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ABSTRACT

When working with individuals who are struggling with substance abuse, counselors must clearly define for themselves their values regarding the use of substances. It is vital that counselors not allow personal issues surrounding substance abuse to influence the work they do with their clients. This paper presents several ways in which to effectively work with substance abusers. First it is suggested that counselors examine their own beliefs and values of substance abuse and abusers, and determine how that might hinder the treatment process. Counselors should be open and receptive to another's reality. Also they should be open to the variety of alternative treatments available. Five stages that occur during a client's change process are discussed, followed by intervention strategies counselors can use to facilitate and encourage increased motivation for change. Three treatment options shown to produce positive results are also presented. Also included is a facilitator's manual which is a practical guide for teaching content through guided experiential projects. Eight objectives are listed, and seven student exercises are provided. (Contains 108 references.) (MKA)

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Treating Addictive Disorders

Susan Varhely

Introduction

There is ever-increasing attention given to seeking effective treatment for substance abuse. The search for "what works" in treatment has contributed to an explosion of research in the field. In the past two decades, there has been a proliferation of information and perspectives related to the effective treatment of substance abuse. Interestingly, however, is the fact that current treatment practice is reflective of very little of this new knowledge and is still relying on various strategies for which there is no scientific evidence (Miller et al., 1995). It seems that we " know how to do our work far better than we actually do it" (LeShan, 1996).

The purpose of this chapter is to present the "what works" in treating clients with substance abuse based on the current research literature. In order, however, to gain meaningful and thus applicable knowledge from this endeavor, counselors must first take a look at themselves. We must move beyond the "assumptions in which we are drenched" (Rich, 1979, p.35) in order to open ourselves to the variety of alternatives offered to us through the extensive study of research into what seems the most effective way to work with individuals who abuse substances. When it comes right down to it, treatment starts with the person of the counselor!

The Inner World of the Counselor

"What lies behind us and what lies before us
are tiny matters compared to what lies within us."
Oliver Wendell Holmes

We, as counselors, have entered the field of counseling to relieve human suffering (Miller, Duncan, et al, 1997). Our ideals are linked to the intention of honoring the full measure and depth of the human experience. We acknowledge that each client is complex, deep, and unique in his or her ability to experience the full gamut of human emotions including hurt, joy, hope, love, and fear. We believe that through listening to clients we teach them to listen to themselves. As we care about our clients, we teach them to care about themselves. We have hopes for the clients and thereby teach them to have hopes for themselves. As we respect the clients, we teach them to respect themselves (LeShan, 1995). Truly, these beliefs are rooted, either consciously or unconsciously, within the hearts of counselors. What is also true, however, is that not infrequently, the idea of counseling someone with a substance abuse problem causes us to question our "skills", to doubt our purpose, to back away. We recall the messages we have heard about people who abuse substances: "they are a tough population to work with" because they are so "resistant" to change. All too often, our own personal experiences with individuals who struggle with substance abuse reinforce our fears and apprehensions. Therefore, before even examining the research pertaining to "what works", we must examine our hearts. We, as counselors, must explore our own inner landscapes, probing and confronting our beliefs, values, myths and fears. We must confront our wounds that have yet to be healed. All this is necessary if we are to let go of our worldview and genuinely be open and present to the worldview of our clients.

This self- confrontation might start with the question: "What do I really believe about people who abuse substances?" Social constructions of substance abuse have included such models of excessive behavior as a moral weakness, a symptom of character pathology, the result of efforts to self-medicate painful feelings, a metabolic deficiency, and a primary progressive disease. The perspectives we hold manufacture our "reality" of substance abuse (Shaffer & Robbins, 1995). We see through the paradigm of our beliefs, filtering out anything that does not fit. These worldviews remain active until new information is allowed in and is assimilated into our belief systems. Under such conditions we, as counselors, can lose the ability to facilitate change in our clients because of this "binding " function of our paradigms. (Shaffer & Gambino, 1979). Through self-awareness we are able to revise and expand "reality", to shift our paradigms, and to develop a position of openness and receptivity to another's reality.

One of the most powerful and positive consequences of the disease concept model of alcoholism is that it removed substance abuse from the realm of morality (Thombs, 1994). All the pejorative beliefs about the intrinsic worth of individuals who abuse substances had to be dismissed in the light of the fact that they had a

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disease, through no fault of their own. No longer was punishment the appropriate treatment of choice. Those who abused substances could no longer be considered "evil"; they were sick. This opened the door to compassionate care. The tremendous degree of shame and blame that is still associated with substance abuse, however, suggests that in our hearts we may not have let go of this belief as completely as these new conceptualizations suggest. We may actually be experiencing ambivalence in our beliefs about substance abuse. Thus, as counselors, we must honestly struggle with this issue, learning to notice how our beliefs play out in our rationalizations about counseling people who abuse substances, i.e. ,they do not want to change.

Another question that each one of us as counselors should wonder about and ask is, "How ubiquitous do I believe the problem of substance abuse is within the person?" Individuals who attend Alcoholics Anonymous usually introduce themselves to the group by using their first names followed by, "I am an alcoholic." Too often, we as counselors see primarily the label "substance abuser" rather than coming from a holistic perspective of the individual struggling, on one hand, with substance abuse, but also having a wider range of experiences, feelings, and actions. Consider the following situation that a colleague encountered while supervising a practicum student working with her volunteer client. Her client was a young, Hispanic father of two, we'll call him Joe, who worked as a heavy machine operator until a work-related injury caused him to seek vocational re-training. Now, unemployed, his wife had to return to work and he entered college to study to become a teacher. The student-counselor was doing a beautiful job of being with Joe, hearing his frustration with college and his profound grief over losing the ability to engage in work he loved, and his guilt over not being able to provide financially for his family. She was empathic, understanding, and connected. In the course of his sharing, Joe told her that he had a drinking problem in the past. He had not considered it a problem until he showed up at his son's birthday party to overhear his son telling a little friend that he did not know if Dad would be at the party because he was always out drinking. Joe was so moved by his child he decided that alcohol must be a problem for him and that he must stop drinking. Observing the video of this counseling session, the supervisor was struck by the immediate change in the student-counselor. At the sound of the words "drinking problem", all her counseling skills left her. She could no longer hear Joe's concerns nor current behaviors, but rather zeroed in on the drinking and immediately tried to refer him to the local mental health agency to speak with a counselor about substance abuse! During supervision, the student-counselor noticed her shift and realized that it was her own issues with people who abused alcohol. Her fears surrounding abusive drinking and the beliefs that this was such unknown territory, vastly different and more baffling than the experiences previously presented by her client, dominated her vision. These thoughts evoked feelings of helplessness and she shut down, disconnected from the client and focused on the "problem", no longer seeing the struggling human being before her. Robert Heinlein (1985) states: "The hardest part about gaining any new ideas is sweeping out the false ideas occupying that niche. So long as the niche is occupied, evidence, proof, and logical demonstration get nowhere" (p. 230). In this case, the "niche" was filled with personal issues, myths, and stereotypes.

