findings have led to further study

of the mechanism by which culture/ethnicity and other contextual factors may influence clinical processes related to engagement *(Santisteban et al.; Santisteban et al. in press)*. The results of the Szapocznik et al. and Santisteban et al. studies strongly support the efficacy of BSFT engagement. Further, the second study with its focus on cultural/ethnic identity supports the widely held belief that therapeutic interactions must be responsive to contextual changes in the treatment population *(Sue et al; Szapocznik and Kurtines)*.

A third study *(Coatsworth et al.)* compared BSFT to a community control intervention in terms of its ability to engage and retain adolescents and their families in treatment. An important aspect of this study was that an outside treatment agency administered the control intervention. Because of that, the control intervention (e.g., usual engagement strategies) was less subject to the influence of the investigators. Findings in this study, as in previous studies, showed that BSFT was significantly more successful, at 81 percent, in engaging adolescents and their families in treatment than was the community control treatment, at 61 percent. Likewise, among those engaged in treatment, a higher percentage of adolescents and their families in BSFT, at 71 percent, were retained in treatment compared to those in the community control intervention, at 42 percent. In BSFT, 58 percent of adolescents and their families completed treatment compared to 25 percent of those in the community control intervention. Families in BSFT were 2.3 times more likely both to be engaged and retained in treatment than were families randomized to the community control treatment.

An additional finding of the *Coatsworth et al.* study warrants special mention. In BSFT, families of adolescents with more severe conduct problem symptoms were more likely to remain in treatment than were families of adolescents whose conduct problem symptoms were less severe. The opposite pattern was evident in the community control intervention, with families that were retained in treatment showing lower intake levels of conduct problems than did families who dropped out. These findings are particularly important because they suggest that adolescents who are most in need of services are more likely to stay in BSFT than in traditional community treatments.

8. Making the Connection: Trauma and Substance Abuse

The following offers providers assistance with delivering comprehensive assessment of and treatment for adolescents with both substance use problems and traumatic stress problems. It contains valuable information for understanding the links between substance use and traumatic stress and for adequately identifying, engaging, and treating adolescents suffering from these co-occurring problems.

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

Therapists and counselors can develop skills to provide a comprehensive and integrated treatment approach. In order to maximize an adolescent's chances of success, this approach should address the adolescent's concerns broadly and take into account the functional relationship between traumatic stress

and substance abuse problems. When developing an individualized treatment plan, special attention should be given to the signs and symptoms of post-traumatic stress, substance abuse, and the relationship between the two.

Adolescents with trauma and substance abuse are often challenging to treat. Consider the case of Raphael below, as told by his therapist:
As you read the pages that follow, think about cases like Raphael's and consider the following questions:

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

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

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

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

The Co-Occurrence of Trauma and Substance Use Among Adolescents

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

- ✓ Experiencing a traumatic event increases the risk of developing a substance abuse problem. Trauma—in the form of physical or sexual abuse, domestic violence, natural disasters, car accidents, traumatic loss, war, or other calamity—may lead to substance abuse and addiction. Adolescents experiencing posttraumatic stress may drink or take drugs in an attempt to manage or self-medicate their feelings of anxiety, physiological arousal, depression, hopelessness, and/or grief. Teens may abuse substances to fit in with peers, to combat feelings of isolation, or to try to become numb when they face triggers and trauma reminders.
- ✓ Adolescents who abuse substances are more likely to experience traumatic events, presumably because they are more likely to engage in risky activities. Traumas such as physical and sexual assaults, domestic violence, accidents, and serious injuries are more common in substance-abusing teens than in their nonsubstance-abusing peers.
- ✓ Youth who are already abusing substances may be less able to cope with a traumatic event as a result of the functional impairments associated with problematic use.

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

- In an epidemiological study, researchers found a moderate overall co-occurrence of PTSD and substance abuse, with rates ranging from 13.5% to 29.7% *(Kilpatrick, Ruggiero, Acierno, Saunders, Resnick, & Best).* In this sample: — 29.7% of males and 24.4% of females who met diagnostic criteria for PTSD also met diagnostic criteria for either substance abuse or dependence — 13.5% of males and 24.8% of females who met criteria for a substance use disorder also met diagnostic criteria for PTSD
- In a sample of New Zealand teens *(Fergusson & Horwood),* rates of substance use disorders were: — 17 - 35% among teens who witnessed domestic violence — 10 - 15% among those who did not witness domestic violence
- Another study *(Funk, McDermeit, Godley, & Adams)* found 71% of teenagers in treatment for substance abuse reported a history of trauma exposure.
- In a study *(Deykin & Buke)* of chemically dependent adolescents in treatment for substance abuse: — lifetime prevalence rates of PTSD: 29.6% (24.3% for males and 45.3% for females) — current prevalence rates of PTSD: 19.2% (12.2% for males and 40.0% for females) — lifetime prevalence of trauma exposure: 73% of males and 80%
- In a study of adolescents seeking outpatient services for marijuana abuse or dependency, 14% of adolescents presenting for treatment met criteria for PTSD *(Diamond, Panichelli-Mindel, Shera, Dennis, Tims, & Ungemack).*

Attending to the Needs of Youth

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

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

Addressing traumatic stress in substance abuse treatment settings

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

Addressing substance abuse problems in mental health settings

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

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

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

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

- Fact: Trauma, as defined in psychological terms, involves experiencing or witnessing a situation that poses a threat to one's own or another person's life or bodily integrity—often resulting in post-traumatic stress symptoms. These symptoms can be alleviated by using specialized treatment approaches and interventions. Although not all youth who experience traumatic events develop post-traumatic stress symptoms, it is important to be prepared to attend to the multiple ways in which youth respond to distressing situations.
    - Myth: By assuming that adolescents use substances of abuse to cope with emotional distress, we relieve them from taking responsibility for their actions.
- Fact: Being aware of this self-medication hypothesis can be extremely helpful to both clinicians and youth while they attempt to make sense of the origins and perpetuation of a youth's substance use. Given that many adolescents are reluctant to acknowledge that their substance use is a "problem," maintaining a neutral stance in trying to understand the functional relationship between emotional problems and substance use can promote a youth's ability to take responsibility for his/her actions.
    - Myth: A. When dealing with an adolescent who has problems with substance abuse as well as a traumatic event history, it is imperative to: treat the substance abuse symptoms first before attempting to address trauma-related symptoms. B. Treat the trauma-related symptoms first before attempting to treat the substance abuse symptoms.
- Fact: Some adolescents with co-occurring traumatic stress and substance abuse problems are denied entry into substance abuse treatment programs until their emotional distress is sufficiently addressed; others are denied entry into mental health treatment centers until they gain sobriety. As the research suggests, symptoms associated with traumatic stress and substance abuse are strongly linked. The decision about which symptoms and behaviors to address first depends on many factors including the relative threat to a youth's safety, health, and immediate well-being that those particular symptoms and behaviors pose.
    - Myth: Most evidence-based assessment tools for trauma or substance abuse are too long and complicated to be implemented in real clinical practice settings.
- Fact: Many of the older evidence-based assessment instruments do have a reputation for being long and complicated, as well as expensive. However, the assessment field has, over the past decade, produced many more assessment tools that are accessible and clinician-friendly in terms of both degree of complexity and length.
    - Myth: Manualized interventions are too rigid and simplistic to accommodate the complex needs of adolescents who have co-occurring post-traumatic stress and substance abuse problems.
- Fact: Today's evidence-based interventions are often manual-guided rather than manualized. This distinction reflects a movement away from promoting scripted and inflexible session content and structure and toward adherence to a clear therapeutic model with increasingly flexible session content and structure.

Common Challenges to Care

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

Challenge: Clinician lack of familiarity with the common presentations of posttraumatic stress symptoms in adolescents**.**

- ➢ **Suggested Solution**: The materials in this toolkit can serve as resources to aid in raising institutional awareness of the need for sound substance abuse and trauma assessment and treatment. Presenting case material that highlights the relationships between trauma and substance abuse can also help raise institutional awareness.

Challenge: Clinician lack of familiarity with the common presentations of posttraumatic stress symptoms in adolescents.

- ➢ **Suggested Solution:** Use the materials in this toolkit to help become familiar with the common presentations of posttraumatic stress symptoms in adolescents. Access more information via the National Child Traumatic Stress Network website: www.NCTSN.org.

Challenge: Time and cost associated with conducting standardized assessments and training staff to use evidence-based interventions.

- ➢ **Suggested Solution:** To convince institutional administrators to invest the time and money required for the initial stages of such program development, present them with research on improved treatment adherence and treatment outcomes when standardized assessments and evidence-based interventions are employed. Once the program has been established and youth outcomes are improved, working with youth will be more rewarding, which may encourage administrators to seek additional funding opportunities.

Challenge: Adolescents with severe co-occurring disorders often require assistance with other practical aspects of life—such as transportation, schooling, court advocacy, health insurance—which not all institutions are equipped to provide.

- ➢ **Suggested Solution:** Partnerships with

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

Today's emphasis on the relationship between substance use and mental disorders dates to the late 1970s, when practitioners increasingly became aware of the implications of these disorders, when occurring together, for treatment outcomes. The association between depression and substance abuse was particularly striking and became the subject of several early studies (e.g., Woody and Blaine). In the 1980s and 1990s, however, both the substance abuse and mental health communities found that a wide range of mental disorders were associated with substance abuse, not just depression. During this period, substance abuse treatment programs typically reported that 50 to 75 percent of clients had co-occurring mental disorders, while clinicians in mental health settings reported that between 20 and 50 percent of their clients had co-occurring substance use disorders.

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

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

The second part of this chapter describes techniques effective in counseling clients with COD. One is the use of motivational enhancement consistent with the client's specific stage of recovery. This strategy is helpful even for clients whose mental disorder is severe. Other strategies include contingency management, relapse prevention, and cognitive-behavioral techniques. For clients with functional deficits in areas such as understanding instructions, repetition and skill-building strategies can aid

progress. Finally, 12-Step and other dual recovery mutual self-help groups have value as a means of supporting individuals with COD in the abstinent life. Clinicians often play an important role in facilitating the participation of these clients in such groups. This chapter will provide a basic overview of how counselors can apply each of these strategies to their clients who have COD. The material in this chapter is consistent with national or State consensus practice guidelines for COD treatment, and consonant with many of their recommendations.

The purpose of this chapter is to describe for the addiction counselor and other practitioners how these guidelines and techniques, many of which are useful in the treatment of substance abuse or as general treatment principles, can be modified specifically and applied to people with COD. These guidelines and techniques are particularly relevant in working with clients in quadrants II and III. Additionally, this chapter contains Advice to the Counselor boxes to highlight the most immediate practical guidance (for a full listing of these boxes see the table of contents).

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

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

Challenges for the clinician

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

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

Challenges in working with clients with serious mental and substance use disorders. Achieving a therapeutic alliance with clients with serious mental illness and substance use disorders can be

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

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

For all clients with co-occurring disorders, the therapeutic relationship must build on the capacity that does exist. These clients often need the therapeutic alliance to foster not only their engagement in treatment but as the cornerstone of the entire recovery process. Once established, the therapeutic alliance is rewarding for both client and clinician and facilitates their participation in a full range of therapeutic activities; documentation of these types of interactions provides an advantage in risk management.

Advice to the Counselor: **Forming a Therapeutic Alliance**

The consensus panel recommends the following approaches for forming a therapeutic alliance with clients with COD:
• Demonstrate an understanding and acceptance of the client.
• Help the client clarify the nature of his difficulty.
• Indicate that you and the client will be working together.
• Communicate to the client that you will be helping her to help herself.
• Express empathy and a willingness to listen to the client's formulation of the problem.
• Assist the client to solve some external problems directly and immediately.
• Foster hope for positive change.

Maintain a Recovery Perspective

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

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

Implications of the recovery perspective

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

- ***Develop a treatment plan that provides for continuity of care over time***. In preparing this plan, the clinician should recognize that treatment may occur in different settings over time (e.g., residential, outpatient) and that much of the recovery process is client-driven and occurs typically outside of or following professional treatment (e.g., through participation in mutual self-help groups) and the counselor should reinforce long-term participation in these constantly available settings.
- ***Devise treatment interventions that are specific to the tasks and challenges faced at each stage of the COD recovery process***. The use of treatment interventions that are specific to the tasks and challenges faced at each stage of the COD recovery process enables the clinician (whether within the substance abuse or mental health treatment system) to use sensible stepwise approaches in developing and using treatment protocols. In addition, markers that are unique to individuals—such as those related to their cultural, social, or spiritual context—should be considered. It is therefore important to engage the client in defining markers of progress that are meaningful to him and to each stage of recovery.

Stages of change and stages of treatment

Working within the recovery perspective requires a thorough understanding of the interrelationship between stages of change and stages of treatment. De Leon has developed a measure of motivation for change and readiness for treatment—The Circumstances, Motivation and Readiness Scales—and provided scores for samples of persons with COD (De Leon et al.). De Leon has demonstrated the

relationship between these scales and retention in treatment for general substance abuse treatment populations and programs (De Leon). It is important that the expectation for the client's progress through treatment stages (e.g., outreach, stabilization, early-middle-late primary treatment, continuing care, and long-term care/cycles into and out of treatment) be consistent with the client's stage of change.

Client empowerment and responsibility

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

Pessimistic attitudes about people with COD represent major barriers to successful system change and to effective treatment interventions … recovery is defined as a process by which a person with persistent, possibly disabling disorders, recovers self-esteem, self-worth, pride, dignity, and meaning, through increasing his or her ability to maintain stabilization of the disorders and maximizing functioning within the constraints of the disorders. As a general principle, every person, regardless of the severity and disability associated with each disorder, is entitled to experience the promise and hope of dual recovery, and is considered to have the potential to achieve dual recovery (AACP).

Continuous support

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

Continuity of treatment

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

Advice to the Counselor: **Maintaining a Recovery Perspective**

The consensus panel recommends the following approaches for maintaining a recovery perspective with clients who have COD:
• Assess the client's stage of change (see section on Motivational Enhancement below).
• Ensure that the treatment stage (or treatment expectations) is (are) consistent with the client's stage of change.

• Use client empowerment as part of the motivation for change.
• Foster continuous support.
• Provide continuity of treatment.
• Recognize that recovery is a long-term process and that even small gains by the client should be supported and applauded.

Manage Countertransference

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

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

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

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

Cultural issues also may arouse strong and often unspoken feelings and, therefore, generate transference and countertransference. Although counselors working with clients in their area of expertise may be

familiar with countertransference issues, working with an unfamiliar population will introduce different kinds and combinations of feelings.

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

Advice to the Counselor: **Managing Countertransference**

The consensus panel recommends the following approach for managing countertransference with clients who have COD:
• The clinician should be aware of strong personal reactions and biases toward the client.
• The clinician should obtain further supervision where countertransference is suspected and may be interfering with counseling.
• Clinicians should have formal and periodic clinical supervision to discuss countertransference issues with their supervisors and the opportunity to discuss these issues at clinical team meetings.

Monitor Psychiatric Symptoms

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

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

Status of symptoms

Substance abuse counselors need to have a method by which to monitor changes in severity and number of symptoms over time. For example, most clients present for substance abuse treatment with some

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

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

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

Potential for harm to self or others

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

For clients who mention or appear to be experiencing depression or sadness, it is always important to explore the extent to which suicidal thinking is present. Similarly, a client who reports that he or she is thinking of doing harm to someone else should be monitored closely. The clinician always should ask explicitly about suicide or the intention to do harm to someone else when the client assessment indicates that either is an issue.

In addition to asking the client about suicidal thoughts and plans as a routine part of every session with a suicidal or depressed person, Blumenthal stresses that *the clinician should immediately follow up appointments missed by an acutely suicidal person.* Management of the suicidal client requires securing an appropriate mental health professional for the client and having the client monitored closely by that

mental health professional. The counselor also should have 24-hour coverage available, such as a hotline for the client to call for help during off hours. However, there are effective ways of managing individuals who have suicidal thoughts but no immediate plan, and are willing and able to contact the counselor in the event these thoughts become too strong, prior to action.

Advice to the Counselor: **Monitoring Psychiatric Symptoms**

The consensus panel recommends the following approaches for monitoring psychiatric symptoms with clients with COD:
• Obtain a mental status examination to evaluate the client's overall mental health and danger profile. Ask questions about the client's symptoms and use of medication and look for signs of the mental disorder regularly.
• Keep track of changes in symptoms.
• Ask the client directly and regularly about the extent of his or her depression and any associated suicidal thoughts.

Use Supportive and Empathic Counseling

Definition and importance

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

However, this type of counseling must be used consistently over time to keep the alliance intact. This caveat often is critical for clients with COD, who usually have lower motivation to address either their mental or substance abuse problems, have greater difficulty understanding and relating to other people, and need even more understanding and support to make a major lifestyle change such as adopting abstinence. Support and empathy on the clinician's part can help maintain the therapeutic alliance, increase client motivation, assist with medication adherence, model behavior that can help the client build more productive relationships, and support the client as he or she makes a major life transition.

Using an Empathic Style

Empathy is a key skill for the counselor, without which little could be accomplished. The practice of empathy "requires sharp attention to each new client statement, and a continual generation of hypotheses as to the underlying meaning" (Miller and Rollnick). An empathic style
• Communicates respect for and acceptance of clients and their feelings
• Encourages a nonjudgmental, collaborative relationship
• Allows the clinician to be a supportive and knowledgeable consultant

• Compliments and reinforces the client whenever possible
• Listens rather than tells
• Gently persuades, with the understanding that the decision to change is the client's
• Provides support throughout the recovery process
(See also TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT], p. 41.)

Confrontation and empathy

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

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

Employ Culturally Appropriate Methods

Understanding the client's cultural background

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

To work effectively with persons of various cultural groups, the provider should learn as much as possible about characteristics of the cultural group such as communication style, interpersonal interactions, and expectations of family. For example, some cultures may tend to somaticize symptoms of mental disorders, and clients from such groups may expect the clinician to offer relief for physical complaints. The same client may be offended by too many probing, personal questions early in treatment and never return. Similarly, understanding the client's role in the family and its cultural significance always is important (e.g., expectations of the oldest son, a daughter's responsibilities to her parents, grandmother as matriarch).

At the same time, the clinician should not make assumptions about any client based on his or her perception of the client's culture. The level of acculturation and the specific experiences of an individual may result in that person identifying with the dominant culture, or even other cultures. For example, a person from India adopted by American parents at an early age may know little about the cultural practices in his birth country. For such clients, it is still important to recognize the birth country and discover what this association means to the client; however, it may exert little influence on his beliefs and practices. For more detailed information about cultural issues in substance abuse treatment, see the forthcoming TIP *Improving Cultural Competence in Substance Abuse Treatment* (CSAT in development *a*).

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

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

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

Cultural perceptions and diagnosis

It is important to be aware of cultural and ethnic bias in diagnosis. For example, in the past some African Americans were stereotyped as having paranoid personality disorders, while women have been diagnosed frequently as being histrionic. American Indians with spiritual visions have been misdiagnosed as delusional or as having borderline or schizotypal personality disorders. Some clinicians would be likely to over diagnose obsessive-compulsive disorder among Germans or histrionic disorder in Hispanic/Latino populations. The diagnostic criteria should be tempered by sensitivity to cultural differences in behavior and emotional expression and by an awareness of the clinician's own biases and stereotyping.

Cultural differences and treatment: Empirical evidence on effectiveness

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

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

Advice to the Counselor: **Using Culturally Appropriate Methods**

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

(*Source: Center for Mental Health Services)*

Increase Structure and Support

To assist clients with COD, counselors should provide an optimal amount of structure for the individual. Free time is both a trigger for substance use cravings and a negative influence for many individuals with mental disorders; therefore it is a particular issue for clients with COD. Strategies for managing free time include structuring one's day to have meaningful activities and to avoid activities that will be risky. Clinicians often help clients to plan their time (especially weekends). Creating new pleasurable activities can both help depression and help derive “highs” from sources other than substance use. Other important activities to include are working on vocational and relationship issues.

