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ABSTRACT

This volume of six lessons provides expert information on a variety of issues in substance abuse counseling. The lessons, which may be applied toward continuing education credits, are: (1) "Ethics in Substance Abuse Rehabilitation" (Robert L. Hewes); (2) "Addressing the Needs of Clients with Traumatic Injury and Alcoholism" (Charles H. Bombardier); (3) "Using Critical Thinking To Improve Outcomes in Substance Use Disorder Counseling" (Michael J. Taleff); (4) "Women, Drugs, and AIDS: Implications for Rehabilitation Counselors" (Debra A. Harley); (5) "Substance Abuse Treatment for Pregnant and Parenting Women" (Rivka Greenberg, Judith Fry McComish, and Jennifer Kent-Bryant); and (6) "Rehabilitating Clients with Gambling Addiction" (Brian T. McMahon). Each lesson contains references. (GCP)

Directions in Substance Abuse Counseling

Volume 6

Directions In Substance Abuse Counseling

Volume 6 Lessons 1–6

Table of Contents

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Directions in
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Volume Number: 1 2 3 4 5 6 *(Circle one)*

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Directions in Substance Abuse Counseling
Volume 6 Lesson 1

Ethics in Substance Abuse Rehabilitation

Robert L. Hewes, RhD, CRC

Dr. Hewes is an Assistant Professor of Rehabilitation and Disability Studies, and Coordinator of the Alcohol and Substance Abuse Counseling Graudate Program, Springfield College, Springfield, MA.

Introduction

The abuse of alcohol and other drugs continues to be an overwhelming societal problem affecting the lives of millions. Evidence of this fact can be seen in the numerous alcohol- and other drug-related fatalities, accidents, and domestic disputes reported in the United States each year. In 1995, the total estimated cost of alcohol abuse and dependency in the United States alone was $150 billion.[1] Additional personal costs—such as emotional and psychological problems, loss of life due to suicide and violence, as well as disruption and trauma in the home—continue to strain and impose complexities on the role of the substance abuse rehabilitation professional.[2]

More specifically, within this complex environment, substance abuse counselors must learn to make difficult case management decisions regarding their client's well-being. Many rehabilitation professionals make such decisions when taking into account specific client-related information (e.g., physical, emotional, social, economical, family support, and coping skills). Ultimately, these decisions are ethical. Practitioners are often influenced by their own personal values, beliefs, and attitudes; the values held by their clients; the values of their professional organization or agency; and the general values held by society. This lesson provides a focused discussion aimed at helping the reader recognize and resolve ethical dilemmas, as well as a step-by-step process designed to facilitate ethical decision making in rehabilitation counseling practice. After completing this lesson, the practitioner should be able to:

- Recognize the contextual forces that influence ethical practice by substance abuse professionals
- Explain the roles that personal values, client values, and organizational values play in ethical decision making
- Interpret the Code of Ethics for Rehabilitation Counselors as an important standard for guiding professional behavior

- Understand basic principles of ethical conduct
- Define an ethical dilemma
- Put an ethical decision-making model into practice.

The Changing Practitioner

The field of substance abuse counseling is especially heterogeneous with respect to gender, culture, race, age, sexual orientation, education, and training. As a result, diverse and often conflicting views have impacted professional practice and further complicated already complex ethical issues.[3] The field of substance abuse counseling has a fairly recent inception and professional identity. **Only in the past few decades has a significant portion of substance abuse counselors received advanced graduate degrees and credentials.**[4] Prior to this surge in advanced education, many substance abuse counselors were persons in recovery. In short, the emphasis on advanced degrees has led to a high turnover rate in the profession, resulting in less experienced practitioners. **Additionally, many of these practitioners have limited training in ethics and are often hard pressed to resolve or even recognize ethical dilemmas in practice.** The responsibility for ethical practice does not fall completely on the practitioner, however. In general, the field does not have an absolute ethical framework within which it works consistently.[3] **In the past, ethical dilemmas in the substance abuse counseling field were resolved when the professional codes of practice of other fields, such as psychology or medicine, were considered.** Given the current state of the field and the diversity of its practitioners, this approach appears to be quite limited.

It is also important to realize that counselors perceive ethical dilemmas in the workplace as increasing. **As a result, they often feel overwhelmed early in their careers due to their lack of preparation in ethics, specifically the process of ethical decision making.**[3] **Part of the problem is that practitioners often feel that ethics is a personal issue separate from organizational structure or boundaries. In fact, ethics should be viewed as a personal, professional, and organizational issue.** Organizations in this field have made attempts to support the practitioner's sense of morality and professional behavior through laws, legislation, and the interpretation of societal attitudes without offering much substantive assistance to prepare the individual to recognize the problems and issues in practice.[3] **In addition, because these practitioners come from a variety of training backgrounds** (e.g., social work, rehabilitation counseling, and psychology) **with limited exposure to ethics education, the task of increasing counselor competence in this area is critically important.** One of the first concepts a new practitioner must understand is that of the contextual forces that influence ethical behavior. These forces are often reflected in societal attitudes and organizational policy.

Societal Values That Affect Service Delivery

Ethical behavior is often influenced by the perception of approval by others. That is, an action may appear to be ethical to a novice practitioner if she or he can be assured of majority support. This sort of chain reaction can be seen in the influence of societal attitudes on substance abuse treatment in the United States.