In an old Zen story, a man came to the Zen Master, searching for wisdom. Before the master would teach him about wisdom, he offered the man some tea. The master poured tea into the man's cup until it overflowed onto the floor. The man was puzzled by this and inquired how come the master would do such a thing. To this, the Zen master replied that the man's mind was so filled with his ideas about what was real that he was unable to learn anything new. He must first empty out some of "the cup" by questioning his ideas; then, he could learn something new (LeShan, 1965). As counselors we must challenge our deepest beliefs, making space for new and perhaps larger views of reality to flow through.

Finally, we have come to believe that people who abuse substances feel helpless over their using. They experience a sense of loss of control when it comes to stopping their using. A primary characteristic of the disease model is this loss of control (Thombs, 1994). However, the whole issue of control is central to all of us. From an existential perspective, the fear of not having control is a major source of anxiety (Willis, 1994). It is important, therefore, for counselors to confront their own sense of helplessness in the world and their own struggles with control. Can we, as counselors, let go of control, opening to our own vulnerability, and join our clients in the process of change?

Ultimately, counselors' interior world, their beliefs, values, hopes, and dreams, are mirrored in actions. Our actions reflect who we really are. The process of self-questioning and self-challenge is constant even when the answers may be illusive or unsettling. Are we willing to engage in this process?

Ethical Awareness

"Some patients, though their condition is perilous, recover their health simply through their contentment with the goodness of the physician."
Hippocrates

An area of critical concern to counselors is the ethical perspective involved in the work we do. Incumbent upon the counselor is the mandate to do no harm to clients. As Bissell & Royce (1994) have pointed out, "harm" can be in the form of both action and omission. We, as counselors, must have foremost in our awareness the commitment to do what is in the client's best interest. Deciding what is best for the client often feels challenging, confusing and something like walking a razor's edge. The ethical principles of our profession offer us some guidelines and possibilities. Unfortunately, although we seek clarity, a "right-wrong," "black-white" perspective, ethics, by definition, often presents more ambiguity and gives rise to more questions than it does definitive answers. Thus, determining what is or is not ethical behavior often creates a dilemma for the counselor. Not infrequently, the confusion and uncertainty are compounded when the client is dealing with a substance abuse problem. Therefore, before we proceed further with what works in counseling individuals with substance abuse problems, it is important to create a context for ethical inquiry and awareness.

"Ethical principles act as a rudder that guides the behavior of counselors; they are the principles that direct the moral-and-values-based decisions that affect the counseling process"(Miller, 1999, p.211). Ethical principles may be involved with laws, but they are not always interchangeable. Ethical behavior deals with the application of concepts of morality, values, and right and wrong, to the various situations that people encounter in life (Capuzzi & Gross, 1999). The ethical code of the counseling profession offers some very important issues that we, as counselors, must always be cognizant of as we work with our clients. Confidentiality and privileged communication, informed consent, dual relationships, professional responsibility and values are, perhaps, the more frequently encountered areas of ethical concern (For a complete presentation see the American Counseling Association *Code of Ethics and Standards of Practice*, 1995).

Confidentiality and Privileged Communication

A foundation stone of the counseling relationship is trust. A major aspect of this trust is the client's belief that what is shared within the counseling relationship will be kept "in confidence." Thus confidentiality is a crucial aspect of counseling. "Confidentiality is the obligation of professionals to respect the privacy of clients and the information they provide" (Handelsman, 1987, p.33).

Privileged communication is a legal right of clients that rests in state and federal statues. It is this right of clients that prevents the revelation of confidential information in a legal proceeding. In other words, the counselor cannot be made to testify in court about a client if the privilege is protected. Privileged communication is owned by the client, and only the client can waive that privilege thus allowing testimony (Hummel, Talbutt, & Alexander, 1985).

There are, however, limits to both professional and legal confidentiality. One such limit is referred to as the "duty to warn" which requires counselors to warn an endangered party when a client has made a direct threat on the life of that person. The following are additional limits to confidentiality: When child abuse and neglect are suspected or substantiated; if the client has revealed an intent to do harm to society; when the counselor is seeking consultation regarding the client from other professionals (in cases of consultation, when possible, identifying information should be concealed or disguised); and finally, the counselor must reveal information to a parent or legal guardian of a minor child client upon the request of the parent or guardian. A written consent from the client is needed in order to share information under any other circumstances. It is the responsibility of the counselor to inform the client, at the inception of treatment, of the limits of confidentiality. This is part of "informed consent" which will be discussed in more detail later.

The issue of confidentiality when working with individuals who are dealing with substance abuse problems becomes more complicated. In addition to professional and state legal mandates requiring confidentiality, federal law also limits release of information related to treatment of those individuals with substance abuse problems when treatment providers receive federal funds for their services. Federal confidentiality laws are imposed on any counseling service received: Assessment, diagnosis, individual and group counseling. The protection of client privacy through these laws facilitates individuals seeking help for their substance abuse

problems without the fear that in the future such help may have negative consequences for them (Cottone & Robine, 1998).

According to Bissell & Royce (1994), a client's involvement at a facility providing treatment for substance abuse problems cannot be disclosed without the proper consent by the client. Proper consent means that the client is made aware of the need for and extent of the disclosure. In these situations, minors have the same rights as adults. Remley (1985) has indicated that minors, too, must be informed before disclosure occurs. It is not unusual, when working with minor adolescent clients, for issues related to parents and schools to arise. According to Anderson (1996), the welfare of the adolescent client must be the primary motivator for the counselor's actions. The client's age, education, relationship with parents (or legal guardians), and the potential harm of disclosing or not disclosing information must be considered.

Informed Consent

Informed consent is the right of individuals to be fully informed about the nature of the counseling service, alternative treatments available, the qualifications of the professionals involved, the limits of confidentiality, and any other information needed for them to make a knowledgeable decision regarding counseling services (Cottone & Tarvydas, 1998). Clients must give their consent to counseling. Here again, informed consent becomes complicated due to substance abuse issues. Frequently, counseling is initiated while the person is under the direct influence of the substance and thus not in any condition to make an informed consent. After the initial intervention, it is incumbent upon the counselor to recognize and respect the individual's right to refuse counseling

It is not unusual for individuals who abuse substances to engage in substance abuse related behaviors that result in their being mandated to counseling by the judicial system. Compulsory treatment is not an automatic denial of the individual's right to consent. In such cases, it is the responsibility of the counselor to explore with the client alternatives and possible consequences for refusing counseling or terminating early (Cottone & Robine, 1998).