In addition to structure, it is also important that the daily activities contain opportunities for receiving support and encouragement. Counselors should work with clients to create a healthy support system of friends, family, and activities. Increasing support, time organization, and structured activities are strategies in cognitive-behavioral therapies (see section below) for both mental disorders and substance abuse treatment.

Techniques for Working with Clients with COD

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

Key Techniques for Working with Clients who Have COD

1. Provide motivational enhancement consistent with the client's specific stage of change.
2. Design contingency management techniques to address specific target behaviors.
3. Use cognitive-behavioral therapeutic techniques.

4. Use relapse prevention techniques.
5. Use repetition and skills-building to address deficits in functioning.
6. Facilitate client participation in mutual self-help groups.

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

Definition and Description

Motivational Interviewing (MI) is a "client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence" (Miller and Rollnick 2002, p. 25). MI has proven effective in helping clients clarify goals and make commitment to change (CSAT 1999*b*; Miller 1996; Miller and Rollnick 2002; Rollnick and Miller 1995). This approach shows so much promise that it is one of the first two psychosocial treatments being sponsored in multisite trials in the National Institute on Drug Abuse (NIDA) Clinical Trials Network program.

As Miller and Rollnick have pointed out, MI is "a way of being with a client, not just a set of techniques for doing counseling" (Miller and Rollnick 1991, p. 62). This approach involves *accepting* a client's level of motivation, whatever it is, as the only possible starting point for change. For example, if a client says she has no interest in changing her drinking amounts or frequency, but only is interested in complying with the interview to be eligible for something else (such as the right to return to work or a housing voucher), the clinician would avoid argumentation or confrontation in favor of establishing a positive rapport with the client—even remarking on the positive aspect of the client wishing to return to work or taking care of herself by obtaining housing. The clinician would seek to probe the areas in which the client does have motivation to change. The clinician is interested in eventually having an impact on the client's drinking or drug use, but the strategy is to get to that point by working with available openings.

A variety of adaptations of MI have emerged. Examples include brief negotiation, motivational consulting, and motivational enhancement therapy (MET). MET combines the clinical style associated with MI with systematic feedback of assessment results in the hope of producing rapid, internally motivated change. For more information, see the Project MATCH *Motivational Enhancement Therapy Manual* (National Institute on Alcohol Abuse and Alcoholism 1994). Rollnick and other practitioners of MI find that the many variants differ widely in their reliance on the key principles and elements of MI (Miller and Rollnick 2002).

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

Guiding Principles of Motivational Interviewing

1. Express empathy	• Acceptance facilitates change.
	• Skillful reflective listening is fundamental.

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

Source: Miller and Rollnick 2002, pp. 36–41.

1. Expressing empathy

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

2. Developing discrepancies

While recognizing the client's ambivalence to change as normal, the counselor is not neutral or ambivalent about the need for change. The counselor advances the cause of change not by insisting on it, but by helping the client perceive the discrepancy between the current situation and the

client's personal goals (such as a supportive family, successful employment, and good health). The task of the counselor is to call attention to this discrepancy between "the present state of affairs and how one wants it to be," making it even more significant and larger in the client's eyes. The client is therefore more likely to change, because he sees that the current behavior is impeding progress to *his* goals—not the counselor's (Miller and Rollnick 2002, p. 39).

3. Rolling with resistance

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

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

4. Supporting self-efficacy

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

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

"Change talk"

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

"Decisional balance"

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

Matching motivational strategies to the client's stage of change

The motivational strategies selected should be consistent with the client's stage of change (summarized in Figure 5-1). Clients could be at one stage of recovery or change for the mental disorder and another for the substance use disorder; to complicate things further, a client may be at one stage of change for one substance and another stage of change for another substance. For example, a client with combined alcohol and cocaine dependence with co-occurring panic disorder may be in the *contemplation stage* (i.e., aware that a problem exists and considering overcoming it, but not committed to taking action) in regard to alcohol, *precontemplation* (i.e., unaware that a problem exists, with no intention of changing behavior) in regard to cocaine, and *action* (i.e., actively modifying behavior, experiences, or environment to overcome the problem) for the panic disorder.

Figure 5-1. Stages of Change

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

Source: Adapted from Prochaska et al.

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

Figure 5-2 illustrates approaches that a clinician might use at different stages of readiness to change to apply MI techniques when working with a substance abuse client showing evidence of COD. For a thorough discussion of MI and the stages of change, the reader is referred to Miller and Rollnick

Figure 5-2. Motivational Enhancement Approaches

Stage of Readiness	Motivational Enhancement Approaches
Precontemplation	• Express concern about the client's substance use, or the client's mood, anxiety, or other symptoms of mental disorder.
	• State nonjudgmentally that substance use (or mood, anxiety, self-destructiveness) is a problem.
	• Agree to disagree about the severity of either the substance use or the psychological issues.
	• Consider a trial of abstinence to clarify the issue, after which psychological evaluation can be reconsidered.
	• Suggest bringing a family member to an appointment.
	• Explore the client's perception of a substance use or psychiatric problem.
	• Emphasize the importance of seeing the client again and that you will try to help.
Contemplation	• Elicit positive and negative aspects of substance use or psychological symptoms.
	• Ask about positive and negative aspects of past periods of abstinence and substance use, as well as periods of depression, hypomania, etc.
	• Summarize the client's comments on substance use, abstinence, and psychological issues.
	• Make explicit discrepancies between values and actions.
	• Consider a trial of abstinence and/or psychological evaluation.
Preparation	• Acknowledge the significance of the decision to seek treatment for one or more disorders.
	• Support self-efficacy with regard to each of the COD.
	• Affirm the client's ability to seek treatment successfully for each of the COD.

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

Source: Reproduced from Samet et al.

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

Motivational strategies have been shown to be helpful with persons who have serious mental disorders. Most programs designed for persons with such disorders recognize “that the majority of psychiatric clients have little readiness for abstinence-oriented substance use disorder (SUD) treatments”; therefore, they “incorporate motivational interventions designed

to help clients who either do not recognize their SUD or do not desire substance abuse treatment to become ready for more definitive interventions aimed at abstinence" *(Drake and Mueser)*.

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

Figure 5-3. A Four-Session Motivation-Based Intervention

Goals	Therapeutic Activities	Purpose
Session 1—Introduction, Assessment, and Information Feedback		
Establish therapeutic alliance and collaborative approach	Introduce intervention	• To elicit reasons and motivations for attending
Begin to develop discrepancy (raise awareness of the extent of use and negative consequences)		• To establish understanding of the nature and purpose of the intervention
	Assess and discuss readiness to change	• To establish mutual understanding of attitudes toward substance use and prospects for change
		• To convey respect for the client's attitudes
		• To evaluate using open-ended and structured techniques
	Feedback of current use, consequences, and risks	• To foster client's awareness of extent of use, comparison to norms, negative consequences, and risks of pattern of use
Session 2—Decisional Balance		

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

Goals	Therapeutic Activities	Purpose
		• To use repetition to compensate for deficits in attention and memory
To leave the client with a clear plan of action	Elicit goals and develop written plan of action	• To help identify and clarify specific, realistic goals around substance use reduction
		• To help develop a plan of action, including mobilizing external supports and internal resources
		• To help the client anticipate barriers and solve problems around him

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

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

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

Future directions include

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

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

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

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

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

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

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

Design Contingency Management Techniques to Address Specific Target Behaviors

Description

Contingency Management (CM) maintains that the form or frequency of behavior can be altered through a planned and organized system of positive and negative consequences. CM assumes that neurobiological and environmental factors influence substance use behaviors and that the consistent application of reinforcing environmental consequences can change these behaviors. CM principles for substance abuse treatment have been structured around four central principles:

- The clinician arranges for regular drug testing to ensure the client's use of the targeted substance is detected readily.
- The clinician provides positive reinforcement when abstinence is demonstrated. These positive reinforcers are agreed on mutually.
- The clinician withholds the designated incentives from the individual when the substance is detected.
- The clinician helps the client establish alternate and healthier activities.

CM techniques are best applied to specific targeted behaviors such as

- Drug abstinence
- Clinic attendance and group participation
- Medication adherence
- Following treatment plan
- Attaining particular goals

The clinician may use a variety of CM techniques or reinforcers. The most common are

- Cash
- Vouchers
- Prizes
- Retail items
- Privileges

Figure 5-4 contains a checklist for a clinician designing CM programs.

Figure 5-4. Checklist for Designing CM Programs

Step	Description
1. Choose a behavior	• One that is objectively quantifiable, occurs frequently, and is considered to be most important.
	• Set reasonable expectations.

Step	Description
2. Choose a reinforcer	• Determine available resources (in-house rewards or donations of cash or services from local businesses such as movie theaters and restaurants).
	• Identify intangible rewards, such as frequent positive reports to parole officers, flexibility in methadone dosing, and increased freedom (smoke breaks, passes, etc.).
3. Use behavioral principles	• Develop a monitoring and reinforcement schedule that is optimized through application of behavioral principles.
	• Keep the schedule simple so staff can apply principles consistently and clients can understand what is expected.
4. Prepare a behavioral contract	• Draw up a contract for the target behavior that considers the monitoring system and reinforcement schedule.
	• Be specific and consider alternate interpretations; have others review the contract and comment.
	Include any time limitations.
5. Implement the contract	• Ensure consistent application of the contract; devise methods of seeing that staff understands and follows procedures.
	• Remind the client of behaviors and their consequences (their "account balance" and what is required to obtain a bonus) to increase the probability that the escalating reward system will have the desired effect.

Empirical evidence on the effectiveness of contingency management

A substantial empirical base supports CM techniques, which have been applied effectively to a variety of behaviors. CM techniques have demonstrated effectiveness in enhancing retention and confronting drug use *(e.g., Higgins; Petry et al.)*. The techniques have been shown to address use of a variety of specific substances, including opioids, marijuana, alcohol *(e.g., Petry et al.)*, and a variety of other drugs including cocaine. However, CM techniques have not been implemented in community-based settings until recently. The use of vouchers and other reinforcers has considerable empirical support *(e.g., Higgins; Silverman et al)*, but little evidence is apparent for the relative efficacy of different reinforcers. The effectiveness of CM principles when applied in community-based treatment settings and specifically with clients who have COD remains to be demonstrated.

Case Study: **Using CM with a Client with COD**

Initial Assessment
Mary A. is a 45-year-old Caucasian woman diagnosed with heroin and cocaine dependence, depression, antisocial personality disorder, and cocaine-induced psychotic episodes. She has a long history of prostitution and sharing injection equipment. She contracted HIV 5 years ago.
Mary A. had been on a regimen of methadone maintenance for about 2 years. Despite dose increases up to 120 mg/day, she continued using heroin at the rate of 1 to 15 bags per day as well as up to 3 to 4 dime bags per day of cocaine. After cessation of a cocaine run, Mary A. experienced tactile and visual hallucinations characterized by "bugs crawling around in my skin." She mutilated herself during severe episodes and brought in some of the removed skin to show the "bugs" to her therapist.
Mary A. had been hospitalized four times for cocaine-induced psychotic episodes. Following an 11-day stay in an inpatient dual diagnosis program subsequent to another cocaine-induced psychotic episode, Mary A. was referred to an ongoing study of contingency management interventions for methadone-maintained, cocaine-dependent outpatients.
Behaviors To Target
Mary A.'s primary problem was her drug use, which was associated with cocaine-induced psychosis and an inability to adhere to a regimen of psychiatric medications and methadone. Because her opioid and cocaine use were linked intricately, it was thought that a CM intervention that targeted abstinence from both drugs would improve her functioning. As she was already maintained on a high methadone dose, methadone dose adjustments were not made.
CM Plan
Following discharge from the psychiatric unit, Mary A. was offered participation in a NIDA-funded study evaluating lower-cost contingency management treatment (e.g., Petry et al, pp. 250–257) for cocaine-abusing methadone clients. As part of participation in this study, Mary A. agreed to submit staff-observed urine samples on 2 to 3 randomly selected days each week for 12 weeks. She was told that she had a 50 percent chance of receiving standard methadone treatment plus frequent urine sample testing of standard treatment along with a contingency management intervention. She provided written informed consent, as approved by the University's Institutional Review Board.

Mary A. was assigned randomly to the CM condition. In this condition, she earned one draw from a bowl for every urine specimen that she submitted that was clean from cocaine or opioids and four draws for every specimen that was clean from both substances. The bowl contained 250 slips of paper. Half of them said “Good job” but did not result in a prize. Other slips stated “small prize” (N=109), “large prize” (N=15), or “jumbo prize” (N=1). Slips were replaced after each drawing so that probabilities remained constant. A lockable prize cabinet was kept onsite in which a variety of small prizes (e.g., socks, lipstick, nail polish, bus tokens, $1 gift certificates to local fast-food restaurants, and food items), large prizes (sweatshirts, portable CD players, watches, and gift certificates to book and record stores), and jumbo prizes (VCRs, televisions, and boom boxes) were kept. When a prize slip was drawn, Mary A. could choose from items available in that category. All prizes were purchased through funds from the research grant.

In addition to the draws from the bowl for clean urine specimens, for each week of consecutive abstinence from both cocaine and opioids Mary A. earned bonus draws. The first week of consecutive cocaine and opioid abstinence resulted in five bonus draws, the second week resulted in six bonus draws, the third week seven and so on. In total, Mary A. could earn about 200 draws if she maintained abstinence throughout the 12-week study.

Clinical Course

Mary A. earned 175 draws during treatment, receiving prizes purchased for a total of $309. She never missed a day of methadone treatment, attended group sessions regularly, and honored all her individual counseling sessions at the clinic. At 6-month follow-up, she had experienced only one drug use lapse, which she self-reported. Her depression cleared with her abstinence, and so did her antisocial behavior. She was pleased with the prizes and stated, “Having good stuff in my apartment and new clothes makes me feel better about myself. When I feel good about me, I don't want to use cocaine.”

Source: Adapted from Petry et al.

Advice to the Counselor: Using Contingency Management Techniques

The consensus panel recommends that substance abuse treatment clinicians and programs employ CM techniques with clients with COD in such activities as

- Providing refreshments for attendance at groups or social activities
- Monitoring urine specimens
- Checking medication adherence
- Rewarding clients for obtaining particular goals in their treatment plan

• Reinforcing appropriate verbal and social behavior

Awareness of the principles of CM can help the clinician to focus on quantifiable behaviors that occur with a good deal of frequency and to provide the reinforcers in an immediate and consistent fashion. CM principles and methods can be accommodated flexibly and applied to a range of new situations that can increase clinician effectiveness. It should be noted that many counselors and programs employ CM principles informally when they praise or reward particular behaviors and accomplishments and that even formal use of CM principles are found in programs where attainment of certain levels and privileges are contingent on meeting certain behavioral criteria.

Use Cognitive-Behavioral Therapeutic Techniques

Description

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

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

CBT for substance abuse

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

CBT for people with substance use disorders also addresses “coping behaviors.” Coping “refers to what an individual does or thinks in a relapse crisis situation so as to

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

CBT and COD

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

Grounding

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

Grounding "can be done anytime, anywhere, by oneself, without anyone else noticing it. It can also be used by a supportive friend or partner who can guide the patient in it when the need arises" (Najavits). It is used commonly for PTSD, but can be applied to substance abuse cravings, or any other intense negative feeling, such as anxiety, panic attacks, and rage. Grounding is so basic and simple that it gives even the most impaired clients a useful strategy. However, it must be practiced frequently to be maximally helpful. For a lesson plan and other materials on grounding, see Najavits. See also the section on PTSD in chapter 8 and appendix D of this TIP.

Case Study: Using CBT With a Client With COD

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

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

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

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

Roles of the client and clinician

CBT is an active approach that works most effectively with persons who are stabilized in the acute phase of their substance use and mental disorders. To be effective, the clinician and the client must develop rapport and a working alliance. The client's problem is assessed extensively and thorough historical data are collected. Then, collaboratively, dysfunctional automatic thoughts, schemas, and cognitive distortions

are identified. Treatment consists of the practice of adaptive skills within the therapeutic environment and in homework sessions. Booster sessions are used following termination of treatment to assist people who have returned to old maladaptive patterns of thinking.

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

Some specific CBT strategies for programs working with clients with COD are described below. See also the text box above for a case example.

Adapting CBT for Clients with COD

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

Source: Adapted from Peters and Hills.

Use Relapse Prevention Techniques

Description

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

use, but also as a process in which indicators of increasing relapse risk can be observed prior to an episode of substance use, or lapse.

A variety of relapse prevention models are described in the literature (e.g., Gorski 2000; Marlatt et al. 1999; Monti et al. 1993; NIDA 1993; Rawson et al. 1993). However, a central element of all clinical approaches to relapse prevention is anticipating problems that are likely to arise in maintaining change and labeling them as high-risk situations for resumed substance use, then helping clients to develop effective strategies to cope with those high-risk situations without having a lapse. A key factor in preventing relapse is to understand that relapses are preceded by triggers or cues that signal that trouble is brewing and that these triggers precede exposure to events or internal processes (high-risk situations) where or when resumed substance use is likely to occur. A lapse will occur in response to these high-risk situations unless effective coping strategies are available to the person and are implemented quickly and performed adequately. Clinicians using relapse prevention techniques recognize that lapses (single episodes or brief returns to drug use) are an expected part of overcoming a drug problem, rather than a signal of failure and an indication that all treatment progress has been lost. Therapy sessions aimed at relapse prevention can occur individually or in small groups, and may include practice or role-play on how to cope effectively with high-risk situations.

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

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

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

Specific aspects of RPT might include

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

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

Adaptations for clients with COD

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

Substance abuse management module

Roberts et al. developed *The Substance Abuse Management Module* (SAMM) based on the previously described RPT approach of Marlatt and his colleagues. SAMM originally was designed to be a component of a comprehensive approach to the treatment of co-occurring substance use dependence and schizophrenia. This detailed treatment manual illustrates many RPT techniques and focuses on the most common problems encountered by clients with severe COD. SAMM offers a detailed cognitive-behavioral strategy for each of several common problems that clients face. Each strategy includes both didactics and detailed skills training

procedures including role-play practice. Emphasis is placed on rehearsing such key coping behaviors as refusing drugs, negotiating with treatment staff, acting appropriately at meetings for mutual self-help, and developing healthy habits. Both counselor and client manuals are available.

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

Overview of SAMM Concepts and Skills

How to Avoid Drugs (Made Simple)	
The concepts and skills taught in this module are designed to help clients follow these four recommendations:	
• If you slip, quit early.	
• When someone offers drugs, say no.	
• Don't get into situations where you can't say no.	
• Do things that are fun and healthy.	
Overview of Module Concepts and Skills	
Clients learn how to follow these recommendations by learning key concepts and the skills. Here are four recommendations restated in terms of the module's key concepts:	
Plain English	**Module Concepts**
If you slip, quit early.	Practice damage control.
When someone offers drugs, say no.	Escape high-risk situations.
Don't get into situations where you can't say no.	Avoid high-risk situations.
Do things that are fun and healthy.	Seek healthy pleasures.
Concepts and Skills Associated With Each Recommendation	
Practice damage control	
Main point: If you slip and use drugs or alcohol again, stop early and get right back into treatment. This will reduce damage to your health, relationships, and finances.	
Concepts: Maintain recovery, slip versus full-blown relapse, risk reduction, abstinence violation effect, bouncing back into treatment.	