Societal attitudes and responses toward persons with disabilities are often determined by the perceived responsibility for the disability.[5] **For example, a person who is believed to have caused her or his own disability by a voluntary action** (e.g., illicit drug use, driving while intoxicated, or promiscuous sexual activity) **will often receive less compassion than a person who is born with a disability and therefore not responsible for it.** Alcohol dependency is widely considered by society to be a "self-inflicted disadvantage" based more on a lack of willpower than an uncontrollable genetic or environmental force. A society with such a perspective will likely treat persons defined as alcohol dependent adversely[5] and show even less compassion.[6] **In fact, those who are perceived as being responsible for and succumbing to alcohol dependency are viewed less favorably than those perceived as being responsible for and coping with their condition.**[7] This sort of perception can have an impact on a novice practitioner, who may treat those clients who appear to be coping with their condition more favorably.

Society's response to persons with disabilities is not influenced solely by perceptions of responsibility. The extent to which society perceives them as a threat will also dictate its response.[5] For example, the ongoing "war on drugs" is the epitome of perceived threat to personal safety. This phrase, which is now part of the national vernacular, suggests that people who abuse alcohol and drugs are enemies of the American people; as such, they should ultimately be feared and avoided.[8] **Persons who are dependent on alcohol or other drugs also elicit feelings of fear and danger that are associated with economic security.** A clear example of this is seen in neighborhoods in which the fear of a reduction in property values develops with the establishment of local high-risk rehabilitation centers, such as drug treatment facilities.[5] The U.S. media often perpetuate these perceptions of fear through negative and stereotypical images.

Bombarded with these images and an "us-vs.-them" philosophy, society naturally concludes that persons who abuse alcohol and drugs are not worthy of compassion or treatment. Such conclusions ultimately place enormous pressure on treatment providers. For example, although alcohol dependency is defined as a disability by the Americans With Disabilities Act (ADA), it is difficult for a person with alcohol dependency to be entitled to the formal status of having a disability. To be covered, individuals with alcohol dependency must be abstinent from illegal drug use and currently or previously in treatment for alcoholism.[9] This condition of exclusivity denies the much needed entitlement status to those with comorbid alcoholism and drug abuse. Societal attitudes that directly influence public policy[10] directly prevent people with comorbid drug and alcohol abuse from gaining entrance to treatment facilities.

A Shift in Treatment Planning

The field of addiction treatment has expanded greatly over the past 20 years and has even become a profitable industry. **Still, the traditional and well-established approach to substance abuse treatment is based predominantly on the disease model and the 12-step principles of Alcoholics Anonymous.**[11] These models have been adopted almost universally by substance abuse treatment facilities for use as a "one-size-fits-all" treatment approach.[12] Although Alcoholics Anonymous and the disease model of treatment are credited, at least anecdotally, with helping millions of people "recover," no empirical research findings support this claim.[13] Nevertheless, clients often have few alternative treatment methods to choose from.

Not surprisingly, there has been an enormous debate on the effectiveness of inpatient vs outpatient treatment programs and the influence of the length of stay (e.g., 14 vs. 28 days) and the intensity of a program. However, in a review of more than 600 studies, Miller and Hester[13] concluded that the content or focus of treatment is more important than the way in which it is provided (ie, its duration, setting [inpatient vs outpatient], or intensity). Furthermore, researchers have recognized that no one treatment approach is likely to be effective for every client.[13,14] As a result, the focus of the alcohol abuse and dependency treatment field has shifted from overall treatment outcomes to the impact of matching clients with appropriate treatment strategies.[14] This emerging model views alcoholism as a complex disorder that demands a complex treatment approach and effective case management decisions. At a time when managed care programs greatly influence treatment design, the organizational pressure to conform to professional wisdom creates numerous ethical problems for the practitioner who must operate on a one-on-one basis with the client.

Realpolitik:

Without a clear set of ethical standards for practice, counselors may feel pressured to conform or comply with a particular set of beliefs, causes, and treatment modalities for persons with alcoholism and drug addiction.[15] **This professional environment, referred to as *Realpolitik*, may contradict a clearly defined set of standards.** In the substance abuse treatment field, Realpolitik is often characterized by the emotional intensity generated by controversial treatment approaches and beliefs which surround the etiology of alcohol addiction.[15] **Moreover, Realpolitik is demonstrated by the force exerted to preserve ideological conformity in treatment modality and etiology.** The professional resistance surrounding controversial treat-

ment approaches, such as controlled drinking strategies, is well documented.[15-17] Counselors often feel anxious and apprehensive when considering such treatment options due to the pressure to conform. Haskell[15] describes this phenomenon as an authoritarian group process that pressures professionals to conform to the disease concept of addiction. In addition, Miller suggests that ". . . there is immense sociopolitical pressure in the U.S. addictions treatment field to endorse an abstinence-only approach."[16] Ultimately, this influence may result in a decreased menu of treatment options available to the client.

Clearly articulated ethics and values can improve and guide professional conduct. **A clear set of standards and an ethical framework may help practitioners clarify case management decisions and increase the counselor's competence in serving the client.** Because professionals must deal with such pressures and make effective case management decisions, an ethical decision-making model is warranted.