Dual Relationships

Dual relationships are those that contain both professional and person/nonprofessional dimensions (Swenson, 1993). Such relationships hold the potential of damaging the professional objectivity needed in the counseling relationship. The infusion of a personal component threatens the integrity of the therapeutic alliance. Friendships outside the counseling context have the tendency to challenge the needed therapeutic boundaries.

Although not all dual relationships are technically unethical, the primary question that must be foremost for the counselor is, "Does this relationship have the potential to cause physical or emotional harm to the client?" Sexual intimacies between counselor and client have been shown through research to put clients in danger of emotional harm (Bouhoustsos et al., 1983). It is a misuse of power for the counselor to cross the line of sexual intimacy. Sexual intimacies with clients are clearly unethical (Cottone & Tarvydas, 1998).

The issue of dual relationships presents additional challenges when the counselors themselves are recovering from substance abuse and are attending self-help groups such as Alcoholics Anonymous or Narcotics Anonymous. Under such circumstances, if client and counselor attend the same group meetings, the relationships shift from client/counselor to peer. The anonymity of the client within AA or NA is compromised. Recovering counselors must be aware of the potentials for these types of dual relationships to occur and therefore should attempt to seek their treatment in environments that will decrease the likelihood of non-treatment contacts with clients.

Professional Responsibility

Professional responsibility relates to the appropriateness of the counselor's professional actions. The advancement of the client's welfare is paramount for the counselor (Margolin, 1982). This means that counselors do not discriminate against those seeking their services and do not subjugate their obligations to the client to their own personal rewards.

The needs of the client are the primary focus of the counselor. When working with individuals who abuse substances it is not unusual for the counselor to see the family of the client also. The counselor must be mindful not to compromise the client's treatment in the service of the larger family system. If counseling has been

undertaken for the purpose of assisting the recovery of the person with a substance abuse problem and with his/her consent, then the individual's welfare is the focus of counselor responsibility (Cottone & Robine, 1998).

Values

As discussed earlier, counselors must strive to be aware of their value system, particularly how it relates to the issues and concerns of their clients. When working with individuals who are struggling with substance abuse, counselors must clearly define for themselves their values regarding the use of substances. Substance abuse can be infused with considerable emotion for counselors depending on their personal experience with substance abuse, their beliefs about people who use substances, and their position within the total abstinence-controlled drinking controversy (Hester & Miller, 1989). It is vital that counselors do not allow their personal issues surrounding substance abuse to influence the work they do with their clients. Self-awareness on the part of the counselor becomes an ethical responsibility.

The Therapeutic Alliance

An important focus of research has been on the nature and quality of the therapeutic alliance and its relationship to treatment outcome (Bachelor & Horvath, 1999). As counselors, we are well aware that Carl Rogers (1951,1957) was a pioneer in exploring the connection between the counseling relationship and the healing process. What may be surprising is that Rogers' core conditions of empathic understanding, positive regard, genuineness, and congruence, and his emphasis upon the therapeutic relationship are supported in research as having a dominant influence on effective intervention in the treatment of people struggling with substance abuse (Miller et al., 1995; Connors, DiClemente, Carroll, Longabaugh, & Donovan, 1997). Briefly, empathic understanding refers to the ability of counselors to feel with their clients. Additionally, it is the ability to understand the feelings, thoughts, ideas, and experiences of the client through the client's eyes. Positive regard refers to the counselor's belief in the innate worth and potential of each client. Finally, genuineness and congruence relate to authenticity within the helping relationship. The counselor's behaviors, words, and actions are real rather than part of a role played (Gross & Capuzzi, 1999).

The therapeutic alliance is a collaborative effort between counselor and client consisting of an emotional bond and a shared presumption regarding the tasks and goals of the treatment process (Bordin, 1979). Research has found that there is a moderate but consistent, positive relationship between the therapeutic alliance and outcome (Horvath & Symonds, 1991). This relationship between alliance and positive outcome is consistent across a variety of therapy modalities (Beutler, Machado, & Allstetter-Neufeldt, 1994; Lambert & Bergin, 1994).

The therapeutic alliance involves the expression of the feelings and attitudes that counselor and client have toward each other (Gelso & Carter, 1985). The critical component of the process is the "working together", the collaboration of counselor and client against a common enemy, that is, the client's suffering (Bordin, 1979). In this alliance, the counselor and the better part of the client feel themselves allied in the search for the best, the thriving, of the whole client. In order to create this environment, there is nothing specific that the counselor does. For too long we have been operating under the assumption that the behaviors associated with this alliance could be standardized and taught (Miller, et al. 1995). However, we have found that the creation of this environment was more complicated than learning techniques (Garduk & Haggard, 1972). Perhaps, the challenge is not about what behaviors should be demonstrated but rather what attitudes need to be held. Research supports that these attitudes must include a real respect for the best of the client, the client's highest self (Miller et al. 1995). The counselor must believe that the healthy parts of the client are already searching for better ways of being, relating, and creating. It is part of the counselor's task to work collaboratively with the client's inner wisdom. If this vision of the client is present, it will naturally influence and help shape the counselor's words, actions, and body language.

We, as counselors, should be motivated, challenged and encouraged by the research findings acknowledging the central role of the counselor-client relationship in the process of client change (Gelso & Carter, 1985; Greenberg & Pinsoll, 1986; Rogers, 1957). Our training as counselors has been rooted in this therapeutic alliance. There is no need to "re-invent the wheel" when working with clients who abuse substances. Perhaps the words of Yalom captures succinctly this message: "It is the relationship that heals...every therapist observes over and over in clinical work that the encounter itself is healing for the patient..." (Yalom, quoted in Willis, 1994, p.109).

Different People, Different Lives, Different Choices

Our own myopia causes us to ignore the diversity of the clients who come to us. In order to be effective with each client, we must loosen the seemingly exclusive hold that our expectations and stereotypes of people with substance abuse problems have on us. Perhaps one of the greatest challenges is to recognize the variability of readiness for change and client motivation that clients who abuse substances present in counseling.

Client motivation is key in recovery. Among those who work with individuals who abuse substance, motivation has been considered a characteristic attributed to the client (Miller et al. 1995). When a client is "resistant" to the counselor's interventions, the client is considered not to be motivated to change. It is the belief that sufficient motivation is acquired by "hitting bottom". This refers to that point when a person experiences enough "world collapse" to admit to having a problem with alcohol or other substances. Within this paradigm, motivation, as a trait of the client, is either present or not. However, more recently, there has been a shift in this black and white type of thinking which can have a tremendous impact upon counseling individuals with substance abuse problems. This shift is influenced by a variety of research findings. Firstly, we have come to realize that extra-therapeutic events have the greatest single impact upon motivation to change (Miller, Duncan, & Berg, 1995). In other words, substance abuse is not just a pathology of one individual, but a complex pattern involving interactions between the individual, those around him or her and the substance (Miller et al. 1995). In addition, despite the many attempts to identify a personality specific to those who abuse substances, longitudinal studies have proven unsuccessful in this regard (Jones, 1968; Vaillant, 1983). Studies have found that substance abusing individuals are as variable in personality characteristics as non-abusers (Loberg & Miller, 1986). Perhaps even more significant, considering the propaganda to the contrary, denial and other defense mechanisms have been found to be no more or less frequent among those who abuse substances than among the general population (Chess, Neuringer, & Goldstein, 1981; Donovan, Rohsenow, Schau, & O'Leary, 1977; Skinner & Allen, 1983). We can no longer hold on to the conviction that people who abuse substances come into counseling with a consistent set of personality traits and defenses. Studies show that although "motivated' vs. "unmotivated" clients do not have predicable characteristics, the counselors who have more motivated clients do have predictable characteristics themselves (Greenwald & Bartmeier, 1963; Rosenberg & Raynes, 1973).