Skills: Leaving a drug-using situation despite some use; reporting a slip to a support person.
Escape high-risk situations
Main point: Some situations make it very hard to avoid using drugs. Be prepared to escape from these situations without using drugs. Realize that it would be much better to avoid these situations in the first place.
Concepts: High-risk situations.
Skills: Refusing drugs from a pushy dealer; refusing drugs offered by a friend.
Avoid high-risk situations
Main point: Avoid high-risk situations by learning to recognize the warning signs that you might be headed toward drug use.
Concepts: Drug habit chain (trigger, craving, planning, getting, using), warning signs, U-turns, removing triggers, riding the wave, money management, representative payee.
Skills: Getting an appointment with a busy person; reporting symptoms and side effects; getting a support person.
Seek healthy pleasures
Main point: You can avoid drugs by focusing on the things that are most important and enjoyable to you. Do things that are fun and healthy.
Concepts: Healthy pleasures, healthy habits, activities schedule.
Skills: Getting someone to join you in a healthy pleasure; negotiating with a representative payee.
Additional Recommendations and Concepts
Understand how you learned to use drugs.
Main point: Drug abuse is learned and can be unlearned.
Concepts: Habits, reinforcement, craving, conditioning, extinction, riding the wave.
Know why you decided to quit.
Main point: Make sure you can always remember why you decided to quit using drugs.
Concepts: Advantages and disadvantages of using drugs and of not using drugs.

Carry an emergency card.
Main point: Make an emergency card that contains vital information and reminders about how and why to avoid drugs. Carry it with you at all times.
Concepts: Support person, coping skills, why quit.

Source: Adapted from Roberts et al.

Integrated Treatment

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

- 1. Doing a detailed functional analysis of the relationships between substance use, Axis I or II symptoms, and any reported criminal conduct

  2. Evaluating the unique and common high-risk factors for each problem and determining their interrelationships

  3. Assessing both cognitive and behavioral coping skills deficits

  4. Implementing both cognitive and behavioral coping skills training tailored to meet the specific needs of an individual client with respect to all three target behaviors (i.e. substance use, symptoms of mental disorder, and criminal conduct)

Summary of RP strategies for clients with COD

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

- Regardless of the client's motivational level or recovery stage, relapse education should be provided and related to the individual's mental disorder. The latter is important, particularly because the pattern typically followed by clients with COD begins with an increase in substance use leading to lowered efficacy or discontinuation of psychiatric medication, or missed counseling sessions. As a consequence, symptoms of mental disorders reappear or worsen, the client's tendency to self-medicate through substance use is exacerbated, and the downward spiral is perpetuated.
- Clients with COD need effective strategies to cope with pressures to discontinue their prescribed psychiatric medication. One such strategy simply is to prepare clients for external pressure from other people to stop taking their medications. Rehearsing circumstances in which this type of pressure is applied, along with anticipating the possibility, enables clients with COD to react appropriately. Reinforcing the difference between substances of abuse—getting “high”—and taking

psychiatric medication to treat an illness is another simple but effective strategy.

- An integral component of recovery is the use of mutual self-help and dual recovery groups to provide the support and understanding of shared experience. To maximize the effectiveness of their participation, clients with COD usually need help with social skills (listening, self-disclosure, expressing feelings/desires, and addressing conflict).

Clients can use daily self-ratings of persistent psychiatric symptoms to monitor their status. Use of the daily inventory and symptom review should be encouraged to help clients with COD to track changes and take action before deteriorating status becomes critical. See the text box below for a case study applying RP strategies.

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

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

High-Risk Factor 1

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

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

High-Risk Factor 2
Stan Z. is getting bored with his relationship with his girlfriend. He feels she is too much of a "home body" and wants more excitement in his relationship with her. He also is having increased thoughts of having sex with other women.
Possible coping strategies for Stan Z. include the following: (1) explore in therapy sessions why he is really feeling bored with his girlfriend, noting he has a long-standing pattern of dumping girlfriends after just a few months; (2) challenge his belief that the problem is mainly his girlfriend so that he sees how his attitudes and beliefs play a role in this problem; (3) talk directly with his girlfriend in a nonblaming fashion about his desire to work together to find ways to instill more excitement in the relationship; (4) remind him of potential dangers of casual sex with a woman he does not know very well and that he cannot reach his goal of maintaining a meaningful, mutual relationship if he gets involved sexually with another woman. His past history is concrete proof that such involvement always leads to sabotaging his primary relationship.
High-Risk Factor 3
Stan Z. wants to stop taking antidepressant medications. His mood has been good for several months and he does not see the need to continue medications.
Possible coping strategies include the following: (1) discuss his concern about medications with his counselor and psychiatrist before making a final decision; (2) review with his treatment team the reasons for being on antidepressant medications; (3) remind him that because he had several episodes of depression, even during times when he has been drug-free for a long period, medication can help "prevent" the likelihood of a future episode of depression.

Source: Daley and Lis

Advice to the Counselor: Using Relapse Prevention Methods

The consensus panel recommends using the following relapse prevention methods with clients with COD:
• Provide relapse prevention education on both mental disorders and substance abuse and their interrelations.
• Teach skills to help the client handle pressure for discontinuing psychotropic medication and to increase medication adherence.
• Encourage attendance at dual recovery groups and teach social skills necessary for participation.
• Use daily inventory to monitor psychiatric symptoms and symptoms changes.

• If relapse occurs, use it as a learning experience to investigate triggers with the client. Reframe the relapse as an opportunity for self-knowledge and a step toward ultimate success.

Use Repetition and Skills-Building To Address Deficits in Functioning

In applying the approaches described above, keep in mind that clients with COD often have cognitive limitations, including difficulty concentrating. Sometimes these limitations are transient and improve during the first several weeks of treatment; at other times, symptoms persist for long periods. In some cases, individuals with specific disorders (schizophrenia, attention deficit disorder) may manifest these symptoms as part of their disorder.

General treatment strategies to address cognitive limitations in clients include being more concrete and less abstract in communicating ideas, using simpler concepts, having briefer discussions, and repeating the core concepts many times. In addition, individuals often learn and remember better if information is presented in multiple formats (verbally; visually; or affectively through stories, music, and experiential activities). Role-playing real-life situations also is a useful technique when working with clients with cognitive limitations. For example, a client might be assigned to practice “asking for help” phone calls using a prepared script. This can be done individually with the counselor coaching, or in a group, to obtain feedback from the members.

When compared to individuals without additional disorders or disabilities, persons with COD and additional deficits often will require more substance abuse treatment in order to attain and maintain abstinence. A primary reason for this is that abstinence requires the development and utilization of a set of recovery skills, and persons with mental disorders often have a harder time learning new skills. They may require more support in smaller steps with more practice, rehearsal, and repetition. The challenge is not to provide more intensive or more complicated treatment for clients with COD, but rather to tailor the process of acquiring new skills to the needs and abilities of the client.

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

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

Facilitate Client Participation in Mutual Self-Help Groups

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

The clinician can assist the client by:

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

not appropriate to share at such meetings. Clients also should be taught how to "pass" and when this would be appropriate. The counselor should be familiar enough with group function and dynamics to actually "walk the client" through the meeting before attending.

- *Helping overcome barriers to group participation.* The clinician should be aware of the genuine difficulties a client may have in connecting with a group. While clients with COD, like any others, may have some resistance to change, they also may have legitimate barriers they cannot remove alone. For example, a client with cognitive difficulties may need help working out how he or she can physically get to the meeting. The counselor may need to write down very detailed instructions for this person that another client would not need (e.g., "Catch the number 9 bus on the other side of the street from the treatment center, get off at Main Street, and walk three blocks to the left to the white church. Walk in at the basement entrance and go to Room 5.")
- *Debriefing with the client after he or she has attended a meeting to help process his or her reactions and prepare for future attendance.* The clinician's work does not end with referral to a mutual self-help group. The clinician must be prepared to help the client overcome any obstacles after attending the first group to ensure engagement in the group. Often this involves a discussion of the client's reaction to the group and a clarification of how he or she can participate in future groups.

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

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

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

10. HIV and Substance Abuse

(Source: U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, Rockwall II, 5600 Fishers Lane, Rockville, MD 20857)

Substance use is common among people with HIV infection. Unfortunately, substance use can trigger and often complicate mental health problems. For many, mental health problems predate substance use activity. Substance use can increase levels of distress, interfere with treatment adherence, and lead to impairment in thinking and memory. Diagnosis and treatment by a psychiatrist or other qualified physician is critical as symptoms can mimic psychiatric disorders and other mental health problems *(Kranzler HR, Rounsavill BJ, eds. Dual Diagnosis and Treatment: Substance Abuse and Comorbid Medical and Psychiatric Disorders. New York: Marcel Dekker).*

The Reference Group to the United Nations on HIV and Injecting Drug Use recently estimated that worldwide about three million injecting drug users might be infected with HIV. About 10% of HIV cases worldwide are attributable to injecting drug use (mostly with opioids, although the use of other substances, including stimulants, has been associated with unsafe injecting practices and sexual risk behaviors). Injecting drug users principally acquire HIV through sharing injection equipment, whereas non-injecting use of drugs, such as cocaine or amphetamine-type stimulants, is associated with transmission of HIV through high-risk sexual behaviors. Some drug users practice unsafe sex with multiple partners in exchange for drugs or money, providing a bridge for HIV to spread from populations with high HIV prevalence to the general population.

Interventions that reduce the spread of HIV in injecting drug users include, among others, HIV testing and counseling, needle and syringe programs, opioid substitution therapy and other drug dependence treatment. Drug dependence is associated with particularly high-risk patterns of drug use and related risks of HIV transmission for the following reasons: drug users experience difficulties in controlling drug-taking behaviors and frequent episodes of intoxication and withdrawal (often accompanied by a strong desire to take drugs); furthermore, they persist with drug use despite clear evidence of harmful

consequences or high risk of such consequences. Effective and ethical prevention and treatment at the early stages of drug use and dependence can reduce the drug-related risks of HIV transmission. A recent WHO collaborative study on drug dependence treatment and HIV/AIDS found that substitution therapy of opioid dependence significantly reduced risks of HIV transmission in opioid-dependent individuals in low- and middle-income countries, consistent with the findings in high-income countries (*World Health Organization, Executive Board EB124/6, 124th Session 20 , Provisional agenda item 4.3).*

The incidence of AIDS-defining illness in patients receiving highly active antiretroviral therapy has been reported to be especially high in injecting drug users. In a study conducted in HIV-positive women in the United States of America, chronic depressive symptoms were associated with increased AIDS-related mortality and rapid disease progression independent of treatment and comorbid substance use (*World Health Organization, Executive Board EB124/6, 124th Session 2, Provisional agenda item 4.3).*

Mental and substance-use disorders affect help-seeking behavior or uptake of diagnostic and treatment services for HIV/AIDS. Mental illnesses have been associated with lower likelihood of receiving antiretroviral medication. In a study of women who were medically eligible to receive highly active antiretroviral therapy, its non-receipt was associated with substance use and with a history of childhood sexual abuse. Among people with HIV/AIDS, those with drug-use disorders typically experience the greatest barriers in accessing treatment because of negative societal attitudes and reluctance to seek any kind of treatment. Injection drug use has consistently been shown to be associated with low uptake of highly active antiretroviral therapy.

Substance-use disorders affect both the progression of HIV disease and the response to treatment. In untreated co-morbid drug dependence, rates of adherence to highly active antiretroviral therapy are low, and rates of co-infection with hepatitis B and C viruses are high. Several randomized controlled trials have indicated that, with integrated treatment of both drug dependence and HIV/AIDS, rates of adherence approach the rate for the non-drug-dependent population. Recent research suggests that harmful patterns of alcohol use are associated with higher mortality in patients with HIV/AIDS. Several mechanisms appear to be responsible, including a direct effect of alcohol on HIV disease progression, probably mediated through the immune system, and the undermining of adherence to treatment. Even relatively low levels of alcohol consumption, such as one standard drink per day, have been associated with a reduction in adherence to treatment regimens (*World Health Organization, Executive Board EB124/6, 124th Session 20, Provisional agenda item 4.3).*

The use of alcohol is known to be associated with an increased risk of unsafe sexual behavior. Given the widespread harmful use of alcohol in many countries with a high incidence and prevalence of HIV, levels and patterns of alcohol consumption may substantially influence HIV spread in populations. Several studies, including those conducted in African countries with high prevalence of HIV, have shown a positive association between HIV and alcohol consumption, with a prevalence of HIV infection among people with alcohol-use disorders higher than in the general population (*World Health Organization, Executive Board EB124/6, 124th Session 20, Provisional agenda item 4.3).*

The National Institute on Alcohol Abuse and Alcoholism reports that the changing patterns of HIV transmission in the United States; the role of alcohol in the transmission of HIV within, and potentially beyond, high-risk populations; the potential influence of alcohol abuse on the progression and treatment of HIV-related illness; and the benefits of making alcoholism treatment an integral part of HIV prevention programs (*Sources: Health Resources and Services Administration; National Institute on Drug Abuse; Alcoholism: Clinical and Experimental Research).*

With 31 percent of all HIV cases among men, and 57 percent among women, attributed to injection drug use, it is obvious the shooting illegal drugs increases the risk of contracting the AIDS virus, but drinking alcohol can also contribute to the spread and progression of the disease. According to the *Health Resources and Services Administration*, non-injection drug use can also lead to contracting the HIV virus, because drug users may trade sex for drugs or money or engage in behaviors under the influence that put them at risk. Binge drinking is also risky. The same is true for people who drink to excess. People who are intoxicated loose their inhibitions and have their judgment impaired and can easily find themselves involved in behavior that would put them at risk for contracting HIV.

National Institute on Drug Abuse research reports that most young people are not concerned about becoming infected with HIV, but they face a very real danger when they engage in risky behaviors, such as unprotected sex with multiple partners.

Alcohol Increases HIV Susceptibility:

Risky behavior is not the only way drinking alcohol can increase the risk for becoming infected with HIV. A study by Gregory J. Bagby at the Louisiana State University Health Sciences Center found that alcohol consumption may increase host susceptibility to HIV infection. Bagby's student, conducted with rhesus monkeys infected with simian immunodeficiency virus (SIV), found that in the early stages of infection, monkeys who were given alcohol to drink had 64 times the amount of virus in their blood than the control monkeys. Bagby concluded that the alcohol increased infectivity of cells or increased the number of susceptible cells (*Sources: Health Resources and Services Administration; National Institute on Drug Abuse; Alcoholism: Clinical and Experimental Research).*

Virus Progresses Faster

For people who have already been infected with HIV, drinking alcohol can also may accelerate their HIV disease progression, according to a study by Jeffrey H. Samet at Boston University. The reason for this is both HIV and alcohol suppress the body's immune system. Samet's research found that HIV patients who were receiving highly active antiretroviral therapy (HAART), and were currently drinking, have greater HIV progression than those who do not drink. They found that HIV patients who drank moderately or at at-risk levels had higher HIV RNA levels and lower CD4 cell counts, compared with those who did not drink (*Sources: Health Resources and Services Administration; National Institute on Drug Abuse; Alcoholism: Clinical and Experimental Research).*

Drinking Impacts Medication Compliance:

Patients with HIV who drink, especially those who drinking heavily, or less likely to adhere to their prescribed medication schedule. Both the Samet study and research at the Center for Research on Health Care at the University of Pittsburgh School of Medicine found that nearly half of their patients who drank heavily reported taking medication off schedule. The researchers reported that many of the heavy drinkers simply would forget to take their medications. This is potentially a big problem for healthcare providers due to the fact that alcohol dependence in those with HIV runs at rates twice as high as the general population (*Sources: Health Resources and Services Administration; National Institute on Drug Abuse; Alcoholism: Clinical and Experimental Research).*

Parents who are HIV positive

More and more resources have been developed for single- and two-parent households in which one or both parents are HIV positive and/or the children are HIV positive. There must be a continued awareness of the needs of these families.

These families experience the need for a variety of services, both child-centered and adult-centered. Concerns about guardianship for children after the parent is unable or unavailable to care for them must be a major focus for the parent and the service provider. Unfortunately, many clients who have long histories of substance abuse may have "burned many bridges," and the family support they need for permanency planning and establishing an appropriate guardian for their children is no longer available. All too often, there is only a tired, abused, and used grandparent who is dealing with chronic ailments, limited resources, and little emotional energy to raise more
children.

If a child also is HIV positive, there will be special needs that the parent may not be able to address while facing her own issues. The already demanding dynamics of childhood, school, and growing up become more challenging for an HIV-infected child and parent. Even if the child is not HIV positive, the demands of parenting can prove rigorous for single parents with HIV/AIDS. Although the parent experiences the relief of knowing the child is all right, the poignant realization that he may not live to see that child grow up can still be painful.

The HIV-infected single parent with a substance abuse disorder is at risk of losing custody of her minor children if convicted of drug possession or substance abuse. If family members disapprove of the single parent's lifestyle, they may seek custody of the active substance abuser's minor children. The counselor may facilitate a plan encouraging the single parent toward goals that support the parenting relationship. This enables the recovery process to take place while the parent and child are working out their own version of permanency planning.

It is difficult for a child to witness the effects of a substance abuse disorder on a parent; surely the difficulty increases enormously when the child is told that the parent has HIV/AIDS. Children whose

parents are in recovery from substance abuse disorders or who are maintaining some stability despite periodic substance abuse may experience some changes in their relationships with their parents.

There are support groups and programs for children whose parents are affected by HIV. Although not available in all communities, these groups offer children a chance to talk about their fears regarding their parents' health, learn more about the disease, and socialize with others who are facing these problems. At the same time, the programs can provide the parent with some respite time. In addition, groups like Al-Anon and Alateen can provide children with support and education about the recovery process. If service providers work in a large urban area, chances are there will be an AIDS Service Organization (ASO) listed in the phone book. This agency is likely to have lists of support groups of all kinds. Single parents with substance abuse disorders who are HIV positive should also have a support group.

Stigma of HIV/substance abuse

Many professional caregivers lack education and experience in working with homebound clients with HIV/AIDS and substance abuse disorders. Even though some home-based service providers employ staff with mental health/substance abuse experience, many do not, and it is important that the counselor intervene in providing coordinated home-based services.

Substance abuse in the home

The client may have a relapse, especially when faced with approaching end-of-life decisions. Both professional and family providers may be unable to continue to provide needed care when faced with a client/family member who has relapsed and who is not capable of following the plan of care. It is critical in these situations that the client and caregivers continue receiving substance abuse counseling and intervention in the home setting. However, providers should be aware that the home setting can present certain problems, including the possibility that other substance-abusing persons in the client's home are stealing or utilizing opioids intended for the client.

Economic needs

Even though home-based services are covered by some Federal, State, and private resources, additional stressors can affect the delivery of services. The loss of income from either the client or the family caregiver can create potential problems with housing, health insurance, nutrition, and medications. The counselor must be aware of how these conditions can disrupt the plan of care.

Emotional needs

As the client continues to need more interventions, the roles of family caregivers change, and health care professionals must be aware of the need to adapt to these changes. Family caregivers will need support in processing the anticipatory grief of losing their family members. After the client's death, help with funeral arrangements and further support of family members, who may also be dealing with their own addiction issues, may be needed.

11. Sexually Transmitted Diseases and Substance Abuse

Infectious diseases are common among drug users. Throughout the past decade, drug use and the frequency of infectious diseases among this population have escalated. The acquired immunodeficiency syndrome (AIDS) epidemic and the resurgence of tuberculosis have magnified the need for the prompt recognition and treatment of these and other infectious diseases *(Source: US Dept of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment).*

Individuals who are dependent on drugs are represented disproportionately in the population with human immunodeficiency virus (HIV) and AIDS; tuberculosis, including multidrug-resistant tuberculosis; syphilis; and hepatitis B and C. Patients who enter drug treatment programs are at risk of having one or more of these diseases. This TIP focuses on these particular infectious diseases because they occur frequently among treatment populations and have significant medical and socioeconomic consequences for infected persons and others if not recognized and treated. In addition, the trained staff of a drug treatment program can screen for and medically manage these diseases *(Source: US Dept of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment).*

Included in this TIP are discussions of other infectious diseases common to treatment populations, including Chlamydia, gonorrhea, herpes simplex, chancroid, and hepatitis A and D. Information is provided about transmission, symptoms, and indications for screening. The TIP is intended for use in a broad variety of clinical settings - inpatient, residential rehabilitation, and outpatient facilities, including methadone and drug-free modalities. The TIP is intended for a wide audience: It is for use by all who come in contact with people who use drugs *(Source: US Dept of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment).*

This TIP focuses on infectious diseases that are prevalent in and especially harmful to patients in drug treatment, and that can be medically managed by treatment staff or through referrals for primary care. The treatment recommendations in this TIP are largely, but not exclusively, based on guidelines from the Centers for Disease Control and Prevention (CDC). Trained medical staff are needed to diagnose and treat these diseases. Treatment providers who do not offer such medical resources are encouraged to refer their patients to community-based health care professionals. Follow up care of those patients referred initially to other health care professionals should be provided *(Source: US Dept of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment).*

Infectious Diseases Linked With Drug Use

Using drugs is an important risk factor for disease. Drug use is associated with such risk behaviors as the sharing of contaminated needles and other drug paraphernalia, and unsafe sexual practices that contribute to transmission of certain infectious diseases.