Broadening Our View of Ethics

Understanding ethics requires a broad view. One must look at the micro- as well as the macro-contextual forces. In short, ethics should be embraced as a systemic issue, one that transcends the counselor–client relationship to address societal and public policy implications, as well.[3,18] **Too often the counselor views ethics as an individual issue based on a personal morality.** In effect, the counselor ignores the contextual forces that influence his or her professional behavior and instead perceives ethical dilemmas as personal issues that are to be resolved on the basis of the individual practitioner's own sense of morality and personal ethics. Understanding the dilemma of subjective variety, many agencies and organizations have adopted codes of professional practice to help guide professional behavior in a complex environment.

Code of Ethics:

The Commission on Rehabilitation Counselor Certification (CRCC) was developed in 1973, in part as a response to the consumer rights movements in the 1950s through the early 1970s. The CRCC first published the Professional Code of Ethics in 1987.[19] **The primary purpose of this code is threefold:** (1) **to protect the health and safety of the client by providing professionals with acceptable standards of quality in such areas as education, training, work experience, and knowledge of the field;** (2) **to provide guidance for professional behavior and practice by outlining canons and rules that specify proper conduct and behavior for the rehabilitation professional; and** (3) **to protect and promote the professional identity and integrity of the profession.** The 10 canons in the Code of Ethics cover moral and legal standards, counselor–client relationships, client advocacy, professional relationships, public statement/fees, confidentiality, assessment, research activities, competence, and CRC credentials. Each canon has several rules that delineate standards of professional conduct. Ultimately, each rule is supported by an ethical principle that is outlined in the following section.

Ethical Principles:

In order to recognize and ultimately resolve an ethical dilemma, a practitioner should be familiar with the ethical principles that serve as the foundation for the professional Code of Ethics. While ethical standards are not identical for all professions, most codes of professional ethics share basic principles.[20] The following five ethical principles have been emphasized extensively in the fields of medical ethics,[21] psychology,[20] and rehabilitation counseling.[22,23]

Autonomy

***Autonomy* refers to independence, freedom and the capacity for self-governance.[20]** The focus of ethical conduct for rehabilitation counselors is to allow the client to have an autonomous voice in his or her treatment. **The counselor should allow the client to make decisions voluntarily and without coercion after all treatment information has been provided. A counselor adheres to the principle of autonomy by respecting a client's right to make choices based on personal values and beliefs. The counselor does not impose his or her will on the client, because "autonomous actions should not be subjected to controlling constraints of others."[21]** An example of autonomy is provided in R2.1 in the Professional Code of Ethics for Rehabilitation Counselors: "Rehabilitation counselors will make clear to the clients, the pur-

poses, goals, and limitations that may affect the counseling relationship."

Beneficence

The ethical principle of beneficence emphasizes an obligation to promote the client's welfare (i.e., the counselor acts for the benefit of others). **Beneficent actions involve the promotion of good and the removal of conditions that will cause harm to others.**[20] Acting in a beneficent manner is considered a professional obligation and should be the primary intent of rehabilitation counselors. The difficulty with beneficent action often concerns the maintenance of a balance between the degree of aid the counselor should provide and the degree of aid the client requests. **Overall, practitioners are charged to place their clients' interests above their own according to the following three conditions:** (1) **the special knowledge, training, and education of the counselor or rehabilitation professional;** (2) **the power and control the counselor has to provide or withhold benefits or resources; and** (3) **societal expectations that the profession will promote the overall well-being of its clients.**[21] An example of beneficence is provided by R3.5 in the Code of Ethics: "Rehabilitation counselors will remain aware of the actions taken by cooperating agencies on behalf of their clients and will act as advocates of clients to ensure effective service delivery."[20]

Nonmaleficence

The first rule of health care is "Do No Harm." Similarly, the principle of nonmaleficence requires the professional to act in manner that either causes no harm to a client or prevents a harmful situation. Nonmaleficence may be achieved by refraining from or avoiding harmful actions or situations, as opposed to beneficence, which is more action-oriented in that it promotes well-being.[22] An example of nonmaleficence is provided by R4.7 in the Code of Ethics: "Rehabilitation counselors will function within the limits of their defined role, training, and technical competency and will accept only those positions for which they are professionally qualified."[19]

Justice

The principle of justice requires practitioners to treat clients fairly. According to Beauchamp and Childress,[21] however, "scarcity and competition make [distributive] justice a troublesome ethical problem." The philosopher John Rawls describes justice in terms of fairness and fundamental rights;[21] most health care professionals, especially rehabilitation counselors, hold the principle of justice to be the fair allocation of monies, resources, and time.[24] **Six criteria are often applied in distributive justice decisions: equal shares** (e.g., each client would receive an equal portion of available resources); **need** (e.g., clients who take an active role in their treatment plan often receive continued services); **motivation and effort** (e.g., veterans are often afforded additional services due to their contribution to society); **contribution** (e.g., clients with an underserved disadvantage often receive additional benefits and services); **free-market exchange** (e.g., private sector rehabilitation); **and fair opportunity** (e.g., clients with an underserved disadvantage often receive additional benefits and services). An example of justice is provided in R5.1 of the Code of Ethics: "Rehabilitation counselors will consider carefully the value of their services and the ability of clients to meet the financial burden in establishing reasonable fees for professional services."[19]