From the above findings, we can conclude that motivation is the result of an interaction between the individual who abuses the substance and those around him or her. Essentially, motivation is not to be viewed as what one has, but rather as something one does. According to Miller et al. (1995), motivation involves recognizing a problem, searching for a way to change it and committing to, and persevering with that change strategy. Counselors' responsibility is to develop ways to increase this movement toward change.

The emphasis on motivation has resulted in the formalization of a stage theory of motivation (Prochaska & DiClemente, 1982, 1986). Recognizing the stage of readiness for change that a client is experiencing and matching counselor intervention to this stage has been found to be the most beneficial approach for positive outcome. The process of change can be viewed as occurring through five stages: precontemplation, contemplation, determination, action, and maintenance (Miller et al., 1995). In the following section, the five stages of change will be addressed, followed by intervention strategies counselors may use to facilitate and encourage increased motivation for change.

Stage I–Precontemplation: Simply, precontemplation describes the situation in which the person, the client, is not even entertaining the possibility of a problem. It is at this stage of change that we frequently first meet our clients who abuse substances. These clients come to counseling because someone else has sent them. This "other" can be a family member, employer, or the judicial system. The "problem" is experienced more as what other people want from them. Therefore, precontemplators are usually in counseling because they are coerced to come. A way to determine this classification is to inquire of the client if he/she is seriously intending to change the "problem behavior" in the near future, the next six months or so. A typical response of the client to such an inquiry might be, "Yea, I know I've got some problems but drinking is not one of them. As soon as I get out of this dead-end job, things are really going to pick up." Or the client may simply say that he/she does not have a problem, the problem belongs to whomever referred him/her for counseling. This lack of recognition of a problem and the belief that no modification of this behavior is needed are hallmarks of the precontemplation stage.

Stage II–Contemplation: In the contemplation stage, the individual is aware that he/she does have a problem with the use of substances and has given some serious thought to overcoming this problem. However,

there is no commitment to action. They have the insight, but the resolve to change the behavior has not yet been developed. It is not unusual for people to stay stuck at this stage. Prochaska, DiClemente, and Norcross (1992) have captured the essence of this position quite well: "...knowing where you want to go but not quite ready yet" (p.1103).

Many clients at the contemplation stage experience intense ambivalence (Miller & Rollnick, 1991). On the one hand, they want to move toward change, and on the other hand, they feel a desire to continue with the abusive behavior. Their moods may vacillate between defending the benefits of the abusive behavior and committing to changing it. They struggle with indulgence and restraint. It is this ambivalence conflict that makes these clients so vulnerable to the approach used by counselors. Perhaps, the least effective way to work in this situation is by using confrontation and direct persuasion. Counselors using these strategies usually find themselves faced with a "Yes, but..." response on the part of the client. Empathizing with the client's experience of conflict is found to be a more beneficial way of connecting with the client's experience at this time. In addition, it is important to recognize that the use of the substance, be it drugs or alcohol, felt useful to the client. To the client it was in some way necessary or good. (Rothschild, 1995). The counselor should not be afraid to talk about this with the client and to engage in a discussion that addresses both sides of the ambivalence. To truly experience the worldview of the client, the counselor must be willing to see the role that the substance plays in the client's life. The counselor must see this through the client's eyes!

Caroline Knapp (1996) chronicled her struggles with drinking in her book, *Drinking: A love story,* where she describes her relationship with alcohol: "I fell in love and then, because the love was ruining everything I cared about, I had to fall out" (p. xv). Knapp expressed her relationship with alcohol as being "about passion, sensual pleasure, deep pulls, lust, fears, yearning hungers. It's about needs so strong they're crippling." When she contemplated giving up drinking, she said it was "about saying good-bye to something you can't fathom living without" (p. 5). These words express the depth, power, and intensity of the relationship with a substance. We have, no doubt, experienced love relationships that have enveloped us and then let us down. The need to talk about these types of relationships can be all-consuming. It may be that in order to heal, these feelings of incredible attachment, loss, and betrayal must be expressed. These feelings may be at the heart of the ambivalence.

Stage III – Determination: During this stage, the ambivalence seems to shift towards change. Through interaction with the counselor as well as extra-therapeutic events, there seems to be enough evidence in the "need for change" column to influence the client's conviction that change is in order. We hear this sentiment in the client's words "I just can't go on like this anymore. I must do something!" This is truly a window of opportunity (Miller et al., 1995).

This window may present itself early in counseling or after many years of struggling with substance abuse and many tries at counseling. The latter is the case with "Mark" who was a long-term heroin addict involved in yet another relapse. He has been in and out of both the mental health and judicial systems as a result of his use and abuse of heroin. He has always been a mandated client in counseling. He would come to counseling as a prerequisite for either keeping his job or as a condition included in sentencing by the courts. Each time, Mark would be focused on the reasons others wanted him to give up heroin. Although considering the difficulties his substance use caused in his life, he generally minimized them, preferring instead to see other people or situations as being the real causes of his life problems. He consistently terminated counseling after the required sessions were finished, stayed drug free for various short periods of time, one to two years being the longest, and then gradually resumed his use of heroin. However, the last time he was directed to counseling by the courts, he began to become aware of his world collapsing. He had already lost his job and discovered that no one else was willing to hire him. His family had left him. His health had severely deteriorated and he was incarcerated for a third time for drug-related behaviors. Emotionally, he felt at a point of despair. Confronted with so many losses, the scale of his ambivalence tipped, and Mark was ready for a change. He clearly acknowledged to the counselor that his addiction to heroin had truly caused him to be unable to manage his life. He spoke from his heart: " Heroin was my primary relationship; it was my life. And it betrayed me." He expressed his commitment to find a way to change his continually defeating cycle of abuse.

We might consider this determination to change as a kind of epiphany. This was the case with a female client who came to the realization that her substance abuse was holding her hostage. She drank alcohol to escape from the struggles in her life. Then she would drink to escape the painful consequences that her drinking caused. At one point, she felt a prisoner of this destructive cycle. Although uncertain as to what to do, she believed her only alternative was to do something different!