For example, research indicates

- ✓ There has been a steady increase in the incidence of hepatitis B, despite the availability of a vaccine since 1982. Most of the increase is attributed to injection drug use The prevalence of hepatitis C in injection drug users is also high.
- ✓ Injection drug use is closely linked to the spread of HIV. Patients infected with HIV, because of their impaired immune systems, are at increased risk of developing numerous infections, the majority of which represent reactivation of prior infection. However, HIV-infected persons are far more likely to develop active TB after exposure to TB than HIV-negative persons.
- ✓ An increase in cases of tuberculosis appears to be related to HIV infection and is seen primarily in the 25- to 44-age group. Multidrug-resistant tuberculosis has been detected in a growing number of States and is seen especially in large cities with high rates of drug use, homelessness, and HIV infection.
- ✓ The association between syphilis and drug use has been substantiated by retrospective studies and is particularly strong among cocaine users (Haverkos).

Other Infectious Diseases Common in Treatment Populations

Persons enrolled in drug treatment programs are vulnerable to a range of debilitating diseases in addition to those that are the focus of this TIP. Detection and treatment of the following diseases should not be overlooked by treatment providers, although their prevalence will vary by risk behavior and, for some infections, by geographic area:

- *Endocarditis* - an infection of the heart valves by certain bacterial and fungal organisms. Immediate medical evaluation, including laboratory tests as indicated, and treatment of patients who exhibit persistent, unexplained fever are crucial to prevent further damage to the heart and other organs, or death. Persons with pre-existing valvular heart disease are at increased risk for developing endocarditis. Among drug users, endocarditis occurs primarily in persons who inject drugs. In most cases, the skin is the source of the infecting organism, but contamination of the injected drug and the drug paraphernalia may also be the source of the infection.
- *Bacteremia/septicemia* - bacterial invasion of the bloodstream that may result from use or sharing of contaminated needles and other drug paraphernalia. Patients exhibiting persistent fever should be medically evaluated and tested as indicated. Hospitalization and treatment with intravenous antibiotics and other appropriate supportive care are required.
- *Fungal infections* - such infections, including candidiasis and histoplasmosis, which can be relatively harmless in patients with normal immune systems, are persistent infections in HIV-infected patients. Cryptococcus and histoplasmosis may be life-threatening for AIDS patients, while Candida is rarely life-threatening. Medical evaluation and testing of patients with persistent fever, unusual skin problems, headache, or other systemic complaints are necessary.
- *Body lice/scabies* - have long been a concern of drug treatment providers, because an undetected case of body lice or scabies could spread to the treatment population. Disinfection of the patient and the patient's clothing and bedding is indicated. The occurrence of one case should trigger an investigation to see if there are additional cases among other patients that require treatment.
- *Venereal warts* - may occur among sexually active treatment program populations. Venereal warts are caused by DNA viruses and are most typically manifested as fleshy growths in the genital and rectal areas. Venereal warts are frequently more severe and less responsive to treatment in HIV-

infected persons. Persons with venereal warts should be screened for syphilis because condyloma lata, which may be confused with viral warts, may occur in secondary syphilis. Venereal warts may be treated topically with cryotherapy or may require surgical excision.

(Source: US Dept of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment).

Special Problems of Sexually Transmitted Diseases in Younger People and Women

Sexually transmitted diseases other than AIDS have the greatest impact on younger people under the age of 25, especially teenagers, and women. The Guttmacher Institute reports that one in five persons in the United States - 56 million people - have a viral sexually transmitted disease (such as genital herpes, human papillomavirus). Women account for about half of all sexually transmitted infections that occur each year, but they suffer more frequent and severe long-term consequences than men *(Source: US Dept of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment).*

Sexually transmitted diseases (STDs) affect women disproportionately, because women tend to show fewer symptoms and as a consequence they go untreated for longer periods of time. A bacterial STD can usually be cured if treated early. However, these diseases are often undetected. Many of the most serious problems from STDs come from undetected Chlamydia and gonorrhea; many of these cases lead to bacterial infection of the uterus, fallopian tubes, or lining of the pelvic organs, sometimes causing infertility. The transmission of an STD to an unborn child or during childbirth can have devastating effects *(Source: Guttmacher Institute).*

Infectious Disease Screening and Drug Treatment

Many drug users are reluctant to become involved with traditional medical providers because of previous poor treatment and insensitive care. As a result, they may not seek testing for and treatment of infectious diseases. In addition, lack of access to health care, either because of financial or other socioeconomic reasons, may mean that drug users may have had minimal or no medical care before enrolling in a treatment program.

Drug treatment providers are ideally situated to reach out to their patient populations and provide infectious disease screening, medical services, and preventive counseling. Program staff have a good understanding of the lifestyles of individuals who use drugs and are sensitive to and knowledgeable about their concerns and needs.

Screening for infectious diseases in patients may be especially important to their recovery effort, may result in improved health and improved treatment compliance, and may prevent the spread of debilitating and life-threatening infectious diseases. Integration of drug treatment and infectious disease screening offers an important therapeutic intervention for patients, their families, and the broader community *(Source: US Dept of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment).*

The Consensus Development Process

The Center for Substance Abuse Treatment (CSAT) has sponsored the development of Treatment Improvement Protocols (TIPs) to provide guidance for the care of patients in drug treatment. The TIP development process was modeled on similar efforts undertaken by the Federal Government to address complex health and social service delivery issues. The consensus model that was used to develop these guidelines drew on the experience and expertise of representative specialists from across the Nation. The process began with CSAT's appointment of a Federal Resource Panel of medical personnel, drug treatment experts, social service providers, and representatives of national organizations. The Federal Panel established the overall scope and direction for the subsequent work of a Consensus Panel of experts charged with preparing guidelines covering medical screening and the treatment of infectious diseases.

The members of the Consensus Panel worked together in teams to prepare these screening and service guidelines. The draft guidelines were reviewed by additional field specialists. The final recommendations of the Consensus Panel reflect the diversity of experience and, most importantly, the agreement of many of the Nation's foremost experts as to the basic principles and guidelines for programs that should be used to provide screening and supportive care needed by patients in drug treatment *(Source: US Dept of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment).*

Recommendations of the Consensus Panel

These guidelines are intended to provide direction for the many disciplines involved in drug treatment, including physicians, physician's assistants, nurses, nurse practitioners, social workers, psychologists, counselors, and other health and social service providers. They are designed to improve the screening of patients and staff for infectious diseases; to improve treatment for these diseases through better coordination of drug treatment programs, primary health care facilities, public health agencies, and infectious disease programs; and to reduce the incidence and consequences of these diseases by changing or modifying behavior. The guidelines may be used in a variety of settings, including inpatient, outpatient, and hospital-based drug treatment programs.

The Consensus Panel supports these key recommendations:

- Screening and counseling for HIV, tuberculosis, multidrug-resistant tuberculosis, hepatitis B and C, syphilis, and other infectious diseases, if indicated, that are prevalent in treatment populations should be offered to patients upon entry into treatment.
- Appropriate medical care is essential for infected patients.
- Patients have the right to refuse to be tested for infectious diseases and should not be denied treatment services based solely on that refusal, except where there is a potential public health threat to other patients or treatment staff. Treatment providers must evaluate the potential exposure risk for other patients and treatment staff, particularly for potential exposure to infectious tuberculosis. In all instances, patients should be educated about the benefits to themselves and others from proper and early diagnosis and treatment of infectious diseases.

- Pre and post-test counseling services are needed to assist patients in preparing for and completing infectious disease screening and treatment, especially with reference to HIV.
- Risk reduction education and counseling interventions are vital to the prevention of infectious diseases. These interventions must be sensitive to and appropriate for the cultural and religious background of patients in treatment.
- Treatment program staff must be knowledgeable about and adhere to Federal and State confidentiality laws and regulations.
- Patients should be encouraged to provide information for contact tracing and partner notification.
- Treatment staff should be screened and treated as appropriate for tuberculosis. Screening should also be done for hepatitis B, with vaccination for those not previously vaccinated for or infected with hepatitis B.

The Consensus Panel encourages drug treatment staff and other service providers to use these guidelines to identify and coordinate their roles in the care of patients in treatment and after discharge.

Using These Guidelines

This TIP is intended to guide and instruct a broad spectrum of treatment and other health and public health care providers caring for drug treatment patients who are at risk for infectious diseases. Some of the guidelines provide information for specific disciplines such as counselors and physicians or other medical staff. Other parts, such as the legal and ethical guidelines, are pertinent to all service providers. A review of the entire TIP will help providers create and maintain the continuum of care that is vital to the well-being and recovery of their patients.

The first part of this TIP addresses issues that affect and support the entire infectious disease screening and treatment process. The remaining chapters provide protocols for specific infectious diseases that are common in treatment populations. The protocols include information on prevalence and disease symptoms, screening procedures, and treatment regimens.
Some chapters include a list of sources. The vast majority of information presented in this TIP is not referenced, however, because it was developed through a consensus process and is the unique product of the experience and expertise of Panel members.

- "Issues for Counselors" presents a discussion of counseling issues relevant to infectious disease screening for treatment populations. The chapter reviews the critical role of the counselor in providing pre- and post-test counseling and risk reduction interventions.
- "Legal and Ethical Issues" provides a discussion of legal and ethical issues such as confidentiality, recordkeeping, reporting, and the duty to warn.
- "Issues for Treatment Program Administrators" offers guidance for treatment program administrators concerning staff training and community development issues and environmental safety.
- "The Initial Patient Contact" discusses establishing a therapeutic relationship, assessing risk, and issues pertaining to taking a history.

- Protocols for the screening and treatment of tuberculosis and multidrug-resistant tuberculosis are presented.
- HIV/AIDS screening and referrals for continuing medical management are discussed.
- Hepatitis B, C, A, and D are discussed.
- The sexually transmitted diseases syphilis, gonorrhea, Chlamydia, herpes simplex, and chancroid are discussed.

A variety of other sexually transmitted diseases, prevalent in treatment populations including many that are common to women, are not addressed in this TIP. For more information, the reader is referred to the Centers for Disease Control, *Sexually Transmitted Diseases: Clinical Practice Guidelines*.

Substance use is common among people with HIV infection. Unfortunately, substance use can trigger and often complicate mental health problems. For many, mental health problems predate substance use activity. Substance use can increase levels of distress, interfere with treatment adherence, and lead to impairment in thinking and memory. Diagnosis and treatment by a psychiatrist or other qualified physician is critical as symptoms can mimic psychiatric disorders and other mental health problems *(Kranzler HR, Rounsavill BJ, eds. Dual Diagnosis and Treatment: Substance Abuse and Comorbid Medical and Psychiatric Disorders. New York: Marcel Dekker).*

The Reference Group to the United Nations on HIV and Injecting Drug Use recently estimated that worldwide about three million injecting drug users might be infected with HIV. About 10% of HIV cases worldwide are attributable to injecting drug use (mostly with opioids, although the use of other substances, including stimulants, has been associated with unsafe injecting practices and sexual risk behaviors). Injecting drug users principally acquire HIV through sharing injection equipment, whereas non-injecting use of drugs, such as cocaine or amphetamine-type stimulants, is associated with transmission of HIV through high-risk sexual behaviors. Some drug users practise unsafe sex with multiple partners in exchange for drugs or money, providing a bridge for HIV to spread from populations with high HIV prevalence to the general population. Interventions that reduce the spread of HIV in injecting drug users include, among others, HIV testing and counseling, needle and syringe programs, opioid substitution therapy and other drug dependence treatment. Drug dependence is associated with particularly high-risk patterns of drug use and related risks of HIV transmission for the following reasons: drug users experience difficulties in controlling drug-taking behaviors and frequent episodes of intoxication and withdrawal (often accompanied by a strong desire to take drugs); furthermore, they persist with drug use despite clear evidence of harmful consequences or high risk of such consequences. Effective and ethical prevention and treatment at the early stages of drug use and dependence can reduce the drug-related risks of HIV transmission. A recent WHO collaborative study on drug dependence treatment and HIV/AIDS found that substitution therapy of opioid dependence significantly reduced risks of HIV transmission in opioid-dependent individuals in low- and middle-income countries, consistent with the findings in high-income countries (*World Health Organization, Executive Board EB124/6, 124th Session 20, Provisional agenda).*

The incidence of AIDS-defining illness in patients receiving highly active antiretroviral therapy has been reported to be especially high in injecting drug users. In a study conducted in HIV-positive women in the

United States of America, chronic depressive symptoms were associated with increased AIDS-related mortality and rapid disease progression independent of treatment and comorbid substance use (*World Health Organization, Executive Board EB124/6, 124th Session, Provisional agenda item).*

Mental and substance-use disorders affect help-seeking behavior or uptake of diagnostic and treatment services for HIV/AIDS. Mental illnesses have been associated with lower likelihood of receiving antiretroviral medication. In a study of women who were medically eligible to receive highly active antiretroviral therapy, its non-receipt was associated with substance use and with a history of childhood sexual abuse. Among people with HIV/AIDS, those with drug-use disorders typically experience the greatest barriers in accessing treatment because of negative societal attitudes and reluctance to seek any kind of treatment. Injection drug use has consistently been shown to be associated with low uptake of highly active antiretroviral therapy (*World Health Organization, Executive Board EB124/6, 124th Session 20, Provisional agenda item 4.3).*

Substance-use disorders affect both the progression of HIV disease and the response to treatment. In untreated co-morbid drug dependence, rates of adherence to highly active antiretroviral therapy are low, and rates of co-infection with hepatitis B and C viruses are high. Several randomized controlled trials have indicated that, with integrated treatment of both drug dependence and HIV/AIDS, rates of adherence approach the rate for the non-drug-dependent population. Recent research suggests that harmful patterns of alcohol use are associated with higher mortality in patients with HIV/AIDS. Several mechanisms appear to be responsible, including a direct effect of alcohol on HIV disease progression, probably mediated through the immune system, and the undermining of adherence to treatment. Even relatively low levels of alcohol consumption, such as one standard drink per day, have been associated with a reduction in adherence to treatment regimens (*World Health Organization, Executive Board EB124/6, 124th Session 20, Provisional agenda item 4.3).*

The use of alcohol is known to be associated with an increased risk of unsafe sexual behavior. Given the widespread harmful use of alcohol in many countries with a high incidence and prevalence of HIV, levels and patterns of alcohol consumption may substantially influence HIV spread in populations. Several studies, including those conducted in African countries with high prevalence of HIV, have shown a positive association between HIV and alcohol consumption, with a prevalence of HIV infection among people with alcohol-use disorders higher than in the general population (*World Health Organization, Executive Board EB124/6, 124th Session 20, Provisional agenda item 4.3).*

The National Institute on Alcohol Abuse and Alcoholism reports that the changing patterns of HIV transmission in the United States; the role of alcohol in the transmission of HIV within, and potentially beyond, high-risk populations; the potential influence of alcohol abuse on the progression and treatment of HIV-related illness; and the benefits of making alcoholism treatment an integral part of HIV prevention programs (*Sources: Health Resources and Services Administration; National Institute on Drug Abuse; Alcoholism: Clinical and Experimental Research).*

It is obvious the shooting illegal drugs increases the risk of contracting the AIDS virus, but drinking alcohol can also contribute to the spread and progression of the disease. According to the *Health*

Resources and Services Administration, non-injection drug use can also lead to contracting the HIV virus, because drug users may trade sex for drugs or money or engage in behaviors under the influence that put them at risk. Binge drinking is also risky. The same is true for people who drink to excess. People who are intoxicated loose their inhibitions and have their judgment impaired and can easily find themselves involved in behavior that would put them at risk for contracting HIV *(Kranzler HR, Rounsavill BJ, eds. Dual Diagnosis and Treatment: Substance Abuse and Comorbid Medical and Psychiatric Disorders. New York: Marcel Dekker).*

National Institute on Drug Abuse Research reports that most young people are not concerned about becoming infected with HIV, but they face a very real danger when they engage in risky behaviors, such as unprotected sex with multiple partners.

***Alcohol Increases HIV Susceptibility**:*

Risky behavior is not the only way drinking alcohol can increase the risk for becoming infected with HIV. A study by Gregory J. Baby at the Louisiana State University Health Sciences Center found that alcohol consumption may increase host susceptibility to HIV infection. Bagby's student, conducted with rhesus monkeys infected with simian immunodeficiency virus (SIV), found that in the early stages of infection, monkeys who were given alcohol to drink had 64 times the amount of virus in their blood than the control monkeys. Bagby concluded that the alcohol increased infectivity of cells or increased the number of susceptible cells (*Sources: Health Resources and Services Administration; National Institute on Drug Abuse; Alcoholism: Clinical and Experimental Research).*

Virus Progresses Faster:

For people who have already been infected with HIV, drinking alcohol can also may accelerate their HIV disease progression, according to a study by Jeffrey H. Samet at Boston University. The reason for this is both HIV and alcohol suppress the body's immune system. Samet's research found that HIV patients who were receiving highly active antiretroviral therapy (HAART), and were currently drinking, have greater HIV progression than those who do not drink. They found that HIV patients who drank moderately or at at-risk levels had higher HIV RNA levels and lower CD4 cell counts, compared with those who did not drink (*Sources: Health Resources and Services Administration; National Institute on Drug Abuse; Alcoholism: Clinical and Experimental Research).*

Drinking Impacts Medication Compliance:

Patients with HIV who drink, especially those who drinking heavily, or less likely to adhere to their prescribed medication schedule. Both the Samet study and research at the Center for Research on Health Care at the University of Pittsburgh School of Medicine found that nearly half of their patients who drank heavily reported taking medication off schedule. The researchers reported that many of the heavy drinkers simply would forget to take their medications. This is potentially a big problem for healthcare providers due to the fact that alcohol dependence in those with HIV runs at rates twice as high as the

general population (*Sources: Health Resources and Services Administration; National Institute on Drug Abuse; Alcoholism: Clinical and Experimental Research).*

12. Substance Abuse and Domestic Violence

This section focuses on heterosexual men who abuse their domestic partners and on women who are abused by men, because these individuals constitute a significant portion of the population seeking substance abuse treatment. Though domestic violence encompasses the range of behaviors above, the TIP focuses more on physical, or a combination of physical, sexual, and emotional, violence. Therefore men who abuse their partners are referred to throughout as *batterers*; women who are abused are called *survivors*. Child abuse and neglect, elder abuse, women's abuse of men, and domestic violence within same-sex relationships are important issues that are not addressed in depth in this document, largely because each requires separate comprehensive review. Other patterns of domestic violence outside the scope of this TIP are abused women who in turn abuse their children or react violently to their partners' continued attacks and adult or teenage children who abuse their parents.

The primary purpose of this document is to provide clinicians with an overview of domestic violence so that providers can understand the particular needs and behaviors of batterers and survivors as defined above and tailor treatment plans accordingly. This requires an understanding not only of clients' issues but also of when it is necessary to seek help from domestic violence experts. This section also may prove useful to domestic violence support workers whose clients suffer from substance-related problems.

As this section makes clear, each field can benefit enormously from the expertise of the other, and cooperation and sharing of knowledge will pave the way for the more coordinated system of care.