Fidelity

Similar to beneficence, fidelity focuses on loyalty and honesty in professional relationships between the rehabilitation counselor and clients, colleagues, organizations, and agencies. This ethical principle requires practitioners to faithfully keep all promises and commitments, both stated and implied, that they have made to others. Protecting client information and refraining from sharing or divulging private information about the client (i.e., confidentiality) are clear examples of the ethical principle of fidelity. Another definition of fidelity is provided by R6.9 in the Code of Ethics: "Rehabilitation counselors will provide employers with only job-relevant information about clients and will secure the permission of clients or their legal guardians for release of any information which might be considered confidential."[19]

Despite the establishment of ethical conduct standards, ethical dilemmas will be encountered by the professional. Often the rules of professional conduct will be the source of conflict. For example, a counselor may

want to support the wish of a particular client to transfer from a local community college to a private college in order to enroll in a special program in hotel management. Following the ethical principle of autonomy, the counselor should incorporate the client's desire into the treatment plan. However, the counselor's agency may not be able to take on the burden of the higher tuition charged by the private college. According to the principle of justice, the counselor must be fair in the distribution of resources to all clients. Thus, the client's request presents the counselor with an ethical dilemma.

Increasing Counselor Competence

It is often difficult for the less experienced counselor to recognize and define an ethical dilemma. For example, a counselor who works with persons who are incarcerated may be offered a gift by an inmate or a client's family. Although it is clearly stated in the counselor's professional code of conduct that employees should not be the recipients of gifts, the counselor may be torn between accepting the gift or refusing it and thus, straining the counselor-client relationship. However, there should be no ethical dilemma: the code of conduct clearly indicates what action should be taken. Still, the gift offer places the counselor in an awkward position.

This example offers a working definition of an ethical dilemma. An ethical dilemma exists when two or more ethical principles or values come into conflict and suggest opposing courses of action. While each course of action can be supported by an ethical principle, one course of action compromises the ethical principles that support the course of action not chosen.[23] Again, this definition demands that counselors understand the foundation of a code of ethics (i.e., the ethical principles) so that they will be able to recognize and resolve ethical dilemmas.

Once an ethical dilemma is recognized, the application of an ethical decision-making model to case management is beneficial; such a model can help the professional critically analyze a case and mitigate any pressure experienced by the counselor. Millard and Rubin[25] offer the following six-step ethical decision-making model:

- Review the case situation and determine the two courses of action from which one must choose.
- List the facts that support each course of action.
- Given the reasons for supporting each course of action, identify the ethical principles that support each action.
- List the fact-based reasons for not supporting each course of action.
- Given the reasons for not supporting each course of action, identify the ethical principles that would be compromised if each action were taken.
- Formulate a justification for the superiority of one of the two courses of action by processing all information from the previous five steps.

Application of the Ethical Decision-Making Model:

Case Study

Ms. A, a 25-year-old woman, is mandated to treatment after her second arrest for driving while under the influence of alcohol (DUI) in 6 years.

The referring agency operates within the disease concept of alcoholism and strongly encourages Ms. A to adopt an abstinence-only treatment goal. Ms. A has no prior history of drug use or alcohol-related problems other than driving while intoxicated. Her first DUI occurred during her senior year in high school, and the current offense occurred after a company holiday party. On each occasion, the client's breath alcohol content (BAC) was between .10 and .13, and the client claimed that she made a conscious effort to stop drinking a few hours before driving home on each occurrence.

Ms. A is the daughter of two alcoholics and recognizes the danger in her use of alcohol, and she has been active in Adult Children of Alcoholics (ACOA) meetings at her church for more than 3 years. She is employed, single, and heavily involved in her local church. Ms. A admits to having used poor judgment. She feels that she does not have a drinking problem and that an abstinence-only treatment goal is both unrealistic and unnecessary. Instead, she would like to adopt a treatment goal that does not involve total abstinence.

Case Study Analysis

Consider the following application of the ethical decision-making model to the case of Ms. A:

1 Review the case situation and determine the two courses of action from which one must choose.

Course of Action A—Support the client's wish to adopt a different treatment goal.

Course of Action B—Mandate the treatment goal of abstinence.

2 List the fact-based reasons for supporting each course of action.

Course of Action A

- Client may continue in treatment.
- Respect the client's desired treatment goal.
- Client is relatively young and presents limited history of alcohol-related problems.
- Incidents involving alcohol appear to be contextually related (eg, senior year in high school, holiday parties).

Course of Action B

- Client may experience additional repercussions from continued alcohol use.
- Adhere to agency treatment philosophy.
- Client presents problematic behavior, as indicated by the legal consequences of her alcohol use.
- Client is a child of two alcoholics and, thus, presents an increased disposition to developing a substance abuse problem.

3 Given the reasons supporting each course of action, identify the ethical principles that support each action.

Course of Action A: Autonomy

Course of Action B: Beneficence

4 List the fact-based reasons for not supporting each course of action.

Course of Action A

- Counselor may experience difficulties at work for going against agency philosophy.
- Client may experience additional repercussions from continued alcohol use.