Perhaps Rollo May (1975) captures the essence of this stage of change when he says that "commitment is

healthiest when it is not without doubt but in spite of doubt" (p. 21). The journey of those who abuse substances takes them inexorably into the abyss of darkness and despair. Healing begins when they reach bottom, "let go", and ask for help.

Stage IV–Action: This stage is about doing something different. The client, being presented with a variety of alternative paths to healing, chooses the best fit. The client actively and with intention engages in the process of change. It is the counselor's role to help the client decide on and carry out the plan of action and comply with the strategies for change. What we generally think of as "treatment" comes at this stage (Miller, et al., 1995).

Treatment must be individualized, and the client must have a sense of control over the treatment process. Offering a "menu" of options (see below for a further exploration of treatment options) and discussing the potential consequences of each option, may help to increase the client's commitment to treatment (Miller & Rollnick, 1991). Psychosocial stressors, medical problems, the level of care needed (inpatient, outpatient) and the nature of the abused substance are all considerations in choosing the best approach to treatment.

Goals for change should be negotiated between counselor and client. "Change goals, like the methods to be used to pursue those goals, are better negotiated than prescribed" (Miller et al., 1995, p. 100). Clients present a wide variety of personal goals. A key goal revolves around total abstinence versus controlled drinking. Some clients choose abstinence while others prefer trying to cut down on their drinking before or instead of committing to life-long abstinence. According to research, there is not a strong relationship between clients' prognoses and their beliefs about the necessity of abstinence (Watson, Jacobs, Pucel, Tilleskjor, & Hoodecheck-Schow, 1984). In addition, it is suggested, clients are more highly motivated to change when their own goals regarding abstinence are acknowledge. (Miller, 1987). Miller et al., (1995) believes that an unsuccessful trial at "controlled drinking" can have more of an impact in terms of the need for total abstinence than any type of direct confrontation from the counselor.

Stage V–Maintenance: Maintaining continual motivation to persevere with change can be a tremendous challenge (Marlatt & Gordon, 1985). If deciding to stop abusing substances is difficult, continuing in this conviction can be even harder! Long–term follow- up studies have offered data that suggest that more than 90% of clients will indulge again some time after treatment (Helzer et al., 1985; Polich, Armor, & Braiker, 1981). Stress is frequently associated with relapse among those who are recovering from substance abuse (Hunter & Salmone, 1986; Milkman, Weiner, & Sunderwith, 1984). Those who do relapse experience greater difficulty in coping with unpleasant emotions, frustrating events, and unsatisfactory relationships with others. Counselors, therefore, must help clients learn new coping skills.

If a lapse occurs, the counselor must help the client recover from it as soon as possible. They can reframe relapse as an opportunity for clients to learn about their high-risk situations, and then help clients identify strategies that they can use to prevent relapses in the future. Counselors must help the clients disengage their personal worth from relapsing, thus avoiding the guilt and shame associated with "slips."

Increasing Motivation to Change: Some Intervention Strategies

Clients at the precontemplation and contemplation stages of motivation offer, perhaps, the greatest challenges to the counselor. The counselor is faced with the objective of strengthening these clients' motivation for change. Six elements of effective intervention have emerged as most significant for increasing motivation. Miller and Sanchez (1994) developed an acronym identifying these as FRAMES: Feedback, Responsibility, Advice, Menu, Empathy, and Self-efficacy.

Feedback

Motivation is found to be strongly influenced through the use of feedback directly related to how the individual has been harmed through his/her abusive behavior (Kristenson, Ohlin, Hulten-Voslin, Trell, & Hood, 1983). The objective of the feedback is to create a sense of discrepancy between how the client's life is at the time, and how he/she would like it to be in the future. It must be kept in mind that often the most salient consequences of abuse are positive and thus reinforcing. Feedback, therefore, must focus on those aspects of substance abuse that, although harmful, are experienced by the client with less vividness and remembered less clearly; perhaps, because they are experienced while the individual is intoxicated. For example, nausea and vomiting are experienced when the person has reached a sufficient level of intoxication that distortions in cognition

have developed as well. Feedback must be delivered in a neutral, empathic, nonjudgmental fashion in order to lessen the likelihood of resistance (Hester & Bien, 1995). The research emphasizes that this type of feedback should be "personal", not given through the use of lectures or films depicting the harmfulness of substance abuse on the person. According to Bien et al. (1993), personal feedback of impairment is found to be an element in the most effective minimal interventions. One way to utilize this practice of giving feedback regarding personal impairment is through the use of a structured and objective intake evaluation. This intake would include a measure of alcohol or drug consumption, dependence, family history, and problem severity. The client's scores can be compared to norms from the general population as well as to the scores of those in treatment. Serum chemistry profiles and neuropsychological testing can be used to assess the physical effects of excessive substance use. These are all concrete presentations of the problem and offered to the client, empathetically but directly, by the counselor. These results can also be used as a baseline to reinforce movement away from substance abuse.

Responsibility

We, as counselors, have no control over changing the substance abuse behaviors of our clients. Ultimately, change is entirely up to the individual. It has been found to be highly therapeutic to simply and directly acknowledge this to the client. "Only you can decide to change your behavior. The choice is completely yours. It's entirely up to you how you use this feedback." Research studies conclude that individuals are more likely to engage in action directed towards change and to persevere with that action when they believe they have personally chosen to do so (Kessin, Platz, & Su, 1971; Costello, 1975; Parker, Winstead, & Willi, 1979). It is up to the counselor to communicate the message that the client must be the one to make the choice: "No one can make you stop drinking or using if you do not want to."

Advice

This, too, is a simple, straight forward intervention for increasing motivation. Clear and direct advice regarding the need for change and how to change has been found to be an effective strategy in triggering change in drinking problems (Bein et al., 1993). Giving advice in no way assumes responsibility for change in the client, neither does it necessitate an overly-directive approach. Advice is merely a recommendation to change given in an empathic manner. Some authors suggest to wait until advice is requested and then to preface it with something like, "I am not sure what will work for you" followed by an inquiry of what has and has not worked previously for the client. Additional suggestions can then be offered (Hester & Bien, 1995).

Menu/Alternatives

Offering a variety of options for change supports the client's perception that he/she has a choice. A "one-way-fits-all" approach to treatment denies the client's individuality as well as strengthening the client's resistance. Hester & Bien (1995) suggest that the counselor and client work together in developing the client's goals regarding substance use. Proposing alternatives allows the client to find the best fit. Presenting the client with alternative change strategies not only increases motivation, but it also helps to enhance the client's individual responsibility, sense of self-efficacy and the expectation that once the client is motivated to act, these actions toward change will be maintained. Several alternative approaches to treatment will be discussed in the section, "A Smorgasbord of Treatment Options."