Identifying the Connections

Researchers have found that one fourth to one half of men who commit acts of domestic violence also have substance abuse problems *(Gondolf, 1995*). A recent survey of public child welfare agencies conducted by the National Committee to Prevent Child Abuse found that as many as 80 percent of child abuse cases are associated with the use of alcohol and other drugs, and the link between child abuse and other forms of domestic violence is well established. Research also indicates that women who abuse alcohol and other drugs are more likely to become victims of domestic violence and that victims of domestic violence are more likely to receive prescriptions for and become dependent on tranquilizers, sedatives, stimulants, and painkillers and are more likely to abuse alcohol. Other evidence of the connection between substance abuse and family violence includes the following data:

- About 40 percent of children from violent homes believe that their fathers had a drinking problem and that they were more abusive when drinking.
- Childhood physical abuse is associated with later substance abuse by youth.
- Fifty percent of batterers are believed to have had "addiction" problems.
- Substance abuse by one parent increases the likelihood that the substance-abusing parent will be unable to protect children if the other parent is violent.

- A study conducted by the Department of Justice of murder in families found that more than half of defendants accused of murdering their spouses -- as well as almost half of the victims -- had been drinking alcohol at the time of the incident.
- Teachers have reported a need for protective services three times more often for children who are being raised by someone with an addiction than for other children.
- Alcoholic women are more likely to report a history of childhood physical and emotional abuse than are nonalcoholic women.
- Women in recovery are likely to have a history of violent trauma and are at high risk of being diagnosed with posttraumatic stress disorder.

(Source: U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, Rockwall II, 5600 Fishers Lane, Rockville, MD 20857)

The Societal Context

Clearly, substance abuse is associated with domestic violence, but it is not the only factor. As discussed above, witnessing or experiencing family violence during childhood is a risk factor as is a history of childhood aggression. Another factor that must be acknowledged is societal norms that indirectly excuse violence against women (tacit support for punishing unfaithful wives, for example, or stereotyped views of women as obedient or compliant). The overt or covert sexism that contributes to domestic violence also bears on connections between violence and substance abuse. Manifestations of that sexism vary across social classes and cultural groups: Some groups more than others accept domestic violence or intoxication as a way of dealing with frustration or venting anger. Though they range from subtle to blatant, sexist assumptions persist and are reflected by society's different responses to domestic violence and substance abuse among men and among women.

For example, substance abuse treatment providers have observed that society tolerates a man's use of alcohol and other drugs more readily than a woman's. They note that batterers often blame a woman they have victimized for the violence, either implicitly or explicitly, and other people, including police, judges, and juries, often accept this argument. Research suggests that intoxicated victims are more likely to be blamed than sober victims and that aggression toward an inebriated victim is considered more acceptable than aggression toward a sober one.

The Connection between Substance Abuse and Domestic Violence

Though experts agree there is a connection between the two behaviors, its precise nature remains unclear. One researcher writes, "Probably the largest contributing factor to domestic violence is alcohol. All major theorists point to the excessive use of alcohol as a key element in the dynamics of wife beating. However, it is not clear whether a man is violent because he is drunk or whether he drinks to reduce his inhibitions against his violent behavior"- Labell. Another expert (Bennett) observes that if substance abuse affects woman abuse, it does so either directly by disinhibiting normal sanctions against violence or by effecting changes in thinking, physiology, emotion, motivation to reduce tension, or motivation to increase interpersonal power.

Within this theoretical framework, the societal view of substance abusers as morally weak and controlled by alcohol or other drugs actually serves some batterers: Rather than taking responsibility for their actions, they can blame their violent acts on the substance(s) they are abusing. Although drugs or alcohol may indeed be a trigger for violence, the belief that the violence will stop once the drinking or drug use stops is usually not borne out. The use of alcohol or other drugs may increase the likelihood that a batterer will commit an act of domestic violence -- because it reduces inhibitions and distorts perceptions, because alcohol is often used as an excuse for violence, and because both alcohol abuse and domestic violence tend to follow parallel escalating patterns -- but it does not fully explain the behavior. The fact remains that non-drinking men also attack their partners, and for some individuals, alcohol actually inhibits violent behavior.

Batterers, like survivors , often turn to substances of abuse for their numbing effects. Batterers who are survivors of childhood abuse also frequently say that they use drugs and alcohol to block the pain and to avoid confronting that memory. It is a self-perpetuating cycle. Panel members report that batterers say they feel free from their guilt and others' disapproval when they are high.

The Impact of Violence on Substance Abuse Treatment

Though it cannot be said that substance abuse "causes" domestic violence, the fact remains that substance abuse treatment programs see substantial numbers of batterers and victims among their patient populations and increasingly are compelled to deal with issues related to abuse.

As substance abuse treatment programs have grown more sophisticated, the treatment offered patients has become more comprehensive and more effective. Questions about vocational, educational, and housing status; coexisting mental disorders; and presence of human immunodeficiency virus (HIV) and other infectious diseases are routinely raised during the assessment process. Treatment providers now recognize the importance of addressing issues that affect clients' patterns of substance abuse (and vice versa) so that these issues do not undermine their recovery. Today, mounting evidence about the varied associations between domestic violence and substance abuse attests to the need to add violent behavior and victimization to the list of problems that should be explored and addressed during treatment. Based on their clinical experience, members of the Consensus Panel who developed this TIP conclude that failure to address domestic violence issues interferes with treatment effectiveness and contributes to relapse.

Practitioners in both fields must be attuned to the connections between the two problems. By sharing knowledge, substance abuse treatment providers and domestic violence workers can understand the complexity of the problem, address their own misperceptions and prejudices, and better serve individual clients -- as well as lay the foundation for a coordinated community response. Building bridges between the fields requires an understanding of the way each problem can interfere with the resolution of the other and of the barriers posed by the two fields' differing program priorities, terminology, and philosophy.

Barriers to Addressing Domestic Violence in the Treatment Setting

Battering, victimization, and treatment effectiveness

Battering and victimization undermine substance abuse treatment in both direct and indirect ways. Consensus Panel members report that a substance-abusing woman often finds that her abusive partner becomes angry or threatened when she seeks help, and his violence or threats of violence may push her to drop out of treatment. Panel members have also seen a violent partner sabotage a woman's treatment by appearing at the program and threatening physical harm unless she leaves with him or by bullying or manipulating her to use alcohol or other drugs with him. Another variation on this theme occurs when a woman manages to continue in treatment, a violent episode occurs, and, as part of "making up," is persuaded to take alcohol or other drugs. Although these patterns occur in nonviolent relationships as well, the threats of physical harm, withholding of financial support, or abuse directed toward children can lead survivors to resort to using substances to buffer their distress. For this reason, recovery from a substance use disorder may not be possible unless client survivors improve their self-esteem, sense of competence, and ability to make sound decisions. Survivors must get to the point where they can recognize and take advantage of their options and alternatives before they can replace their substance use with positive coping strategies.

When batterers enter treatment, their partners also may subvert their efforts to achieve sobriety. Some batterers are less violent and easier to handle when they are drunk or high. If a batterer is more violent when sober or abstinent, his partner may encourage drinking or taking drugs. "Enabling" is actually a safety measure in these cases. Another complicating factor is some women's perception that they are responsible for their partners' substance abuse, a perception that often is reinforced by their partners, friends, and family. In the same way that they hold themselves culpable for their battering, those women believe that their "bad" behavior prompts their partners' use of alcohol or other drugs, a position that abusers exploit to rationalize their continued substance abuse.

Program Priorities, Terminology, and Philosophy

The problems of substance abuse and domestic violence intersect in destructive ways; furthermore, differences in priorities, terminology, and philosophy have hampered collaboration between providers in the two fields. For substance abuse, attaining abstinence is a key goal; for domestic violence programs, ensuring survivors' safety is of paramount concern. While both goals are valid, the reality is that they may be difficult to balance. The problem for substance abuse and domestic violence staff then lies in the perception that one goal invariably must be selected to the exclusion of the other for a program to preserve its identity and thereby carry out its mission.

A heightened awareness of the two problems, however, reveals that programs can forego an "either/or approach," shift priorities to accommodate a client's situation, and still retain program identity and orientation. A female substance abuser's living arrangements, for example, may be so dangerous that regular attendance at treatment will be impossible until safety issues are resolved. In this case, substance abuse treatment could be temporarily postponed and then reinitiated after a more secure environment can be achieved. Conversely, some survivors remain in traumatic relationships because of their

addiction. Their batterer is their supplier, and they endure the intolerable in order to feed their habit. Delaying development of a safety plan until the drug problem is addressed could be a more effective strategy under those circumstances. Adjusting priorities on a case-by-case basis does not undermine a particular program's philosophy; instead it recognizes the need for flexibility in responding to individual client needs.

Differences in terminology pose another potential barrier to effective networking. Domestic violence programs try to avoid negative language by using such positive terms as *empowerment* to encourage battered women to move forward and build a new life. *Denial*, *enabling*, *codependency*, and *powerlessness*—terms widely used in the substance abuse field to describe typical client behaviors and aspects of recovery -- strike some domestic violence workers as stigmatizing, repressive, and counter to appropriate goals for violence survivors.

Other features of substance abuse treatment that have posed problems for domestic violence programs and have inhibited collaboration between the two fields are the largely male clientele, the emphasis on family involvement, and the use of confrontational group therapy. Some domestic violence professionals worry that the male orientation in many substance abuse treatment programs makes these programs irrelevant to the realities of women's lives, insensitive to their needs, and inapplicable to the issue of domestic violence. They also believe that enlisting the help of family members and significant others in the treatment process can, in the case of violent partners, endanger the survivor. Likewise, domestic violence professionals who work with survivors consider the confrontational techniques used by some substance abuse treatment providers to overcome denial and resistance to treatment as "bullying" and inappropriate.

Although there is some validity to these characterizations (as well as to the claim that domestic violence staff are uninformed and naive about substance abusers and the manipulative behaviors they sometimes employ), education, communication, and cross-training can help to overcome barriers between substance treatment and domestic violence programs. Increased understanding within both disciplines will equip practitioners to address the particular problems of substance abusers who are victims or perpetrators of domestic violence.

Survivors of Domestic Violence: An Overview

The battered woman lives in a war zone: She rarely knows what will trigger an abusive episode, and often there is little, if any, warning of its approach. She spends a great deal of time and energy trying to read subtle signs and cues in her partner's behavior and moods in order to avoid potential violence, but she is not always successful. Financial constraints and fear that the batterer will act on his threats to harm family members or continually harass, stalk, and possibly kill her often inhibit victims from leaving (Rodriguez et al). If the batterer is also the victim's drug supplier, that further complicates the situation. Assuming all these issues can be resolved, the effects of continual abuse and verbal degradation can be so inherently damaging to self-esteem that the survivor may believe that she is incapable of "making it" on her own.

Entering the Treatment System

Crisis Intervention

When a client presents for substance abuse treatment and informs staff that she is a victim of domestic violence, treatment providers should focus on

1. *Ensuring her safety:* Whether a client is entering inpatient or outpatient treatment, the immediate physical safety of her environment must be the chief concern. If inpatient, security measures should be intensified; if outpatient, a safety plan (which may include immediate referral to a domestic violence or battered women's shelter) should be developed. In both cases, staff should be cautioned about the importance of vigilantly guarding against breaches in confidentiality.
2. *Validating and believing her, and assuring her that she is believed:* Reinforcement of the counselor's belief of a survivor's victimization is a critical component of ongoing emotional support. Affirming the survivor's experience helps empower her to participate in immediate problem solving and longer term treatment planning.
3. *Identifying her options:* Treatment providers should ask the survivor to identify her options, share information that would expand her set of available options, explore with her the risks associated with each option, and support her in devising a safety plan.

These three goals remain important for a survivor throughout treatment. Other needs that must be addressed immediately are:

- Stabilizing detoxification (including withdrawal symptoms, if any).
- Evaluating and treating any health concerns, including pregnancy. The latter is especially important for a survivor client because batterers often intensify their abuse when they learn their partner is pregnant. Injuries should be documented for any future legal proceedings that might occur.
- Attending to immediate emotional and psychological symptoms that may interfere with the initiation of treatment, such as acute anxiety and depression.

Once survivor clients' physical safety and symptoms have been addressed, treatment providers can obtain the information necessary to design a treatment plan.

Obtaining a History

A number of issues unique to domestic violence survivors must be considered by substance abuse treatment providers who work with these clients. Chief among these is the need to uncover the extent of the client's history of domestic violence. The survivor client's current substance abuse problems must be placed in the context of whatever violence and abuse she may have experienced throughout her life, both within her current family and in her family of origin. Childhood sexual abuse has been associated with a higher risk for “re-victimization" later in life.

Substance abuse counselors should be aware that survivors often are reluctant to disclose the extent of violence in their lives. Often a survivor's denial that violence occurs is so pervasive that it has become an integral element of her psyche. And, especially if violence existed in her family of origin, she may simply consider it a normal part of an intimate relationship.

At the same time, it is important to recognize that many survivors consciously keep the fact or extent of their battering concealed for good reasons, such as fear for themselves, their children, or other family members. When a battered woman leaves her abuser, her chances of being killed increase significantly.

Treatment Planning for the Survivor Client

Treatment providers can best serve clients by establishing strong linkages to domestic violence referral and intervention services and by employing staff who are thoroughly familiar with local and State laws regarding domestic violence and with the unique needs of the domestic violence survivors. Ideally, counselors should be able to refer to those services and staff members when domestic violence is suspected and call on them for consultation as needed. If a client denies a history of domestic abuse but the treatment provider still suspects it is possible, additional attempts to discuss it with the client should be made and documented. Once the client has entered treatment, a treatment plan that includes guarantees of safety and a relapse prevention plan should be developed. Considerations specific to domestic violence survivors should be integrated into each phase of the treatment plan.

Safety from the Batterer

In the early stages of the survivor's treatment, the substance abuse counselor should help her develop a long-term safety plan either by referring the client to or employing domestic violence service providers. If substance abuse counselors have been well trained in this area, they can work with clients to develop such a plan as part of intake.

One of the purposes of screening is to assess the degree to which the survivor is in physical danger. Screening for this purpose should be conducted early in the treatment process. However, domestic violence and safety issues do not always arise in the early stages of treatment of these clients. Thus substance abuse treatment providers are wise to be prepared to develop a safety plan whenever the need becomes known or acknowledged. In this regard, it is also important to remember that the client's sobriety may threaten the batterer's sense of control. In response, he may attempt to sabotage her recovery or increase the violence and threats in order to reestablish control. It is important to address this issue in treatment and to help the client minimize her risk of harm so that she can continue to comply with her treatment plan. In addition, although involving the family in counseling is usually a precept of successful substance abuse treatment, couples and family therapy may be dangerous for domestic violence survivors and should be undertaken cautiously, if at all.

It is also important for the substance abuse provider to assess the degree to which an addicted client's drug problem is tied to the abusive partner: Her batterer may be her supplier. A survivor client who relies on a batterer to obtain or administer drugs may have a difficult time remaining in treatment or avoiding the batterer. A batterer who understands his partner's addiction may simply wait for the victim to resurface. The treatment provider should be alert to the possibility that a survivor client may sabotage both her treatment and her safety in the service of her addiction.

Physical Health

Domestic violence survivors often present with acute injuries and long-term sequelae of battering as well as the physical health problems more commonly associated with substance abuse (e.g., skin abscesses and hepatitis). Cuts and bruises from domestic violence tend to be on the face, head, neck, breasts, and abdomen. Abdominal pain, sleeping and eating disorders, recurrent vaginal infections, and chronic headaches are also common among survivors. While it may be necessary to attend to pressing legal and financial concerns before chronic health problems can be addressed, medical staff should be available to assess the client's most immediate physical, emotional, and mental health needs.

When a woman presents for treatment with obvious signs of or complaints about physical battering or sexual abuse, staff should consider enlisting a forensic expert to help the survivor client obtain proper medical documentation of her injuries. Forensic medicine programs have been employed successfully in pediatric populations, and are now being expanded to include adult victims of abuse. Forensic examiners are medicolegal experts (e.g., nurses, emergency room physicians, and forensic pathologists) specially trained to evaluate, document, and interpret injuries for legal purposes. They can assess whether an injury is consistent with events as described by the victim or perpetrator client, information especially valuable when the victim is unable to accurately recount the circumstances surrounding her injuries because she was using alcohol or other drugs at the time of the assault. Forensic examiners frequently are called to testify in court and may be viewed as a valuable asset in any court proceeding relating to the assault.

Other health concerns that need attention early in treatment include screening and care for pregnancy, HIV infection, and other sexually transmitted diseases (STDs). Battered women are at extraordinarily high risk for STDs because they are frequently unable to negotiate the practice of safe sex with their partners and are often subjected to forced, unprotected sex. They also may have been forced by their partners to share needles. Not only do STDs and pregnancy require immediate medical attention, but they can also be triggers for more battering.

One of the coping mechanisms used by many survivors is the repression of physical sensations, including physical pain. Often the survivor's awareness of physical pain and discomfort resurfaces only when the traumatic effects of the abuse have been relieved. An increase in a client's somatic symptoms is also common as emotional issues surrounding her victimization begin to emerge. Such a newfound awareness can be confusing and frightening for the survivor, and it is important to ensure that this awareness is addressed both in her medical care and through psychotherapeutic counseling.

Shift of Focus and Responsibility to the Abuser

A key aspect of treatment for substance abuse is encouraging the client to assume responsibility for her addiction. For a survivor client, it is critical at the same time to dispel the notion that she is responsible for her partner's behavior. *She is only responsible for her own behavior.* The survivor client must realize that she does not and cannot control her partner's behavior, no matter what he says. Treatment should help move her toward becoming an autonomous individual who is not at the mercy of external circumstances. Concrete steps to ensure her safety or, if she decides to leave the batterer, to set up a new life will do more toward this end than anything else. As she frees herself from the violence, she will feel more independent. A counselor can help reinforce the client's view of herself as capable and competent

by eliciting information about her efforts to address the violence, even if they were unsuccessful. A counselor can point out that her efforts reflect determination, creativity, resourcefulness, and resilience, many of the same qualities that will equip her to take responsibility for her substance abuse.

Improving Decision-making Skills

Poorly developed decision-making skills can be a problem for many substance abusers. When a client is a battered woman, that inadequacy may be compounded by the domestic abuse. For some battered women, every aspect of their lives has been controlled by the batterer, and a "wrong" decision (as perceived by the batterer) may have served as another excuse to batter her. The paralyzing effect of being battered for making independent decisions must be overcome as the survivor begins to exercise choices without fear of reprisal. Thus one of the first steps in the process of empowering the survivor client is to help her develop, strengthen, focus, or validate her decision-making skills.

For a proportion of domestic violence survivors, decision-making is a new skill that must be acquired for the first time rather than a lost skill that must be relearned. Exploring her own wants, needs, and feelings, although an unfamiliar and sometimes uncomfortable process, can be a stepping stone to making larger and longer term decisions. It is important for the treatment provider to avoid underestimating the importance to the survivor of making even seemingly mundane decisions, such as what to wear or when to eat. Like most substance abusers, the survivor client must examine those areas of her life that will either support or undermine her recovery. Like others in treatment, she must disengage from drug-using friends, and she will need support as she begins the task of making new social contacts who support her recovery.

Reevaluating relationships with partners who support and encourage drinking or drug-taking is another therapeutic task for those undergoing substance abuse treatment. In a pattern that parallels the experience of many survivors of domestic violence, female substance abusers are often introduced to and supplied with drugs by male partners. Among the myriad reasons for continuing use are to maintain a relationship, to please a partner, or to share a common activity. Since safety poses such a serious problem for survivor clients, reevaluating ties to her significant other in the context of her goals for recovery requires careful consideration. For many of these women, recovery will not be possible without separation from their partners -- a reality that may be extremely difficult for them to acknowledge, accept, and translate into action. Furthermore, because of the toll that the battering has taken on many survivor clients' belief in their ability to make decisions, they are likely to need additional help in evaluating and identifying sources of stress in their relationships. Despite the time and effort involved in working through this issue, however, it is not uncommon for survivor clients to change their views about which relationships feel safe as they begin to make choices that support recovery.