Course of Action B

- Respect the client's right to choose a treatment goal.
- Client may leave treatment.

5 Given the reasons for not supporting each course of action, identify the ethical principles that would be compromised if each action were taken.

Course of Action A: Beneficence

Course of Action B: Autonomy

6 Formulate a justification for the superiority of one of the two courses of action by processing all information from the previous five steps.

The ethical principles involved in the case of Ms. A are autonomy and beneficence. First, the client's choice of treatment is restricted based on beneficent actions. In other words, the agency/counselor may feel that the client is denying the existence of a problem, which coincides with the agency's definition of alcoholism within the disease model. Accordingly, the counselor may not be willing to respect the client's wish for an alternative treatment goal because he or she wants to promote the client's well-being. From the agency's point of view, a treatment goal of abstinence is more likely to protect the client from future alcohol-related incidents than one that allows any consumption of alcohol. Second, in adhering to the philosophy of the agency, the counselor may feel pressured to conform to agency practice and advocate the abstinence treatment goal, thereby restricting the services provided. The client, however, should be allowed to adopt an alternate treatment goal. This decision is based on the fact that the agency/counselor should respect the client's autonomy in the decision-making process. Additional reasons for this course of action include the following: (1) the client is relatively young and has no alcohol- or drug-related incidents other than multiple DUI convictions; (2) the client presented "responsible" drinking behaviors (e.g., she stopped drinking hours before driving); (3) the client appears to be an active member of her community and has a stable support system; and (4) the client stated that abstinence was unrealistic and unnecessary, and if it were forced on her, she might become noncompliant or discontinue treatment.

Therefore, Course of Action A (i.e., therapy that includes behavioral modification strategies) should be chosen for this client.

Conclusion

The case presented here only begins to touch on the numerous potential ethical dilemmas that substance abuse professionals may encounter in practice. For example, issues of justice or the allocation of resources and services may conflict with the counselor's attempt to respect the client's autonomy. In addition, issues of dual relationships, mandatory drug testing, the counselor in relapse, and confidentiality (to name just a few) may arise. As White has stated, "Ethical issues fester in the silence of denial until they detonate into humiliating exposés of our personal and institutional shortcomings."[3]

The substance abuse treatment field is rapidly changing. Treatment facilities are attempting to individualize therapy to meet the needs of a diverse clientele by increasing the menu of treatment options, while more and more counselors are entering the field with less mentoring and limited training in ethics. Ethical practitioners are aware of the contextual forces in the profession that influence their ethical practices. They realize that their own personal values may prejudice service delivery. They have mastered the professional Code of Ethics and are aware of the role that the five ethical principles play in case management decision making. Most importantly, the ethical practitioner has developed the ability to recognize ethical dilemmas and formulate ethically appropriate solutions. Ultimately, the use of an ethical decision-making model can reduce the anxiety and trepidation induced by ethical complexity in rehabilitation counseling and improve counselor competence.

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

1. **According to this lesson, which one the following statements is *not* correct?**

A. Ethics is often viewed as personal and based on each practitioner's sense of morality.

B. The substance abuse profession appears to be changing rapidly to include a diverse group of practitioners who originate from a variety of academic disciplines.

C. Ethical dilemmas in practice do not appear to be increasing, yet more practitioners are demanding ethics training for liability reasons.

D. Ethical principles are the foundation of any code of professional conduct.

2. **According to the author, societal values that can affect service delivery in substance abuse counseling include all of the following, *except*:**

A. The perception of responsibility for acquiring the substance abuse problem.

B. The degree of independence and productivity in the workforce.

C. Whether the person is coping with or succumbing to the condition.

D. The perception of a threat that substance abusers impose on society.

3. **According to the author, problems in substance abuse counseling due to "Realpolitik" include all of the following, *except*:**

A. The pressure to conform to beliefs of etiology and treatment modalities.

B. A contradiction in a clearly defined set of standards.

C. Feelings of anxiety and apprehension when considering confrontational treatment options.

D. An increase in treatment options.

4. **Which of the following statements is *not* correct?**

A. Professional codes of conduct serve to guide professional behavior and protect clients.

B. Most codes of professional ethics share the same basic principles.

C. Allowing a client to have a voice in his or her treatment is an example of the ethical principle of autonomy.

D. Counselors should adhere to their own personal ethical code when faced with an ethical dilemma in practice.

Directions in Substance Abuse Counseling
Volume 6 Lesson 2

Addressing the Needs of Clients With Traumatic Injury and Alcoholism

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Introduction

Alcohol is arguably the most used and abused drug in the United States. While most people manage to use alcohol safely without incurring significant harm, 1 in 10 American adults has significant problems related to their use of alcohol.[1] This lesson will show that alcohol use and abuse are of particular concern among people with acquired disabilities and that rehabilitation professionals should, therefore, become more knowledgeable about these issues. Rates of preinjury alcohol problems are particularly high among persons with traumatic injuries, including traumatic brain injury (TBI)[2] and spinal cord injury (SCI).[3] Therefore, TBI and SCI will be used as examples of disabling conditions in which alcohol-related problems play a significant role. The links between alcohol problems and these two forms of acquired disability will be described in terms of the prevalence and effects on outcome. The lesson will describe the major ways alcohol problems are conceptualized and how common beliefs about alcoholism may interfere with potential interventions. Practical strategies for screening and intervening in alcohol-related problems will be discussed. The lesson will show that rehabilitation professionals are in a good position to identify and provide brief interventions for clients with alcohol-related problems.