Empathy

Rogers' core conditions are found to be one of the strongest predictors of counselor success with regard to motivating and treating clients who abuse substances. Empathy is one of the most powerful of these ingredients. By definition, an empathic counselor is one who maintains a person-centered approach which involves listening to and reflecting the client's messages and inner experiences. The counselor creates a warm and attentive experience for the client. Higher levels of therapist empathy are related to lower levels of client alcohol consumption (Miller & Taylor, 1980). It is important to note here that "empathy" is not synonymous with identifying with the client. Contrary to popular belief, the effectiveness of counselors is not found to be related to the counselors themselves being "in recovery." In fact, Manohar (1973) has found that being in the early stages of one's own recovery interfered with the counselor demonstrating therapeutic

empathy.

Self-efficacy

Efficacy expectation is the client's belief that he/she can accomplish the necessary course of action in order to obtain desired outcome (Monte, 1980). Clients must have some hope that change can be achieved, and that their actions have an impact on change. They must believe they can change (Rogers & Mewborn, 1976). In addition to clients' beliefs that change can occur, it is essential that counselors believe change is possible. Research suggests that the expectations of the counselor for a positive prognosis are predictive of favorable outcomes among substance abusing clients (Leake & King, 1977). Optimism is key!

A Smorgasbord of Treatment Options

Outcome research has received tremendous incentive from the strength of the accountability movement. Several promising treatment approaches have risen to the top as a result of this efficacy research (Miller et al., 1995). The following is by no means an exhaustive review but attempts to present those options that seem to be associated with more positive outcomes.

Brief Therapies

Among the modalities explored in the research dealing with substance abuse treatment, briefer and more efficient therapies emerge as having one of the largest literature bases and, at this time, one of the most positive. Cummings, Dorken, Pallack and Henke (1990) studied over 16,000 Medicaid patients with drinking problems and found that only six sessions of counseling resulted in a significant impact on the problem. In general, most of the studies indicate that brief therapy should be an intervention of choice, particularly with less severe substance abusing individuals. This may come as a surprise to many as the more popular perception of treating people with substance abuse problems is that it requires an intensive, extensive intervention process. Research over the past 20 years or more has challenged this belief (Sobell & Sobell, 1993). Heather (1995) suggests that brief interventions may be beneficial for "hazardous drinkers." These individuals are not considered "alcoholics" but do drink excessively and have had their lives affected adversely due to their drinking (Moore & Gerstein, 1981). In addition, brief therapy may be appropriate for low to moderate dependence problem drinkers and high dependence problem drinkers who have not benefited from the more conventional type of treatment. In determining the appropriateness of brief intervention, there are several instruments available that can help assess the level of dependence. Among these are: The *Severity of Alcohol Dependence Questionnaire* (SADQ) (Stockwell, Hodgson, Edwards, Taylor, & Rankin, 1979); the *Alcohol Dependence Scale* (ADS) (Skinner & Allen, 1982); the *Edinburg Alcohol Dependence Scale* (EADS) (Chick, 1980); and the *Short-Form Alcohol Dependence Data Questionnaire* (SADD) (Raistrick, Dunbar, & Davidson, 1983).

Within the variety of brief therapy approaches, **solution-focused brief therapy** has been found to be as effective, if not more so, as the traditional intensive, in-patient treatment (Berg & Miller, 1992). The procedures of the solution-focused approach emerged out of the poststructural and social constructivistic tradition. It requires a paradigm shift from the problem-solving approach to solution building (de Shazer, 1991; Berg & Miller, 1992; Berg, 1994). According to Berg (1995), solution-focused treatment can be either a single contact or a series of brief and intermittent contacts throughout the recovery process. The focus is on the individual goals of each client. Rather than treat substance abuse as a unitary problem, the counselor concentrates on each client's perception and experience of substance abuse. Essentially, solution-focused intervention is atheoretical and client-determined. As such, it allows the counselor to "relinquish the role of expert or teacher in favor of the role of student or apprentice" (Berg & Miller, 1992, p.7). Through attending and listening, the counselor learns about the worldview of the client, discovers what the client wants, and speaks the language of the client. Utilizing the client's strengths and wellspring of resources, client and counselor work together to construct solutions to the client's problem. An underlying assumption of solution-focused brief therapy is the belief that any presenting problem, including substance abuse, has exceptions. Problems are more sporadic than constant. There are periods when the problem does not occur. Therefore, the solution-focused counselor pays attention to these exceptions. This attention offers the client and the counselor clues and ideas for constructing a solution to the client's problem (Berg & Miller, 1992).

Broad-Spectrum Skill Training

Another category of intervention that has been correlated with positive outcome is broad-spectrum skill training which focuses on other life problems rather than just the substance abuse (Miller & Hester, 1980). Underlying this approach is the rationale that the substance abuse problem develops as a result of the individual's lack of important coping skills. In addition, there is the belief that once the individual has stopped using the substance, he/she will be faced with a variety of circumstances that will challenge his/her sobriety due to a lack of effective coping skills.

The **Community Reinforcement Approach** (CRA) is a comprehensive broad- spectrum behavioral treatment approach (Smith & Meyers, 1995). The underlying assumption of CRA is that it takes a variety of supports in one's environment to facilitate the recovery from substance abuse. These supports include social, recreational, familial and vocational. There is an emphasis upon motivational techniques and positive reinforcement. Contingency management is a central theme of CRA, emerging from the belief that environment contingencies have an extremely powerful effect on an individual's behavior. The various reinforcers used in CRA (social, recreational, familial, vocational) are made contingent upon an individual's continuing sobriety. Nathan & Niaura (1985) have noted that for contingency contracting to be effective, the uniqueness of each individual must be taken into consideration. What is rewarding or punishing for one individual is not necessarily rewarding or punishing for another. They also believe that contingencies must be mutually agreed upon, carefully observed and consistently implemented. It is also important to involve people and institutions that are significant to the individual.

Research studies on CRA have consistently shown it to be effective in reducing alcohol use and in improving individuals' over-all adjustment (Institute of Medicine, 1990; Miller & Hester, 1986). For a more extensive description of this approach see Meyers and Smith (1995).

Coping/Social Skills Training (CSST), another broad-spectrum approach, offers general coping skills designed to be used in a variety of problem situations. It has evolved from a social cognitive learning theory orientation. Monti, Rohsenow, Colby, and Abrams (1995) report that research strongly supported the efficacy of CSST, and they believe that it should be "an integral part of any state-of-the-art intervention for...alcohol prevention and treatment" (p. 221). The underlying assumption driving this approach is that substance abuse is a habitual, maladaptive way of dealing with difficult and stressful life situations that can be alleviated through the development of social skills. Accordingly, the focus of this training is upon enhancing relationships through interpersonal skill development, learning cognitive-emotional coping in order to regulate moods, learning to deal with stressful life events, and learning how to cope in the face of substance abuse triggers.