When working with some survivor clients, substance abuse treatment providers may have to discard traditional notions about the wisdom of making major life decisions, such as moving, early in the course of treatment. For a domestic violence survivor who fears being pursued by a batterer, relocation to another community may be a priority. As part of treatment, the stress of uprooting herself and her children and the accompanying risk of relapse must be weighed against safety issues. Should a client

decide to move, every effort should be made to refer her to appropriate resources and supportive services within the new community.

Ensuring Emotional Health

Posttraumatic Stress Disorder

PTSD is included in the category in the DSM-5, Trauma- and Stressor-Related Disorders. All of the conditions included in this classification require exposure to a traumatic or stressful event as a diagnostic criterion for PTSD. The following summarizes the diagnostic criteria:

Criterion A (one required): The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s):
- Direct exposure
- Witnessing the trauma
- Learning that a relative or close friend was exposed to a trauma
- Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics)

Criterion B (one required): The traumatic event is persistently re-experienced, in the following way(s):
- Intrusive thoughts
- Nightmares
- Flashbacks
- Emotional distress after exposure to traumatic reminders
- Physical reactivity after exposure to traumatic reminders

Criterion C (one required): Avoidance of trauma-related stimuli after the trauma, in the following way(s):
- Trauma-related thoughts or feelings
- Trauma-related reminders

Criterion D (two required): Negative thoughts or feelings that began or worsened after the trauma, in the following way(s):
- Inability to recall key features of the trauma
- Overly negative thoughts and assumptions about oneself or the world
- Exaggerated blame of self or others for causing the trauma
- Negative affect
- Decreased interest in activities
- Feeling isolated
- Difficulty experiencing positive affect

Criterion E (two required): Trauma-related arousal and reactivity that began or worsened after the trauma, in the following way(s):
- Irritability or aggression

- Risky or destructive behavior
- Hyper vigilance
- Heightened startle reaction
- Difficulty concentrating
- Difficulty sleeping

Criterion F (required): Symptoms last for more than 1 month.

Criterion G (required): Symptoms create distress or functional impairment (e.g., social, occupational).

Criterion H (required): Symptoms are not due to medication, substance use, or other illness.

These symptoms are shared by many battered women. One study of 77 battered women in a shelter found that 84.4 percent of them met the PTSD criteria in the DSM-IV. Though the DSM-IV states that the disorder is "more commonly seen in association with an interpersonal stressor (e.g., childhood sexual or physical abuse, domestic battering, being taken hostage, incarceration as a prisoner of war or in a concentration camp, torture)" (p. 425), some domestic violence support workers have been reluctant to acknowledge PTSD among survivor clients. Their fear is that thus labeling the victim moves the onus for the violence from the abuser to the victim and provides another excuse for the batterer's behavior (e.g., "she's crazy"). A treatment provider, however, must be aware of the possibility that a survivor may be suffering PTSD and must make the appropriate referral.

Emergence of Trauma from Childhood Abuse

Many survivor clients also suffered abuse as children. Emotional and psychological trauma from childhood abuse is often repressed and may surface once the client is in a safe setting, such as an inpatient substance abuse treatment facility. The emergence of this memory can be an overwhelming experience, and treatment providers should not attempt to address it before the survivor is ready or if program staff are unprepared to handle the results. If the issue surfaces in a group setting, the substance abuse counselor should allow the survivor client to express her emotions initially. Thereafter, however, a client should be referred if possible to a therapist with special training in treating victims of childhood abuse.

Life Event Triggers

Recovering substance abusers are trained to deal with relapse triggers -- events or circumstances that produce cravings and predispose them to resume their use of alcohol or other drugs. A potential trigger for relapse can be something as seemingly benign as walking through a neighborhood where the recovering individual once purchased drugs. A domestic violence survivor is vulnerable to an additional set of triggers -- situations or experiences that may unexpectedly cause her to feel the fear and victimization she experienced when being battered. Such life event triggers may cause the client to relapse and should be addressed directly by counselor and client. Examples of life event triggers are sensory stimuli (sights, sounds, smells); the close physical proximity of certain people, particularly men; or situations that trigger unpleasant memories (such as witnessing a couple arguing). They also include stressful situations that evoke trauma responses and recreate the sense of victimization. Such triggers

may push these feelings to the surface many years later, after the survivor is out of the abusive relationship; some disappear over time, but others may always be present to some degree. Counselors should help patients identify these stressful situations and rehearse alternative responses, just as they should for substance use triggers.

Increased Stress with Abstinence

Survivors of domestic violence usually experience strong emotional reactions when they stop abusing alcohol or other drugs, which may have been a form of self-medication. They may be flooded by formerly repressed emotions and physical sensations. Abstaining from substance abuse, which often helps a survivor repress her responses, may also eradicate her ability to psychologically dissociate (distance herself emotionally so she does not "experience" feelings) from what was happening during the abuse. This dissociation may have provided her with an effective coping mechanism that allowed her to function on a day-to-day basis, despite the abuse. Its elimination may give rise to somatic symptoms, such as headaches or backaches, as formerly blocked physical sensations and experiences reenter her awareness.

Another issue for the survivor upon becoming abstinent may be the freeing of time and energy formerly spent procuring alcohol or other drugs, leaving her feeling empty or directionless and with too much time to dwell on her life situation. Other problems may surface as well. In the Panel's experience, eating disorders as well as other kinds of obsessive-compulsive behavior tend to reemerge after substance abuse ceases. Treatment providers should be alert to this possibility and prepared to refer survivor clients for specialized help (such as a local eating disorders program or chapter of Overeaters Anonymous).

Perceptions of Safety

Paradoxically, the very concept of "safety" may itself seem "unsafe" to a survivor of domestic violence. As one survivor expressed it, "The minute you (think you) are safe, you are not safe." For these clients, feeling safe from the perpetrator, even if he is dead or incarcerated, is equated with letting one's guard down and making oneself vulnerable to attack. Survivors tend to be hyper vigilant and are accustomed to always being on guard. The substance abuse treatment provider needs to understand and respect the domestic violence survivor's concept of and need for safety. Helping a client rebuild a more appropriate general level of trust is an important long-term therapeutic goal.

Medications

For some survivors, anxiety, depression, suicidal thoughts, and sleep disorders are severe enough to require medication during their treatment for substance abuse. In such cases, it is of utmost importance to strike a balance between the need for medication and the avoidance of relapse. On the one hand, the recurrence of the physical and emotional sequelae of abuse may tip a survivor into emotional trauma; on the other hand, however, the client may risk relapse with the possible misuse or abuse of the medication. Physicians should weigh carefully the risks and benefits of prescribing drugs to battered women for symptom relief. For battered women who use or are dependent on alcohol or other drugs, the drug may affect their awareness, cognitive reasoning, or motor coordination, which can, in turn, reduce their ability to protect themselves from future incidents of physical abuse. A thorough medical and psychological assessment should be conducted by a trained clinician experienced in addiction medicine

before any psychoactive medications are prescribed. As with other medicated substance abusers, regular monitoring and reassessment of symptoms are essential.

Issues for Children of Survivors

Children of domestic violence survivors have special problems and needs that may not be readily apparent to the substance abuse treatment provider. Often this is because the more obvious, acute needs of the mother tend to eclipse those of her children. Children's issues must be addressed; if ignored, they can become antecedents to more severe problems, such as conduct disorders or oppositional defiant disorders.

Emotional and Behavioral Effects of Violence on Children

Children of survivor clients typically display strong feelings of grief and loss, abandonment, betrayal, rage, and guilt. Older children also may have feelings of shame. Some indications that such feelings may be developing into serious problems for the child include

- Emotional lability
- Aggression
- Hostility
- Destructive behavior
    - Toward others
    - Toward objects or animals
    - Toward self; self-mutilation
- Inappropriate sexual behavior
- Regressive behavior
    - Bedwetting
    - Thumb-sucking or wanting a bottle (older child)
    - Rocking
    - Needing security objects (i.e., blankets)
    - Not speaking
    - Dependent behavior

The child of a survivor may have his or her own, less apparent triggers for emotional trauma that may be quite different from the mother's. Children's triggers generally have to do with abandonment and separation issues, particularly if the children have been in foster care. Possible problem behaviors include the child's becoming overly clinging and needy upon reuniting with the mother, being fearful of a separation from her again, and acting out with hostility and violence to gain attention. Children of survivors may also become "parentified," trying to be "perfect." Often this is the result of the child's feelings that he or she is somehow to blame for a parent's anger and subsequent violence. These children may also become extremely protective of their mothers. Other children may have somatic complaints, such as hives, headaches, stomachaches, or other unexplained aches or pains.

Children's Protective Services Agencies

Some survivor clients may be or will become involved with children's protective services (CPS) agencies because their children have been or are being abused and neglected. Since many battered

women fear that CPS will take their children from them, they may resist efforts to involve CPS, and some will undermine their treatment to do so.

Treatment providers must adhere to the laws in their States regarding mandated reporting of child abuse and neglect even though clients may perceive those actions as a betrayal of trust. One way to minimize problems is to discuss reporting requirements and the procedures the treatment program follows prior to treatment. Providers should also establish working relationships with CPS to ensure an appropriate and best-case response to the family situation and the child's protection.

The Role of Treatment Providers in Supporting the Mother

The substance abuse counselor is involved with the children—directly or indirectly -- through the mother. A key responsibility, then, is to understand how to interact with and support the mother in her parenting role.

Substance abuse treatment counselors must understand that the mother may be involved with multiple agencies, all of which make demands on her limited time and energy. To help her focus on her abstinence, treatment providers should

- Help the mother identify and coordinate the various services she needs via external case management services or, if unavailable, by acting as an advocate on her behalf.
- Support her efforts to participate in and take advantage of these services.
- Listen empathetically as she voices her frustration about the difficulties of meeting the demands made by the various agencies and service programs with which she is involved.
- Help her clarify the sometimes mixed messages she receives from these agencies, each of which tends to consider its "problem area" a priority (and, as a corollary, ensure that the substance abuse program's messages do not contribute to her confusion and frustration).
- Serve as an intermediary and advocate when other agency providers ask her to do more than is reasonable given her progress in treatment (e.g., resume custody before she is prepared to take on responsibility for her children or begin working while still striving to maintain abstinence).

Treatment providers also can assist survivor clients by inviting staff from domestic violence agencies such as Homebuilders and from CPS, jobs training agencies, and other organizations involved with domestic violence survivors to the substance abuse program so they can better understand the treatment and recovery process. Substance abuse treatment counselors also should request cross-training in domestic violence support as well as in-service training on the mission and operation of those agencies that come in contact with survivor clients.

Case Scenario: Profile of a Survivor

Judy, a white high school graduate in her late 20s, is a recovering substance abuser and a survivor of domestic violence. Her story is typical of the many problems and circumstances faced by women who enter both the domestic violence support and substance abuse treatment systems.

She was molested by her uncle from the age of 3 until she was 10; the molestation included vaginal penetration. Like many victims of sexual abuse, Judy was threatened by her abuser and never disclosed the abuse. On one occasion, her mother asked whether her uncle had ever touched her, and she replied, "No, he does nice things for me." At age 15, she became sexually active with her 23-year-old boyfriend, Alex. Alex and she began using marijuana. When she was 18, she started using cocaine with Alex, who was now occasionally slapping her and forcing her to have sex. At that time, she also discovered that she was pregnant. She decided to have the baby but received only sporadic prenatal care. During her pregnancy, both Judy and Alex used cocaine and marijuana and drank alcohol. The infant, a girl named Candace, was born at full term but was small for her gestational age. Alex left Judy soon thereafter, and she and Candace moved in with a new boyfriend, Billy. He used drugs and was both extremely possessive and violent. He intimidated Judy and sometimes threatened to kill her, Candace, and himself.

When Candace was 3, Judy, then 21, became pregnant again. Billy did not welcome the pregnancy and began hitting her in the abdomen and breasts when he was angry. Judy received no prenatal care during her second pregnancy and delivered a preterm, small-for-gestational-age baby whom she named Patricia. Neither Judy nor her baby was screened for drugs or HIV before or immediately after the birth. By the time Patricia was born, Judy's drug use had escalated to include crack and increasing amounts of alcohol. Despite her mounting problems, Judy recognized that her new baby was a poor feeder. Judy was frightened enough to keep a 6-week post delivery pediatric visit during which Patricia was diagnosed as "failing to thrive." At the same visit, 3-year-old Candace was weighed and found to be only in the 10th percentile of weight for her age. Two weeks later, Judy and Billy were arrested on drug charges—Judy for possession and Billy for dealing. She received probation, and she and her children moved in with her mother, Vivian. Billy was incarcerated, and Judy was required by the court to participate in substance abuse treatment.

In a group therapy session in her substance abuse treatment program, Judy acknowledged her history of family violence, childhood sexual abuse, and battering. Her case manager in this program wanted her to join another group of childhood incest survivors, but Judy felt ashamed and did not want to discuss the incest further. She began attending treatment sessions sporadically and, after 2 months, dropped out. In the meantime, tension developed between Judy and Vivian. Judy felt that her mother cared more for her granddaughters than she had about Judy when she was a child. Now that Judy had acknowledged her history of sexual abuse, she found herself blaming her mother for "allowing" it to happen. She also was jealous because she felt that Vivian was a better mother to Patricia and Candace than she was.

After a series of violent fights with her mother, Judy moved out and got a minimum-wage job, leaving her children with Vivian. Around this time, Judy met Cody, a drug dealer. Cody moved in with her, but their relationship was characterized by frequent arguing and mutual battering. Judy's work habits became erratic; she often had bruises and sprains that she refused to discuss when her concerned coworkers questioned her about them. Although she saw her children infrequently, she would call late at night when she was high and criticize Vivian for keeping her children from her.

Meanwhile, under Vivian's care, Candace gained weight but exhibited a language delay. Her preschool teacher called Vivian repeatedly about Candace's problem behavior and acting out; she was having

trouble paying attention in school, was defiant to her teachers, and was domineering with her peers. The school also reported that Candace had language problems and that she frequently cried for her mother.

Meanwhile, Vivian had quit her job in order to care for her grandchildren and was receiving Aid to Families with Dependent Children (AFDC). At this time, Vivian's health began to deteriorate, and she asked for help with Candace and Patricia. When a social worker began to talk about sending the children to a foster home, Judy was scared into action. Developmental evaluations were recommended for both children, and Judy took them to those appointments. Both children were found to have marginal developmental problems, possibly due to Judy's drug use during pregnancy. In response to the psychologist's advice, Judy enrolled Candace in a developmentally more appropriate preschool program that required parental involvement. Judy participated in this program with her daughter and resumed treatment.

For a brief time, Judy's life appeared to stabilize. Although she had not finished her substance abuse treatment program, she and Cody were both working, and she continued to receive negative screens for drugs (although she was still using occasionally). At the next CPS hearing, the children were returned to Judy's custody with the stipulation that she participate in parenting classes as well as continue in treatment.

Once her two children moved in with her and Cody, the situation began to deteriorate. Cody could not tolerate the children, and his episodes of violent behavior increased. He put his fist through the wall and kicked the door down. He became increasingly angry at Judy's frequent absences as a result of "all this kid stuff" (parenting classes and Candace's preschool program). He began to "spank" the children or grab them roughly by their arms when he wanted their attention. They showed up at their respective day care and preschool programs with bruises, which were attributed to "accidents." No one at the day care or preschool programs was aware of Judy's history or her disclosures of childhood abuse and battering in the treatment program.

Cody's violence continued to escalate and, increasingly, was directed at the children. While Judy was concerned about his hitting and yelling at the children, she didn't know what to do about it. She was feeling overwhelmed by her job, the parenting classes, her meetings with social services workers and her probation officer, and her child care responsibilities. In time, however, she began intervening when Cody yelled at or hit the children, deliberately provoking him in order to divert his attention away from the children and onto herself. The neighbors called 911 frequently, but the police never found any substantial evidence of violence.

A year passed with no improvement. The children continued to attend school, but Judy appeared only sporadically at her parenting classes and the preschool program. She was now beginning to suspect that Cody was sexually abusing 5-year-old Candace. She had begun to notice the same kinds of behavior in her daughter that she remembered in herself when she was sexually abused at that age. One day she asked Candace whether Cody had ever touched her in certain ways. Candace replied, "No, he is always nice to me." Judy remembered using almost identical words to her own mother years before and was certain that her daughter was being victimized in the same way. All the rage from her own abuse by her

uncle erupted. She verbally and physically confronted Cody, and a battle ensued, which Candace witnessed. (Later this episode became a major treatment issue for the child, who believed that the violence in her household was her fault.)
Both Judy and Cody sustained injuries in their fight. Candace ran next door with her little sister, screaming about "all the blood." The neighbors called the police; Judy and Cody were both taken to the hospital, and the children were taken to a CPS emergency shelter. Judy and Cody were arrested for disturbing the peace and for possessing drug paraphernalia. Cody was charged with first degree (later reduced to third degree) assault, for which he eventually received a suspended sentence.

In the hospital, a social worker referred Judy and the children to a program for domestic violence survivors. After she was treated and released from the hospital, Judy stayed overnight in jail. The next day she was given a court appearance date, and a domestic violence advocate arranged transportation to the domestic violence program for her and her children. Program staff also assisted Judy in obtaining a restraining order against Cody and accompanied her to court to obtain it. When Candace and Patricia were reunited with their mother in the domestic violence facility, they clung to her, crying. Over the ensuing days, they experienced nightmares.

Despite the minor drug charge, the domestic violence program agreed to accept Judy because her drug screens were negative; the program had no knowledge of Judy's substance abuse treatment history. During intake, staff explained the program's drug use policy: If Judy used while in the program, her choices were to leave the facility or participate in treatment. The domestic violence program advocates did not think Judy was using drugs at the time of her admission and did not believe that she would use during her stay.

One day, Judy returned to the domestic violence program intoxicated, and a joint fell out of her purse. The program staff members saw and reported it to CPS. CPS then took away her children and again sent them to live with their grandmother. Judy's choices were now to either get substance abuse treatment or leave the facility. She entered a 1-year residential treatment program and was assigned to a counselor who was not only a recovering addict but a survivor of domestic abuse and with whom Judy felt an immediate rapport. The counselor and Judy together developed a treatment plan that took Judy's concerns and goals as well as the needs of her children into account. Although they agreed that intensive outpatient treatment would have been preferable, she had no place to stay where she would have been safe from Cody. She could not stay at the domestic violence program for that long, and Cody knew where her mother lived. Without a safe haven, her recovery and her life would have been in jeopardy, so Judy and her counselor decided on residential treatment. The counselor walked her through the admissions process.

Judy has been in recovery for 2 years, and her mother -- who was encouraged to participate in family sessions -- is supportive. Judy goes to work every day and has begun to date an older, recovering alcoholic she met at an AA meeting. He is more established and sees her children regularly. Vivian has again quit her job and is receiving AFDC. Cody is receiving substance abuse treatment and counseling for domestic violence, which were conditions of his suspended sentence. Another condition is that he remain in treatment and make no attempt to contact Judy or the children. The children are seen on a

daily basis in the domestic violence program. But because the program can provide only supportive care and play activities, the children have been referred to a local agency with special supportive and mental health services for children.

Screening, Referral, and Treatment of Survivor and Batterer Clients

Survivors

- If a client believes that she is in immediate danger from a batterer, the treatment provider should respond to this situation before addressing any other issues and, if necessary, should suspend the screening interview for this purpose. The provider should refer the client to a domestic violence program and possibly to a women's shelter and to legal services.