The Prevalence of Alcohol Problems Among Persons With TBI and SCI

Corrigan[2] reviewed the literature on alcohol and TBI and found that the prevalence of pre-injury alcohol abuse or dependence ranged from 16%–66%. The most rigorous studies and those conducted in rehabilitation settings produced the highest prevalence rates, between 44% and 66%. Persons with SCI also report greater than average preinjury alcohol consumption, and 35%–49% report a history of significant alcohol problems.[4]

Another indication of alcohol-related problems among people with TBI or SCI is alcohol intoxication (blood alcohol level greater than 100 mg/dL) at the time of injury. Among patients with TBI, Corrigan[2] found that rates of alcohol intoxication ranged from 36% to 51% among the seven studies he reviewed. Alcohol intoxication rates for SCI reported in the literature are 40%[5] and 36%.[6]

Longitudinal surveys of alcohol use and alcohol problems among persons with TBI and SCI show that drinking declines during the months immediately following injury, followed by increased drinking during the first and second years after injury.[5,7] Drinking problems after injury typically represent a continuation of preinjury problems, though there appears to be a small percentage of persons with TBI and SCI who develop alcohol problems for the first time following their injury.[8,9] Cross-sectional data suggest that alcohol consumption after TBI and SCI may be somewhat higher than in the general population.[10,11] However, rates of alcohol abuse may be particularly high among selected groups such as vocational rehabilitation patients,[12] those in post-acute rehabilitation programs,[13] and among veterans with SCI.[14]

Taken together, these studies provide considerable support for the idea that a history of alcohol problems is common among people who sustain an SCI or TBI. **Rates of lifetime alcohol abuse or dependence approach 50% while current dependence at the time of injury is nearly 25%, or 3 to 6 times higher than in the general population.** Males are at higher risk than females. Drinking declines soon after injury, but increases over time, probably as the person resumes greater independence. There is little known about who resumes drinking, why, or when. People in post-acute and vocational rehabilitation settings may have especially high rates of alcohol abuse, possibly because alcohol problems interfere with achievement of community integration goals and necessitate additional psychosocial services.

The Effect of Alcohol-Related Factors on Outcome

A preinjury pattern of chronic alcohol abuse or dependence is predictive of numerous negative outcomes after TBI and SCI. Preinjury alcohol abuse is associated with increased risk of mortality and more severe brain lesions.[2] **Patients with a history of alcohol abuse demonstrate poorer neuropsychological test performance one month and one year post injury.**[15] Those with a history of alcohol problems are at higher risk for emotional and behavioral problems, are less likely to successfully integrate back into the community, and are at higher risk for recurrent TBI.[2] Since many of these studies were not able to completely control for potential confounding factors, the precise role alcohol plays in poorer outcomes merits further study.[15] Persons with SCI who had premorbid alcohol problems were found to spend less time in productive activities such as rehabilitation therapies[16] and have higher rates of suicide.[17]

Studies of the effects of alcohol intoxication on neurological outcomes provide mixed results. Some studies have shown that alcohol intoxication at the time of TBI is associated with poorer short-term outcomes such as longer length of coma, a longer period of agitation,[2] and greater cognitive impairment one to two months post injury.[18] Other studies of persons with TBI have found no relationship between blood alcohol level and neurological outcome.[19] These conflicting data may derive from the fact that, on a physiological level, alcohol may have both neuroprotective and neurotoxic effects following acute TBI.[20] On the other hand, both animal[21] and human studies[6] suggest that alcohol intoxication may be associated with more severe SCI.

It is widely suspected that even moderate alcohol consumption after TBI may dampen neurological recovery and magnify cognitive impairments.[13] Yet there is surprisingly little empirical research in this area. Clearly, alcoholism can cause cognitive impairment, including permanent brain damage.[22] Cognitive

impairment also can develop in heavy "social drinkers" and the effects are roughly dose-dependent.[23] There is speculation that, by interfering with the reestablishment of dendritic connections among surviving neurons, alcohol may inhibit neurological recovery.[2] The only study of brain functioning influenced by drinking after TBI found that event-related potentials are more impaired among persons with TBI who also abused alcohol compared with persons who only had a TBI or only abused alcohol.[24] Additional support for the idea that TBI magnifies the acute neurocognitive effects of alcohol comes from self-reports of increased sensitivity to alcohol[25] and the finding that alcohol intoxication and TBI produce similar neuropsychological impairments.[26]

Regarding persons with SCI, Krause[27] speculates that return to drinking may interfere with health maintenance behaviors secondary to impaired judgment, coordination, and memory. Curiously, people with preinjury alcohol problems who abstained from alcohol after injury have been found to have increased risk for developing pressure sores.[28]