Assertiveness skills training and stress management techniques are two specific strategies that appear often in the literature related to broad-spectrum treatments (Morgan, 1996). The primary purpose of assertiveness skills training is to teach individuals how to be more direct and appropriate in expressing thoughts and feelings. Through learning how to be more assertive, individuals have some tools to resist social pressures to use substances. In addition, they are able to assert their needs in various situations and with a variety of people. There seems to be mixed reviews in the literature regarding the effectiveness of assertiveness skills training for the maintenance of sobriety (Ferrell & Galassi, 1981; Miller, Taylor, & West, 1980). What is suggested, however, is that training in assertiveness skills may be more appropriate for those individuals who have a more severe problem with substance abuse.

Stress management has also been a popular treatment strategy for individuals struggling with substance abuse. The rationale underlying the inclusion of stress management techniques is that stress has been found to be a significant component of substance use as well as relapse. Studies related to stress management training have included relaxation training and systematic desensitization. Research studies offer inconsistent support for the effectiveness of stress management techniques (Miller et al., 1995). Relaxation training has been found to have no positive treatment effects on drinking status (Institute of Medicine, 1990). Rosenberg (1979) did find a relationship between relaxation training and reduced alcohol consumption but only among individuals who were assessed as having high anxiety.

Alcoholics Anonymous

Perhaps the most controversial, least understood and least evaluated approach for treating substance abuse is the 12-step model whose prototype is Alcoholics Anonymous (AA) (Morgenstern, Labouvie, McCrady, Kahler,

& Frey, 1997). Developed at a time, 1935, when modern methods of medical therapy, clinical psychology, and professional counseling were nearly non-existent in the field of substance abuse, Alcoholics Anonymous filled a vacuum. In a letter written to Carl Jung in 1961 (cited in the Bill W-Carl Jung Letters, 1987), Bill Wilson, the founder of Alcoholics Anonymous, presents, in abbreviated form, the philosophy upon which Alcoholics Anonymous was built: "...there came a vision of a society of alcoholics, each identifying with and transmitting his (sic) experience to the next – chain-style. If each sufferer were to carry the news of the scientific hopelessness of alcoholism to each new prospect, he (sic) might be able to lay every newcomer wide open to a transforming spiritual experience. This concept proved to be the foundation of such success as Alcoholics Anonymous has since achieved" (p.20). Indeed, it has provided assistance to hundreds of thousands of individuals. For decades after its founding, substance abuse treatment has modeled itself after the same basic philosophy and methodologies as Alcoholics Anonymous (Lemanski, 1997). According to the National Institute of Alcoholism and Alcohol Abuse (1993), approximately one million Americans receive formal treatment for substance abuse each year in 12-step oriented programs (NA, Narcotics Anonymous is a spin-off of AA). Approximately 3.5 million attend Alcoholics Anonymous meetings or similar 12-step self-help groups (Room, 1993).

The prevalence of the Alcoholics Anonymous movement is attested to by the fact that rarely does one come upon a person who does not have familiarity with or an opinion about Alcoholics Anonymous. The media has locked onto Alcoholics Anonymous as the symbol of "recovery" from substance abuse. This is evident in such popular films as "When a Man Loves a Woman" and "Clean and Sober." The "Andy Spiowitz" character in the television series NYPD Blue struggles with his substance abuse and finds recovery in Alcoholics Anonymous which he then "transmits" to another substance abusing character in the series. The population at large has come to view Alcoholics Anonymous, and 12-step treatment, as the primary intervention for someone who abuses substances. AA's supporters believe that the 12- steps and the Alcoholics Anonymous message of powerlessness over alcohol and its accompanying dictum, submission to a higher power, is nothing less than a lifesaving gospel. Critics, on the other hand, are purporting that the 12-steps are outdated, oppressive, and sexist (Judge, 1994).

The professional literature lends itself to ambiguous interpretation when it comes to a precise definition of 12-Step theory, its derivative, 12-step treatment, and outcome (Wallace, 1996; Morgenstern et al., 1997). Much of the writings focusing on the relationship of Alcoholics Anonymous to outcome are anecdotal. Concern is raised by many regarding the dominance of the 12-step model and the ubiquitous practice of recommending Alcoholics Anonymous affiliation as the prime form of aftercare following treatment, as well as the only source of intervention for those who do not seek formal treatment (Emrick, Tonigan, Montgomery, & Little, 1993; Miller & Hester, 1980).

Two types of theories are proposed to explain the underlying effects of Alcoholics Anonymous affiliation on substance use. The first set of theories, emerging from the proponents of Alcoholics Anonymous, argues that the mechanisms used by AA are unique and are focused on resolving basic characterological problems, such as grandiosity and self-centeredness, that maintain the substance abuse (Brown, 1993). Within the framework of these theories, acceptance of powerlessness, belief in substance abuse as a disease, surrender and conversion experiences are keys in the therapeutic processes facilitated by affiliation with Alcoholics Anonymous (Bateson, 1971).

Another group of researchers propose an alternative approach to understanding the mechanism that is working within AA affiliation. They argue that despite apparent theoretical differences between the Alcoholics Anonymous model and other approaches to treatment, there are a number of common change strategies that are transtheoretical but powerful in terms of effecting change (DiClemente, 1993; McCrady, 1994). Through studies conducted over the past 15 years, DiClemente and Prochaska (1982, 1983, 1985, 1986, 1992) have demonstrated that Alcoholics Anonymous focuses on several levels of change which are found to be common factors related to positive change outcome for substance abusers. These various levels of change are reflected in AA's emphasis on maladaptive thinking and beliefs, interpersonal conflicts, and intrapersonal issues of values and character. It is significant to note that this focus demonstrates AA's concern with a larger transformation of the individual rather than simply drinking behavior modification. DiClemente (1993) also suggested that the action orientation of Alcoholics Anonymous, the lack of personal skills training that is provided and the emphasis upon the intervention of a vague higher power that requires individual interpretation, may make the AA path to change for some difficult to follow. He offers the possibility that some of the drop-out rate from Alcoholics Anonymous may reflect mismatches between some Alcoholics Anonymous principles or practices, and the individual with

the substance abuse problem.

There is some research that attempts to explore the question of who are the individuals who partake of what Alcoholics Anonymous has to offer? In other words, what is the relationship between the individual's characteristics and his/her affiliation with Alcoholics Anonymous? The most significant characteristic showing a positive relationship with Alcoholics Anonymous affiliation is related to individuals having a history of using external supports to stop drinking. Also, a modest positive relationship is found between affiliation and being more physically dependent on alcohol (Emrick et al., 1993). Studies attempting to identify personal qualities of individuals who are more likely to affiliate with Alcoholics Anonymous have resulted in only very tentative hypotheses. Consequently, there is a need for additional research in this area. According to McCrady and Irvine (1989) " with increasing interest in matching patients to treatment, it seems that further research to identify the distinguishing characteristics of Alcoholics Anonymous affiliates is important" (p.155).