- To determine if a woman is a victim of domestic violence, look for physical injuries, especially patterns of untreated injuries to the face, neck, throat, and breasts. Other indicators may include a history of relapse or noncompliance with substance abuse treatment plans; inconsistent explanations for injuries and evasive answers when questioned about them; complications in pregnancy (including miscarriage, premature birth, and infant illness or birth defects); stress-related illnesses and conditions (such as headache, backache, chronic pain, gastrointestinal distress, sleep disorders, eating disorders, and fatigue); anxiety-related conditions (such as heart palpitations, hyperventilation, and panic attacks); sad, depressed affect; or talk of suicide.

- Always interview clients about domestic violence in private.

- Ask about violence using concrete examples and hypothetical situations rather than vague, conceptual questions.

- In framing screening questions, it is extremely important to convey to the survivor that there is no justification for the battering and that substance abuse is no excuse. Questions such as, "Does he blame his violence on his alcohol or drug use?" or, "Does he use alcohol (or other drugs) as an excuse for his violence?" serve the dual purpose of determining whether the client's partner may be a substance abuser while reinforcing to her that substance abuse is not the real reason for his violence.

- Though addictions counselors can be trained relatively easily to screen clients for domestic violence, once it is confirmed that a client has been or is being battered, domestic violence experts should be contacted. Violence assessment requires in-depth knowledge and skill and should be conducted by a domestic violence expert.

- Providers should be alert to the possibility that the mother of a child who has been or is being abused by her partner is also being abused herself.

- Once the client has entered substance abuse treatment, a treatment plan that includes a relapse prevention plan and a safety plan (see Appendix D) should be developed.

- Survivors appear to benefit by participating in same-sex treatment groups that do not use confrontational techniques.
- Should a client decide to relocate to another community, she should be referred to the appropriate programs within that community.

Batterers: An Overview

There are myriad reasons why substance abuse counselors should address the domestic violence of clients who batter their partners. Consensus Panel members have observed that the violent behavior of a batterer client can interfere with his treatment for substance abuse, and conversely, his substance abuse can interfere with interventions aimed at changing his violent behavior (Bennett). Clients who are incarcerated, for example, or accused of assault or murder have limited access to substance abuse treatment. Practitioners have observed that for those clients in treatment, battering may precipitate relapse and thwart the process of true recovery, which includes "adopting a lifestyle that enhances one's emotional and spiritual health, a goal that cannot be achieved if battering continues" *(Zubretsky and Digirolamo*).

Use of psychoactive substances, on the other hand, may interfere with a client's capacity to make a safe and sane choice against violence by impairing his ability to accurately "perceive, integrate, and process information" about another's behavior toward him (Bennett). Intoxication appears to increase the likelihood that a batterer may misinterpret or distort a partner's remarks, demeanor, or actions by "blunting whatever cognitive regulators the abuser possesses" (Stosny). While abstinence from drugs and alcohol does not alter battering behavior, substance abuse problems negatively affect a batterer's capacity to change and increase the chance that violence will occur (Tolman and Bennett).

Both battering and substance abuse result in harm to the client and others. Responding to a client's penchant for violent behavior is as vital as responding to his depression or to the array of other conditions that may impede progress in treatment and interfere with recovery.

Perspectives on Substance Abuse and the Batterer Client

Although domestic violence occurs in the absence of substance abuse, there is a statistical association between the two problems. Alcohol use has been implicated in more than 50 percent of cases involving violent behavior. Research by Kantor and Straus suggested that approximately 40 percent of male batterers were heavy or binge drinkers. A recent study found that more than half of defendants accused of murdering their spouses had been drinking alcohol at the time (Bureau of Justice). Another study of incarcerated batterers found that 39 percent reported a history of alcoholism and 22 percent reported a

history of other drug addiction. A total of 50 percent self-reported current addiction; however, this figure rose to 89 percent when the researchers examined court documents. All but one of the subjects admitted to having been drunk at the time the battering occurred (Bergman and Brismar). Higher rates of substance abuse consistently correlate with higher rates of domestic violence, although one important study concluded that "chronic alcohol abuse by the male rather than acute intoxication is a better predictor of battering" (Tolman and Bennett). As one field reviewer noted, however, "Assaultive men, in general, have high alcohol use scores. Indeed the more a man matched the gauge for having an abusive personality, the greater his alcohol consumption. When a batterer says, 'the alcohol made me do it,' he's blaming one symptom -- violence -- on another -- alcohol abuse."

Most Consensus Panelists and field reviewers concur that the exact nature of the correlation between battering and substance abuse remains unclear.

Anger and hostility are more frequently generated by interactions between people, and alcohol or other drug use is likely to be linked to violent behavior through a complicated set of individual, situational, and social factor The prevalence of violence between partners cannot be adequately explained merely as the consequence of alcohol and other drug abuse, nor can it be understood outside the context within which it occurs.

Current research supports the finding that substance abuse is only one of many factors that influence a batterer's violent behavior. As with substance abuse, other factors are also correlated, such as depression, psychopathology, violence in the family of origin, social norms approving of violence (especially toward women), high levels of marital and relationship conflict, and low income. Although intoxication may trigger an individual episode of violence, addiction does not predispose one to be a batterer. This distinction is crucial for a provider to understand when treating batterer clients, because *a batterer's violence does not necessarily end when he stops abusing alcohol or other drugs*.

In characterizing substance abuse and domestic violence, practitioners have observed that the two problems are "separate but similar, and they each interact and exacerbate each other. For example, both problems are passed on from generation to generation; both involve denial, with substance abusers and batterers blaming victims for their behavior; usually, neither problem decreases until a crisis occurs; and secrecy is often the rule, with victims of abuse (wrongly) blaming themselves for their partner's substance abuse or violent behavior".

Profiling Batterers

In the past, research has focused more on attempts to identify characteristics of victims rather than perpetrators of violence (Hotaling and Sugarman). While information about batterers is relatively sparse and subject to some debate, it can provide the basis for a rudimentary understanding of their behavior. One caution is in order, however. Exploring batterers' individual characteristics addresses only one dimension of the domestic violence phenomenon. Some experts believe that battering is driven by socially supported sexism and inequitable distributions of power that feed the batterer's belief that he has an inherent right to control his partner's behavior. Others contend that analysis of batterers' characteristics has limited value if attention is not also directed to the larger culture of violence and social injustice in which battering occurs (Stosny). Research has clearly asserted the importance of socioeconomic factors in understanding battering: Approval of violence against women, low income, and belief in gender-based stereotypes emerge repeatedly as correlates of domestic violence (Bennett). As in the case of substance abusers, multiple internal and external risk factors appear to influence problem development among men who batter.

Individual Characteristics

Although batterers are a heterogeneous group, research has uncovered a number of characteristics that differentiate men who batter from men who don't. Many batterers (particularly those who engage in severe physical assaults against their partners) witnessed parental violence when they were children. While not replicated, findings from the large-scale National Family Violence Survey that included over 6,000 families suggest that experiencing corporal punishment as an adolescent may be a risk factor for later partner abuse (Straus and Kantor). As mentioned above, chronic alcohol abuse is another predictor of, and some studies have found that batterers are more likely to suffer from depression.

Screening and Referral of Survivors and Batterers in Substance Abuse Treatment Programs

It is crucial for substance abuse treatment providers to learn if their clients are either perpetrators or victims of domestic violence as early as possible in the treatment process. This chapter details signs to look for and techniques for eliciting information about domestic violence, which many affected clients are understandably reluctant to discuss. The suggestions and recommendations in this chapter are presented primarily for substance abuse treatment providers who work with clients involved in domestic violence as either batterers or survivors. They may also prove helpful to those providing domestic violence support services to their clients who have concomitant substance abuse problems.

Screening

Because of the well-documented relationship between domestic violence and substance abuse and because domestic violence affects survivors' and batterers' recovery from substance abuse, it is

recommended that all clients who present for substance abuse treatment services be questioned about domestic violence. Questions should cover childhood physical and sexual abuse as well as current abuse.

Screening for domestic violence in substance abuse treatment settings is undertaken to identify both survivors and batterers. The domestic violence assessment, like the other elements of a substance abuse assessment, gathers the specific and detailed information needed to design appropriate treatment or service plans. While addictions counselors can be trained relatively easily to screen clients for domestic violence, assessment services are more complex and require in-depth knowledge and skill. Assessment should be conducted by a domestic violence expert if possible.

Once it is determined that a client is a victim of domestic violence, a provider must determine the client's needs for violence-related services such as medical care and legal advocacy. In addition to identifying violence as an issue affecting substance abuse treatment planning, another important purpose of screening for domestic violence is to ensure the safety -- both physical and psychological -- of a survivor client. (A word of caution: There is a tendency to think of residential treatment as a safety zone for both batterers and survivors with substance abuse problems. Domestic violence experts, however, note that batterers in treatment frequently continue to harass their partners by circumventing program rules and threatening them by phone, by mail, and through contacts with other approved visitors. Telephone and other communication and visitation privileges should be carefully monitored for identified batterers and survivors in residential programs.)

Methods of Screening for Domestic Violence: Survivors

Substance abuse treatment providers and domestic violence support staff use different terms to describe the screening process. Domestic violence programs refer to the initial contact with a client as *intake*, which is roughly analogous to what substance abuse treatment providers refer to as *screening*. Once a woman has been accepted to the program, domestic violence staff will conduct a *psychosocial intake*, which is similar to *assessment* in the substance abuse treatment field.

Welfare Reform

The issue of preventing domestic violence has important implications for welfare reform; when considered in conjunction with issues involving substance abuse treatment, the overall picture becomes extremely complicated. In fact, some States (such as Kansas) have established laws that require people receiving welfare to be screened, assessed, and treated for substance abuse. It is important for treatment providers to be aware of the issues involved; careful coordination of services with domestic violence workers can help to avoid serious problems.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193), signed into law on August 22, 1996, calls for greater use of paternity determinations to enforce child support regulations. This can be problematic for welfare recipients who are victims of domestic violence. Abuse is often exacerbated or reactivated when legal action is taken against the batterer for child support. Many abused women are afraid to seek child support because they fear that doing so will

result in the batterer being given visitation rights, which would force disclosure of their new location. Although current Federal law does provide "good cause" exemptions in a number of situations, including domestic violence, this option is used by fewer than 1 percent of welfare applicants nationally (Raphael; Zorza). Providers should tell survivor clients concerned about confidentiality that these exemptions exist.

Linkages: A Coordinated Community Response

Isolation is a salient characteristic of domestic violence: It occurs in isolation and it isolates its victims from community life. Countering this pervasive isolation with a coordinated community response is perhaps the strongest way to eliminate domestic violence from our society, "If we are ever to eradicate domestic violence, the whole community must become alerted to the problem and how best to support the victims and convey to the abusers that abuse is a crime that is never justified" *(Zorza)*.

Although the primary focus of this section is on linking substance abuse treatment and domestic violence support services, the linkages cannot stop there: Other efforts to link and integrate community resources are essential, not only to ensure that the needs of individual survivors and batterers are met but also to raise public awareness and to begin to create the coordinated community response that is necessary for change. Coordinated intervention is crucial. These efforts must address needs for housing, child care, emotional and physical safety, health and mental health care, economic stability, legal protection, vocational and educational services, parenting training, and support and peer counseling, among others.

Linkages will also help each agency fulfill its own mission. Few programs have the resources available to address the sometimes overwhelming number of problems faced by substance abuse treatment clients who are affected by domestic violence. Increasingly, programs are looking to strong collaboration and linkages with other service agencies to meet their clients' needs. Such collaboration is particularly important in isolated rural communities where lack of resources and distance from services are significant problems.

In all communities -- urban, rural, and suburban -- individuals who provide substance abuse and domestic violence services in the public sector generally have experienced the negative consequences of fragmented and unintegrated service systems. Historically, their resourcefulness in obtaining necessary care for their clients has created an informal system of referrals and unofficial case management. Such linkages are becoming more formalized as system administrators realize the cost-effectiveness of collaboration and coordination of services and as public sector purchasers of Medicaid managed care become more sophisticated in contracting with managed behavioral health care organizations to ensure a continuum of services for clients served in the public sector.

Thus the current behavioral health care environment may be one especially open to change in the direction of linkages, collaboration, coordination, and service integration. This chapter calls on providers to be especially positive and creative in thinking about these issues and designing action plans. Those who have seen past efforts at service integration fail, who are skeptical about structural change within

State service delivery systems, and who may be ambivalent about giving up turf are encouraged to support coordination and collaboration -- that is, separate agencies planning together and working together to create new delivery approaches with support at the State level. This chapter focuses on two approaches to building linkages; the first based on systemic reform and the second rooted in the community. Two crucial linkages are highlighted -- that between substance abuse treatment and domestic violence support services and that between these services and the criminal justice system.

Community Assessment

Before linkages can be developed, it is necessary to know what resources exist within the community. Each entity has its own organization and its own culture that must be understood for collaboration to be successful. Every State has a unique infrastructure for housing the health care, legal, social, and other services related to substance abuse treatment and domestic violence services. Communities themselves also vary in government structure, available resources, and funding streams. Some combine alcohol treatment with treatment for other substance abuse, whereas others separate the two. Some locate services for victims of domestic violence in the criminal justice system, which affects the tone and procedures used to deliver services, while others locate such services in a hospital system linked to the emergency department. A program within a nonprofit entity in the private sector has far different restraints than one housed in a government agency.

Disciplines also differ dramatically in structure and orientation. Some substance abuse treatment programs, for example, are staffed by nurses, and others are staffed by certified addiction counselors. Many existing programs, such as Minnesota's Turning Point and African American Services, have incorporated family violence issues into substance abuse treatment, and communities throughout the United States are increasingly integrating the two areas. A single treatment approach would be enhanced by making programs accountable to the local community, strengthening the linkages between the two fields and the court system, and improving evaluation procedures.

The Argument for Case Management

In the current early stage of development of linkages between the fields of substance abuse treatment and domestic violence services, it has been suggested that "the linkage mechanism that seems most appropriate is case management" *(Collins et al., 1997, p. 400)*. Increasingly, the substance abuse treatment field has recognized that case management may be a key contributor to successful treatment. In the case management approach, a specially trained single practitioner or case management team is responsible for coordinating linkages to the wide variety of services -- including domestic violence support -- needed by many if not most clients in substance abuse treatment.

Although locating and gaining initial access to these services can be challenging, many programs have found that use of case management is well worth the effort, since it helps clients work through problems that may trigger use of alcohol and other drugs or that interfere with progress in treatment. Such problems may include homelessness, mental illness, HIV infection, lack of vocational skills, and unemployment. An additional advantage is that the case manager serves as a client advocate,

representing the client's interests in both accessing other agencies and ensuring that their services are used effectively.

Linking Substance Abuse Treatment and Domestic Violence Services

Several locales have attempted to develop model programs integrating substance abuse and domestic violence services. These include the Amend Program in several Colorado communities (Rogan), the Intercede Program of Longford Health Sources in Ohio (Burkins), and the Pittsburgh Veterans Affairs Medical Center (Gondolf). A study of linkage efforts in Illinois found that staff cross-training is inadequate to meet the goals of these efforts (Bennett and Lawson).

Linkages with the Criminal Justice System

One of the first linkages that must be identified by a substance abuse treatment program that is working with domestic violence survivors is with the legal system. A legal professional or legal service is the best resource for resolving problems that pertain to individual clients' involvement in the justice system and may be the best resource for information and guidance regarding the Violence Against Women Act (VAWA). Many of the Act's provisions -- such as those relevant to immigrants -- are complex and detailed. In addition, other Federal and State statutes may include provisions that appear to contradict those of the VAWA.

To treat substance abuse clients who are either survivors or batterers, treatment providers must be knowledgeable about policies and laws related to domestic violence; they must understand the roles of police, judges, probation staff, and other representatives of the justice system and be able to interact effectively with these individuals when necessary. As one field reviewer noted, "Integrating the criminal justice system's efforts should be the first step in forming linkages. If a provider wants assistance protecting a woman or getting a batterer to attend treatment, it is the criminal justice system that can get this done."

Specialized courts to process domestic violence cases, which combine intensive survivor services, treatment for batterers, and an active judicial role in the social contexts of the community, have been established. Some data indicate that recidivism rates among treated batterers processed through these courts are high and comparable to rates found in studies of the deterrent effects of protective orders and arrests. Failure rates are strongly correlated with lengthy prior records and a history of abuse in the batterer's family of origin (Fagan).

In pursuing victim protection goals, criminal justice agencies have been required to expand their traditional focus on the detection and punishment of crimes. Placing these expectations on police and prosecutors may require tasks and roles for which they are not well trained. Such role and policy ambiguities can affect the performance of agencies with respect to their missions. As Fagan notes:

There is no doubt that linkages between legal institutions and services for domestic violence victims are critical to stopping violence. However, these linkages may best be accomplished through a strategic

division of roles among institutions that tap the strengths of each organization. . . . Although legal systems should be open and accessible to battered women, these institutions should not take on the role of managing the coordination of services that involve social service, shelter, and other interventions. (Fagan)

Collaborative Treatment Planning for Survivors and Batterers

Treatment plans for substance abuse clients who are survivors or batterers must incorporate all the issues surrounding both sets of problems and ideally will be coordinated by a case manager. Treatment planning for matters such as time sequencing (e.g., when to start support for a domestic violence survivor in substance abuse treatment) and goals of treatment is not effective without consideration of all the factors that have a bearing on the client's best interests. Substance abuse treatment providers, domestic violence experts, and legal or other relevant professionals should plan treatment collaboratively.

Because treatment plans for domestic violence survivors are built around the premise that safety must always be the first priority, substance abuse treatment may initially take a back seat. For example, a client who lives with a violent partner may report being pressured or coerced by him to use alcohol or other drugs. In these instances, some degree of relapse may need to be tolerated in light of the threat to the client's safety. A survivor's frequent reporting of such a situation, however, signals the need for substance abuse treatment and domestic violence staff to jointly reconsider treatment priorities.

A batterer entering treatment for substance abuse can be required to sign a contract agreeing, among other stipulations, to refrain from using violence (see Chapter 4). Such "no-violence contracts" are most effective when linkages are made with other agencies involved with his case, and violations should be reported to all involved agencies, especially the criminal justice system.

Treatment providers can help persuade the courts to consider alternative sanctions that take the victim's circumstances into account. Incarcerating batterers can actually harm their victims by taking away the family income. On the other hand, not incarcerating the batterer may give him the false message that his behavior is not that bad and thus tacitly give him "permission" to continue his violence. Courts may order the batterer to receive counseling, perform public service, or a variety of other sanctions.

Establishing a Linkage Relationship

All relationships begin with a "getting-to-know-you" phase; initial, face-to-face interactions often establish the tone for future interaction. These initial meetings should include a discussion of the origins of both communities in order to help each understand the other's beliefs and attitudes. Other topics for discussion include each program's goals for its clients, the barriers routinely faced with clients, typical interactions with clients, and expected outcomes. Key individuals in each system can coach the staff of the other in working with and understanding that system and the needs of its clients. During the initial phase, it also may be helpful to acknowledge some of the stereotypes held by each field about the other and to discuss them frankly.

At these initial meetings, using a staff member with strong facilitation skills can be invaluable. An alternative is to use a facilitator from an outside agency not affiliated with either program (e.g., from a university or community college). The facilitator can recognize burgeoning problems and defuse them before group members become defensive and uncooperative, and he or she can help participants bridge gaps in understanding by clarifying terminology and asking for feedback to ensure that all parties are interpreting information the same way. A follow-up memo documenting the understandings that emerged from the meeting and listing areas of agreed-upon responsibility can also assist the collaborative process.

Cultural Competence

Substance abuse treatment and domestic violence professionals also must educate themselves on issues particular to each cultural or ethnic subgroup their clients represent. Failure to do so diminishes outcomes and completion rates for minority populations. Cultural competence is more important than ever now, as the country moves toward a "majority-less" ethnic composition and major cities become pluralities of cultures rather than majority-minority paradigms. Responding to the needs of clients will require an awareness of practice and attitude and an organizational structure that continually monitors:

- How are services provided to diverse groups?
- What is the environment in which services are offered?
- What is the composition of the group?
- How included do diverse clients feel during the treatment process, and what cultural activities are directed to a specific population?
- How can treatment be tailored to a particular group?
- Are there staff members who know the language of non-English-speaking clients?
- What networks have been created with other experts and members of the community to provide services to this population?