The relevant literature suggests that alcohol intoxication at the time of injury is most likely to affect early indicators of cognitive function, but that with time and physical recovery the influence of intoxication on cognitive functioning diminishes. The effect of preinjury alcohol abuse on post-injury outcomes is the most well established finding. However, even this relationship remains controversial due to the potential confounding effects of numerous variables, including education level and preinjury socioeconomic status as well as post-injury drinking. Extremely little is known about the harm associated with alcohol use or abuse that occurs after TBI or SCI. The limited data, however, suggest that drinking may interfere with recovery and increase risk of reinjury.[29]

Historical Perspective on Alcoholism

Alcoholism can be conceptualized in categorical terms as a disease, or as a continuum of alcohol-related problems. The prevailing disease model is represented by the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV)[30] definition of alcohol dependence. The disease model views alcoholics as qualitatively different from normal persons. That is, persons with alcoholism are thought to have a medical or psychological defect resulting in behaviors such as excessive consumption. **Disease-model alcoholism is believed to be progressive and can only be put in remission through abstinence.** Nonalcoholics are assumed to have no such defect and to experience no adverse consequences from alcohol.

Contemporary theory and research on alcoholism are moving away from the strict disease model toward a continuum model, which holds that alcohol-related problems occur along a spectrum of severity.[1] The movement away from conceptualizing alcoholism categorically as a disease follows an historical pattern similar to that of other medical conditions:

> The historical record also suggests that treatment for any problem tends to originate as a result of attention being drawn to severe cases. Initially, treatment consists of applying to these cases the existing remedies that are available when the problem is first recognized. As time passes, however, it becomes increasingly clear that (a) cases other than severe cases exist and (b) other methods can be used to deal with them . . . Thus, it is not surprising to find the same progression in the treatment of persons with alcohol problems.[31] (pg. 59, italics added).

The Institute of Medicine (IOM) report, "Broadening the Base of Treatment for Alcohol Problems,"[31] was an important milestone in progress away from a strict disease model. The IOM report explicitly adopted the terminology "alcohol problems" to look at the issue from a broad public health perspective. The IOM report emphasizes that prototypical alcoholics represent a minority of Americans with alcohol problems. A large proportion of Americans consumes hazardous amounts of alcohol and incurs significant harm from alcohol use without meeting criteria for alcohol dependence. It is estimated that persons with less severe alcohol problems outnumber people with severe alcoholism by a ratio of 4:1.[32] The DSM-IV also recognizes gradations of alcoholism other than dependence through the diagnosis of alcohol abuse.[30] The modal "alcoholic" whom rehabilitation professionals will encounter is someone with mild-to-moderate problems with alcohol.

Second, the IOM model emphasizes that there are no clear boundaries between normal use and abuse

of alcohol or between alcohol abuse and dependence. Consumption and problems seem to exist along a continuum. Therefore, it makes little sense to create the false dichotomy the word disease tends to imply. Third, rather than a universal downward course, consumption and the degree of alcohol-related problems vary significantly over the lifetime of the average person with alcoholism.[33] Moreover, the majority of changes that occur in drinking patterns and problems are probably not attributable to treatment.[34]

Common Assumptions Associated With the Disease Model

In addition to these broad conceptual differences, there are other assumptions attributed to the disease model that deserve examination. These common assumptions appear to conflict with the contemporary literature on addictive behaviors and potentially interfere with innovations in clinical care.

First, there is the belief that clients must acknowledge that they have an alcohol problem before any intervention can begin. Research suggests that requiring a client to admit that he or she is an alcoholic is not only unnecessary for therapeutic change, but may actually generate resistance.[35] In contrast, a nonjudgmental attitude on the part of the therapist and avoiding labels are thought to facilitate greater motivation to change and more valid self-report.[35]

Next, there is the belief that not wanting professional help is a sign of "denial." Yet most people with addictive behaviors or other psychological problems do not seek professional help.[36] Our research has shown that, while most people with TBI or SCI and alcohol problems do not want treatment, most do want to change their use of alcohol.[4,37] The term "denial" unnecessarily pathologizes and blames the client for a condition that most people seem to have, minimizing their problems and preferring to change on their own.

Two corollary beliefs are that denial is a personality trait of alcoholics and that denial must be confronted. Numerous studies have failed to find differences between alcoholics and nonalcoholics on measures of denial.[35] Rather, denial has been shown to be an interpersonal phenomenon.[38] **Therapist behaviors seem to influence denial more than client personality traits. A consistent finding in the literature is that therapist confrontation increases client resistive behaviors, while empathic listening decreases resistance.**[35] Confrontational therapist behaviors are also associated with negative outcomes in the longer term. Higher levels of confrontational therapist behaviors predicted greater alcohol consumption among clients one year after treatment.[38]

Another widely held belief is that specialized treatment is always necessary to address alcohol problems. Instead, the research literature suggests there are many routes to recovery and that only a little help may go a long way among persons with milder alcohol problems. For example, a review of at least 44 controlled studies showed that brief interventions of one to three sessions produced significant change and were often as effective as more intensive treatment.[39] In fact, there is more evidence for the efficacy of brief interventions than any other substance abuse treatment modality.[40] People with mild alcohol problems also may benefit significantly from following a self-help guide.[41] Studies of persons with alcoholism show that the majority of those who recovered (77%) did so on their own, without treatment, professional help, or even Alcoholics Anonymous.[34]