Summary

"In my end is my beginning."
T.S. Eliot, Four Quartets.

It is apparent that treating people who abuse substances is complex. As the treatment field becomes more professional and is influenced by more and more research, we are developing the awareness that a "one-fits-all" approach to treatment is not effective. We are also learning that there are definitely effective alternatives that recognize the differences among individuals. Although still in its infancy, studies focusing on matching clients with appropriate treatment are becoming increasingly popular (Allen & Kadden, 1995). According to the Institute of Medicine (1990), "There is no single treatment that is effective for all persons with alcohol problems. A number of different treatment methods show promise in particular groups. Reason for optimism in the treatment of substance abuse problems lies in the range of promising alternatives that are available, each of which may be optimal for different types of individuals " (p.147). With the various alternatives that are emerging, counselors are faced, perhaps, with more questions than answers. We, as counselors, must approach our clients with exploring minds, open and compassionate hearts, and a mindfulness of our own struggles. Ultimately, change is not about a particular intervention or treatment model. Change is intimately woven into the fabric of the encounter in which two struggling human beings share the path of discovery and healing.

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Treating Addictive Behaviors

Rationale

The field of substance abuse treatment has for many years been dominated by a one-way-fits-all model of treatment. Although relapse rates are consistently high, treatment seemed unchanging. However, more recently, the accountability movement has resulted in a need to re-evaluate and revamp the way counseling addresses substance abuse problems. The strength of this movement has contributed to an explosion of research into more effective and efficient ways of treating substance abuse problems. The purpose of this chapter is to present the most current and promising research in the field of substance abuse counseling.

Overview

This chapter deals with the research exploring the more effective models for counseling individuals with substance abuse problems. The importance of counselor self-awareness and the creation of the therapeutic alliance are examined. Motivation is seen as a key ingredient in changing problem behaviors. The stages of motivation are explored and strategies for increasing and maintaining motivation are described. Finally, various cognitive and behavioral treatment interventions are identified.

Objectives

1. To understand the importance of counselor self-awareness in the effective counseling of individuals with substance abuse problems.
2. To become aware of the significance and importance of the therapeutic alliance.
3. To be able to identify the components of the therapeutic alliance.
4. To be able to engage in a therapeutic relationship in role-play situations.
5. To understand the stages of motivation and the strategies for increasing and maintaining motivation among those individuals with substance abuse problems.
6. To be able to identify the stages of change that clients are experiencing in role-play and simulated situations.
7. To become familiar with the research on effective treatment models.
8. To gain an overview knowledge of various treatment approaches in the field of substance abuse.

Activities

1. The person who is the counselor is key in the counseling process. Counselors must be aware of their inner worlds, their beliefs, biases, and perceptions, in order to be fully present and effective in the counseling relationship. The following three exercises, moving from the cognitive to the experiential, are designed to facilitate self-challenge and to enhance self-awareness within the student-counselor. Students, individually, should consider what they believe about substance abuse, in general, and the person who abuses the substance, in particular. After this individual contemplation, students should work in dyads, sharing and discussing with each other their beliefs. This is essentially a cognitive process and thus their thinking should be the focus.
2. Students, again individually, must begin to question where their beliefs came from. How did they develop their perceptions regarding substance abuse? They should each ask themselves questions such as "How did I come to believe this"? Students must focus on what is going on inside of them when they consider and speak about their beliefs regarding substance abuse. In order to get in touch with what they are experiencing, it would be helpful for students to close their eyes and take a few, slow breaths, noticing their inhaling and exhaling. This will help to clear their minds a little and even

slow down their thinking. Then, keeping their awareness focused inward, they should ask themselves "What is going on inside of me when I consider what I believe about substance abuse"? The students should be encouraged to just sit with these experiences for a few moments without trying to identify them to themselves. Then, after they have allowed the experience to just "be," they can begin to describe it to themselves. These inner experiences should then be shared in the dyad.

4. The therapeutic alliance creates the environment for healing and growth to occur. Students, working in triads, should role play, one person being the client, another the counselor, and the third person being the observer. The client should present a situation that in some way involves substance use. The counselor's responsibility is to create the therapeutic relationship, communicating to the client a non-judgmental, empathetic interest, encouraging and facilitating the client sharing his or her concerns. After engaging in this process for about 15-20 minutes, the observer should seek feedback from the client and the counselor as well as share his or her observations with the counselor. Each member of the triad should remain mindful of his or her inner experience during the role play and share these with each other. Roles should continually be reversed, until each person has an opportunity to be the counselor and receive feedback.

   Following the role play, the students come together as a group and share their experiences with the whole group.

5. The media has a powerful impact on our perceptions of substance abuse and its treatment. It can contribute to the stereotypes we form as well as offering us opportunities to expand our knowledge. The following activity uses popular films that develop their stories around individuals with substance abuse problems. Some of the films of this genre are "When a Man Loves a Woman," "Clean and Sober," "Less than Zero," and "Days of Wine and Roses." However, other films of this type can be used.

   Although individuals involved in substance abuse may be at varying stages of motivation to change when in counseling, these differences are frequently overlooked or ignored by the counselor. Either during class time or as an out-of-class assignment, the students, considering the stages of motivation, will view the movies "When a Man Loves a Woman" and "Clean and Sober." After viewing the films, they will work in groups of three or four, and will discuss with the main characters in these films, (i.e., the Meg Ryan character in "When a Man Loves a Woman" and the Michael Keaton character in "Clean and Sober," identifying the stages of motivation that each goes through. The students will then discuss how they, should they have been the counselors for these characters, would have used the interventions (FRAMES) to work with them, in order to increase their motivation to change. After discussing this in their small groups, they will return to the larger group and share their ideas.

6. Students will form triads. Using the situations from the films, students will role play a counselor and one of the characters as the client. The counselor will focus on influencing the client's motivation for change through the use of the interventions described in FRAMES. These role plays will last about 15-20 minutes, followed by feedback from the observer and client as well as processing what the experience was like for the counselor. Students will rotate the roles until each one has had the chance to be the counselor and to receive feedback.

7. It is important for students to understand the culture of Alcoholics Anonymous as well as to become aware of the similarities and differences among various AA groups. Students will attend at least one open AA meeting. They will be instructed that they will introduce themselves to the group as students who are learning about AA. During the meeting, they are to stay aware of their inner experiences and record these soon after leaving the meeting. During class, in small groups, they will share what it was like for them during the AA meeting and their reactions to what went on at the meeting. They will then try to identify what they noticed as being key factors within the AA meeting that seem to influence the participant maintaining their commitment to change.

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