Lastly, cultural competence implies that agencies are equipped to respond to "insensitivity" and that they make inclusiveness an institutionalized value, in part by employing highly skilled multicultural staff .

13. Substance Use and Mental Health Among College Students

Alcohol, illicit drug, and tobacco use is more common among young adults than in any other age group. Substance misuse among college students reflects this broader prevalence but has specific differences based on factors that include the college setting, culture, experience, and demographics. The most prominent feature of college substance misuse is excessive drinking, with the highest rates occurring among a growing population of 18- to 22-year-olds who are full-time students. In addition to a long history of alcohol and marijuana use, increased misuse of medications has added a new dimension to college substance misuse.

Substance misuse brings a variety of problems to the entire population of college students and presents difficult challenges for campus administrators and surrounding communities. Mental health issues among college students are also common. This trend reflects sources of stress that include individual characteristics and experiences such as family dysfunction, low tolerance for frustration, and weak interpersonal attachments, as well as the often overwhelming pressure of college life, the changing ethnic/cultural and age composition of the student population, and the fact that more of today's students already have mental health diagnoses when they enroll.

Social Influences

Substance misuse among college students is largely driven by the social environment, featuring a longstanding culture of alcohol use that often includes dangerously excessive drinking. This culture is especially pronounced in groups such as fraternities and sororities, often referred to as Greek organizations, and in some groups of athletes. Students' use of marijuana, the most common illicit drug, is also boosted by a recreational mindset that views use of the drug as a rite of passage. Much of college students' use of other illicit drugs, mostly misuse of medications, appears to be related largely to the pressures of college life. Tobacco use, though less common among full-time college students than in the rest of the college-age population, often is fostered by a desire for social inclusion. Social influences on substance use also include norms—also known as widespread but often mistaken beliefs—about the extent and acceptability of substance use among students. Like other young people, college students are buffeted by broader forces in popular culture, including advertisements, as well as portrayals of substance use and product placements in entertainment. These messages often glamorize or encourage substance use, treat it as normal and integral to social and other situations, and do not accurately depict its adverse consequences. Friendship, adventure, sex appeal,
wealth, status, sophistication, and humor are some of the key ingredients in messages that may hold special allure. Marketing of alcohol and tobacco on and near campuses, ranging from promotions in bars to sponsorship of concerts and sporting events, adds immediacy to the pressure of popular culture.

Research supports the notion that exposure to media messages that promote or favor substance use may result in beliefs and intentions that prompt it.10 However, the varied messages and pervasiveness of popular culture means that effects are cumulative and hard to separate from other factors. Research focused on adolescents has shown that media influence on substance use is mixed with other factors and is secondary to the influence of peers and parents. Although the extent to which messages and social forces in the public arena account for substance misuse among college students is unclear, they form a backdrop that campus-based prevention strategies must acknowledge and address.

Even as college students enter adulthood and may be away from home, parents can exert important influence on students' substance use. This influence can range from expressing positive expectations that students will behave responsibly and adhere to rules and laws, to conveying the unhelpful message that substance use is a normal and even positive part of college life, perhaps with reference to the parents' own college years. Depending on school policies, parents may be notified when students violate a college's Consequences

Substance misuse among college students has frequent and severe negative consequences. These consequences include violent and sometimes fatal effects.

Much of the research on the consequences of college student substance misuse focuses on alcohol. While most injury and death among college students is unintentional, some students consider taking their own lives and some of them attempt it. Studies show a strong connection between suicidal behavior and substance use in both the college and general populations. Substance use also can damage students' health. Consequences of excessive drinking include sleep issues and depression. Substance use disorders cause significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. Alcohol use also plays a large role in sex-related harm among college students. College students are more likely to engage in unprotected sex when drunk or high and are more likely to engage in sexual activity with someone they just met. In a study of undergraduates, 42 percent reported engaging in unplanned sexual activity in the past year as a result of their alcohol use. Each year, an estimated 97,000 college students are victims of alcohol-related sexual assault that includes rape as well as forced touching or kissing. Sexual assault often is linked to substance use by victims as well as by perpetrators. Students who misuse alcohol or use illicit drugs are also more likely than students who abstain to have difficulty meeting academic responsibilities. Consequences of college substance use include falling behind in studies, getting poor grades, and dropping out. More broadly, the impact of substance misuse on students' academic performance undermines the very purpose of higher education and the financial sacrifices families make for it.

College substance use may bring disciplinary penalties imposed by schools. In addition to non-punitive actions such as substance misuse education, counseling, and treatment, students may be subject to disciplinary action, including suspension and expulsion from the college. Such actions may be based on substance use or on other violations of college standards, such as damaging property and causing or threatening physical harm. Moreover, substance use often has legal consequences. Students may be arrested for alcohol and drug violations, fighting, and damaging property. Finally, substance-using college students often diminish the quality of campus life for other students, many of whom report having study and sleep time interrupted and having personal property damaged and destroyed because of intoxicated students.

College and Underage Drinking: The Surgeon General's Call to Action

The Surgeon General's Call to Action and 2016 Report on Alcohol, Drugs, and Health summarized:

- Establish, review, and enforce rules against underage alcohol use with consequences that are developmentally appropriate and sufficient to ensure compliance. This practice helps to confirm the seriousness with which the institution views underage alcohol use by its students.
- Eliminate alcohol sponsorship of athletic events and other campus social activities.
- Restrict the sale of alcoholic beverages on campus or at campus facilities, such as football stadiums and concert halls.
- Implement responsible beverage service policies at campus facilities, such as sports arenas, concert halls, and campus pubs.

- Hold all student groups on campus, including fraternities, sororities, athletics teams, and student clubs and organizations, strictly accountable for underage alcohol use at their facilities and during functions that they sponsor.
- Eliminate alcohol advertising in college publications.
- Educate parents, instructors, and administrators about the consequences of underage drinking on college campuses, including secondhand effects that range from interference with studying to being the victim of an alcohol-related assault or date rape, and enlist their assistance in changing any culture that currently supports alcohol use by underage students.
- Partner with community stakeholders to address underage drinking as a community problem as well as a college problem and to forge collaborative efforts that can achieve a solution.
- Expand opportunities for students to make spontaneous social choices that do not include alcohol (e.g., by providing frequent alcohol-free late-night events, extending the hours of student centers and athletics facilities, and increasing public service opportunities).
- Implement use/lose laws allowing states to suspend a person's driver's license for underage alcohol violations.
- Raise the minimum legal drinking age.
- Initiate criminal state social host liability laws. Specifically, "social host" refers to adults who knowingly or unknowingly host underage drinking parties on property that they own, lease, or otherwise control. With social host ordinances, law enforcement can hold adults accountable for underage drinking through fines and potentially criminal charges.
- Intervene with Brief Alcohol Screening and Intervention for College Students (BASICS), an example of a brief motivational intervention for which results have been positive. BASICS is designed to help students reduce alcohol misuse and the negative consequences of their drinking.

Follow-up studies of students who used BASICS have shown reductions in drinking quantity in th general college population, among fraternity members, with heavy drinkers who volunteered to use BASICS, and among those who were mandated to engage in the program from college disciplinary bodies. In addition, there are federally supported resources dedicated to the prevention of substance misuse problems at America's colleges and universities. NIAAA's College Drinking–Changing the Culture website, at http://www.collegedrinkingprevention.gov, provides comprehensive, research-based information on issues related to alcohol misuse and binge drinking among college students. NIAAA's CollegeAIM provides research-based information to assist college administrators in comparing and selecting effective alcohol misuse prevention strategies. Strategies are rated for effectiveness, costs, and other criteria. Enlisting campus and community partners can expand the effectiveness of campus underage drinking and alcohol misuse prevention strategies and interventions. Models of campus community collaboration and matrices of effective strategies are available on the CollegeAIM website at https://www.collegedrinkingprevention.gov/CollegeAIM/Default.aspx.

Facts

- Among full-time college students in 2017, 53.6 percent were current drinkers, 34.8 percent were binge drinkers, and 9.7 percent were heavy drinkers. Among those not enrolled full time in college, these rates were 48.2, 32.8, and 8.8 percent, respectively.
- Current, binge, and heavy drinking rates among full-time college students have decreased slightly since 2016, when the rates were 57.2 (now 53.6), 38 (now 34.8), and 10.5 (now 9.7) percent, respectively.
- In 2017, young adults ages 18 to 22 enrolled full time in college were more likely than their peers not enrolled full time (i.e., part-time college students and persons not currently enrolled in college) to use alcohol in the past month, binge drink, and drink heavily.
- Among young adults one to four years past high school, college students are less likely than non-students to use nearly all types of illicit drugs.
- Among 17-year-olds, 22.6 percent reported past-month alcohol use and 12.5 percent reported current binge drinking in 2017.
- Available data point to substantially higher rates of alcohol consumption and binge drinking among LGBT teens.
- In 2017, 6.4 percent of 18- to 22-year-old full time college students had an illicit drug use disorder, and 9.6 percent had an alcohol use disorder.
- College students are not passive victims of the risky drinking campus culture. Instead, many incoming students appear to seek out environments that facilitate existing drinking behaviors.

14. References

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

Alcoholics Anonymous. "For Anyone New Coming to A.A.; For Anyone Referring People to A.A.". Alcoholics Anonymous World Services, Inc.. http://www.alcoholics-anonymous.org/en_information_aa.cfm?PageID=11.

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

American Psychiatric Association, Definition of Crisis Behavior & A Mental Disorder by DSM-V (Diagnostic & Statistical Manual of APA)

American Psychiatric Association, Definition of Crisis Behavior & A Mental Disorder by DSM-5 (Diagnostic & Statistical Manual of APA), & Crisis Management

Centers for Disease Control and Prevention (2013) 'Diagnoses of HIV Infection and AIDS in the United States and Dependent Areas, 2011’

Centers for Disease Control and Prevention, *Adverse Childhood Experiences Study: Data and Statistics*. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Retrieved January 12, 2009 from: http://www.cdc.gov/nccdphp/ace/prevalence.htm

Crews F, He J, Hodge C, "Adolescent cortical development: a critical period of vulnerability for addiction". *Pharmacol Biochem Behav* 86 (2): 189–99. doi:10.1016/j.pbb.2006.12.001.PMID 17222895.

Coatsworth, J.D.; Santisteban, D.A.; McBride, C.K; and Szapocznik, J. Brief strategic family therapy versus community control: Engagement, retention, and an exploration of the moderating role of adolescent symptom severity. *Family Process* 40:313-332, 2001.

Dhalla S, Kopec JA (2007). "The CAGE questionnaire for alcohol misuse: a review of reliability and validity studies". *Clin Invest Med* **30**(1): 33–41.

Diamond, G.M.; Liddle, H.A.; Hogue, A.; and Dakof, G.A. Alliancebuilding interventions with adolescents in family therapy: A process study. *Psychotherapy* 36:355-369.

Diamond, G.S., and Liddle, H.A. Resolving a therapeutic impasse between parents and adolescents in multidimensional family therapy. *Journal of Consulting and Clinical Psychology* 64:481- 488, 1996.

"Gender differences in alcohol use and alcohol dependence or abuse:" The NSDUH Report.

Kilpatrick DG, Acierno R, Saunders B, Resnick HS, Best CL, Schnurr PP. "Risk factors for adolescent substance abuse and dependence: data from a national sample". *J Consult Clin Psychol*

Hayes, S.C.; Strosahl, K.D.; and Wilson, K.G. *Acceptance and Commitment Therapy: An Experiential Approach to Behavior Change.* New York: Guilford Press.

Henricson, C., and Roker, D. Support for the parents of adolescents: A review. *Journal of Adolescence* 23:763-783.

Johnston, L. D., O'Malley, P. M., Bachman, J. G., Schulenberg, J. E. & Miech, R. A. (2016). Monitoring the Future national survey results on drug use, 1975–2015: Volume 2, College students and adults ages 19–55. Ann Arbor: Institute for Social Research, The University of Michigan. Retrieved from http://www.monitoringthefuture.org//pubs/monographs/mtf-vol2_2015.pdf

Johnston, L. D., O'Malley, P. M., Bachman, J. G., & Schulenberg, J. E. (2011). Monitoring the Future national results on adolescent drug use: Overview of key findings, 2010. Ann Arbor: Institute for Social Research, The University of Michigan.

Jonas DE, Amick HR, Feltner C, Bobashev G, Thomas K, Wines R, Kim MM, Shanahan E, Gass CE, Rowe CJ, Garbutt JC (14 May 2014). "Pharmacotherapy for Adults With Alcohol Use Disorders in Outpatient Settings". *JAMA* **311** (18): 1889–900.doi:10.1001/jama.2014.3628. PMID 24825644.

Kranzler HR, Rounsavill BJ, eds. Dual Diagnosis and Treatment: Substance Abuse and Comorbid Medical and Psychiatric Disorders. New York: Marcel Dekker.

Lantz, J., and Gregoire, T. Existential psychotherapy with Vietnam veteran couples: A twenty-five year report. *Contemporary Family Therapy* 22:19-37.

Liddle, H.A. *Multidimensional Family Therapy: A Treatment Manual.* Cannabis Youth Treatment Manual Series Vol. 5. DHHS Pub. No. BKD388. Rockville, MD: Center for Substance Abuse Treatment.

Lowinson, Joyce H; Ruiz, Pedro; Millman, Robert B; Langrod, John G (eds). *Substance Abuse: A Comprehensive Textbook* (4th ed.). Philadelphia: Lippincott Williams & Wilkins. ISBN 0-7817-3474-6.

Mason BJ, Heyser CJ. "Acamprosate: A prototypic neuromodulator in the treatment of alcohol dependence". *CNS Neurol Disord Drug Targets* **9** (1): 23–32. doi: 10.2174/187152710790966641.PMC 2853976. PMID 20201812.

Mason BJ, Heyser CJ. "The neurobiology, clinical efficacy and safety of acamprosate in the treatment of alcohol dependence". *Expert Opin Drug Saf* **9** (1): 177–88.doi: 10.1517/14740330903512943. PMID 20021295.

Mitrani, V.B.; Szapocznik, J.; and Robinson Batista, C. Structural ecosystems therapy with HIV+ African-American women. In W. Pequegnat, and J. Szapocznik (eds.), *Working With Families in the Era of HIV/AIDS.* Thousand Oaks, CA: Sage, pp. 243-279.

National Institute on Alcohol Abuse and Alcoholism.http://pubs.niaaa.nih.gov/publications/AA76/AA76.htm

National Center on Addiction and Substance Abuse at Columbia University (CASA). Missed Opportunity: National Survey of Primary Care Physicians and Patients on Substance Abuse, New York: CASA.

NBCC Code of Ethics (2012), NBCC Board of Directors, 2012

US Department of Health and Human Services, Administration on Children and Youth NIDA (National Institute on Drug Abuse), *Galanter and Kleber*.

The National Council on Alcoholism and Drug Dependency (NCADD)References from chapter: Brief Strategic Family Therapy for Adolescent Drug Use

Office of the Surgeon General. (2016). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington, DC: U.S. Department of Health and Human Services. Retrieve from: https://addiction.surgeongeneral.gov/surgeongenerals-report.pdf

Substance Abuse and Mental Health Services Administration. (2018). Results from the 2017 National Survey on Drug Use and Health: Detailed Tables. Retrieved from https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2017/

NSDUHDetailedTabs2017.pdf

Ozechowski, T.J., and Liddle, H.A. Family-based therapy for adolescent drug abuse: Knowns and unknowns. *Clinical Child and Family Psychology Review* 3(4):269-298.

Peters, G. and Woolley, J. (2015). Richard Nixon: Special Message to the Congress on Drug Abuse Prevention and Control.. [online] Presidency.ucsb.edu. Available at: http://www.presidency.ucsb.edu/ws/?pid=3048 [Accessed 11 Mar. 2015].

Pham-Kanter, Genevieve. "Substance abuse and dependence." *The Gale Encyclopedia of Medicine*. Second Edition. Jacqueline L. Longe, Ed. 5 vols. Farmington Hills, MI: Gale Group.

Perrino, T.; Gonzalez-Soldevilla, A.; Pantin, H.; and Szapocznik, J. The role of families in adolescent HIV prevention: A review. *Clinical Child and Family Psychology Review* 3(2):81-96.

Rector, N.A.; Zuroff, D.A.; and Segal, Z.V. Cognitive change and the therapeutic alliance: The role of technical and nontechnical factors in cognitive therapy. *Psychotherapy* 36:320-328.

Robbins, M.S.; Alexander, J.F.; and Turner, C.W. Disrupting defensive family interactions in family therapy with delinquent youth. *Journal of Family Psychology* 14:688-701.

Rösner S, Hackl-Herrwerth A, Leucht S, Lehert P, Vecchi S, Soyka M (2010). Rösner, Susanne, ed. "Acamprosate for alcohol dependence".*Cochrane Database of Systematic Reviews* (9): CD004332.doi: 10.1002/14651858.CD004332.pub2. PMID 20824837.

SAMHSA, Substance Abuse and Mental Health Services Administration, *TIP SERIES*

Santisteban, D.A.; Coatsworth, J.D.; Briones, E.; and Szapocznik, J. *Acculturation and Parenting,* manuscript submitted for publication. University of Miami.

Santisteban, D.A.; Muir-Malcolm, J.A.; Mitrani, V.B.; and Szapocznik, J. Integrating the study of ethnic culture and family psychology intervention science. In H. Liddle, D. Santisteban, R. Levant, and J. Bray (eds.), *Family Psychology: Science Based Interventions.* Washington, DC: American Psychological Association Press, pp. 331-352.

Santisteban, D.A.; Szapocznik, J.; Perez-Vidal, A.; Kurtines, W.M.; Murray, E.J.; and Laperriere, A. Efficacy of intervention for engaging youth and families into treatment and some variables that may contribute to differential effectiveness. *Journal of Family Psychology* 10:35-44.

Stavro K, Pelletier J, Potvin S (January 2012). "Widespread and sustained cognitive deficits in alcoholism: a meta-analysis.". *Addict Biol***18** (2): 203–13. doi:10.1111/j. 1369-1600.2011.00418.x.PMID 2226435

Steinberg, L. Adolescent transitions and alcohol and other drug use prevention. In E.N. Goplerud, ed., *Preventing Adolescent Drug Use: From Theory to Practice.* OSAP Prevention Monograph No. 8. DHHS Pub. No. 91-1725. Rockville, MD: U.S. Department of Health and Human Services, Office for Substance Abuse Prevention, pp. 13-51.

Substance Abuse and Mental Health Services Administration. (2019). Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health (HHS Publication No. PEP19−5068, NSDUH Series H−54). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

Substance Abuse and Mental Health Services Administration (2014). Behavioral Health Barometer: United States, 2014. Rockville, MD: U.S. Department of Health and Human Services.

Substance Abuse. (2015). In: Oxford English Dictionary, 2nd ed. [online] Oxford, England: Oxford University Press. Available at: http://www.oed.com.ezproxy.bu.edu/view/Entry/193042?redirectedFrom=substance++abuse& [Accessed 11 Mar. 2015].

Substance Abuse Treatment and Family Therapy, *Treatment Improvement Protocol (TIP) Series* U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, Rockwall II, 5600 Fishers Lane, Rockville, MD 20857

Summary of state laws. Washington, DC: US Department of Health and Human Services

Tarasoff v. Regents of University of California, 551 P. 2d 334.

Thomas F. McGovern; William L. White. *Alcohol Problems in the United States: Twenty Years of Treatment Perspective*. Routledge. pp. 7–. ISBN 978-0-7890-2049-9.

UNAIDS (2012) 'UNAIDS Global Report 2012: AIDSinfo'

World Health Organization (2010). "Alcohol".