Finally, there is the belief that lifetime abstinence is the only acceptable goal. There is little question that lifetime abstinence is the best option for many persons with alcohol problems. However, there are also good reasons to support moderate drinking when this is the person's clear preference. Having clients set their own treatment goals is thought to be more therapeutic than prescribing goals; requiring a commitment to abstinence at the outset may unnecessarily exclude individuals who could make other meaningful changes in their drinking.[42] Many clients who initially refuse abstinence will reconsider it after a trial of moderate drinking fails.[43]

In summary, common assumptions associated with the disease model may not be applicable to all persons with alcohol problems. The picture that emerges from the recent research literature is one in which alcohol-related problems are more treatable and have more in common with other psychological disor-

ders. In fact, one way to improve how we address alcohol-related problems is to provide less intensive interventions to more people, and to do so in the context of the rehabilitation setting. The following section describes efficient ways to identify rehabilitation clients with alcohol problems and promote positive change in their drinking habits.

Screening for Alcohol Problems

A number of authors have argued that universal alcoholism screening is needed to address the underlying cause of nearly half of the traumatic injuries in the United States.[44] Systematic screening forms the foundation for any effective intervention. Without universal screening, alcohol problems are under-recognized and may undermine the rehabilitation process.[45] Screening can be conducted with little investment of time by clinical or nonclinical staff. However, federal law requires special protection for information related to alcohol and drug abuse and these data should not be released without appropriate informed consent.[46]

Some clinicians may be reluctant to institute alcohol screening and assessment procedures because they are doubtful that the results will be valid. Yet, reviews of the literature have concluded that persons with alcohol problems generally provide reliable and valid reports if proper measures and procedures are used.[47] To maximize the validity of self-reports, interviews should be conducted in clinical settings when the subject is alcohol free and given reassurances of confidentiality. Alcohol screening measures should be imbedded within the context of a larger battery of health-related assessments and emphasis should be placed on alcohol use as one of several behavioral risk factors that might have an impact on health or rehabilitation outcomes. Adjunctive biomedical data such as blood alcohol levels or liver function tests can enhance validity, partly as a "bogus pipeline." Any alcohol-related assessments should be conducted in a nonjudgmental fashion, avoiding terms such as "alcoholism" or similar labels.

There are a number of brief screening measures that have been found to be reliable and valid indicators of significant alcohol-related problems. One valid tool for identifying people with alcohol dependence is the CAGE questionnaire.[48] **The CAGE acronym stands for four questions:** Have you ever felt you should **Cut** down on your drinking? Have you ever felt **Annoyed** by someone criticizing your drinking? Have you ever felt bad or **Guilty** about your drinking? Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**Eye opener**)? Each affirmative response is scored one and a total score of two or greater is considered clinically significant. The CAGE has been used extensively in medical settings and requires less than one minute to administer. The CAGE has documented internal consistency and criterion-related validity with sensitivity and specificity ranging from 60%–95% and 40%–95%, respectively.[47] Simple questions about typical of quantity and frequency of alcohol use can complement the CAGE to distinguish people with current abuse or dependence from those who are in remission.

Another recommended measure is the Alcohol Use Disorders Identification Test (AUDIT). **The AUDIT was developed by the World Health Organization to promote early identification of problem drinking in primary care medical settings.**[49] The AUDIT consists of ten items: three questions on alcohol consumption, four questions on alcohol-related life problems, and three questions on alcohol dependence symptoms. A cut-off score of eight is recommended.[49] The AUDIT requires two minutes to administer and approximately 1 minute to score. Reported sensitivities have typically been above 90% with specificity in the 80%–90% range.[49]

Advice and Brief Interventions

Once persons with alcohol problems are identified, what can rehabilitation professionals reasonably do to influence drinking? In the previous sections it was emphasized that while for some people alcoholism is a chronic progressive condition requiring specialized treatment, for others, probably the majority of problem drinkers, change is possible. **Moreover, the research literature suggests that there is considerable hope that nonspecialists may have a significant impact on drinking behavior through advice, brief interventions, or by facilitating referrals to substance abuse specialists. Therefore, this last section contains strategies that counselors from a variety of backgrounds can learn to use with little time investment.**

These strategies will not help every person, but if used systematically, will likely help a substantial proportion of persons with alcohol problems.

Advice:

Giving at-risk clients brief advice to abstain or reduce drinking is possible for any rehabilitation professional who works with these client populations. **Numerous controlled studies in medical settings have shown that brief physician advice results in significant, lasting decreases in drinking.**[47] **For example, a recent study showed that two 10–15 minute interactions with a primary care physician resulted in a 40% reduction in alcohol consumption among problem drinkers who were measured one year after treatment.**[50] Advice may be more effective when it is combined with self-help materials or personalized feedback and information about the adverse health effects of alcohol.[47] Several self-help guides are available,[51,52] including one written specifically for persons with TBI[53] An excellent resource for giving advice has been developed for primary care physicians and can be obtained from the National Institute on Alcohol Abuse and Alcoholism (http//silk.nih.gov/silk/niaaa1/publication/physician.htm).

Effective advice begins with broaching the subject of alcohol and screening for excessive alcohol consumption and alcohol-related problems as described above. The next step is to convey concern based on what is considered sensible or normal drinking. For example, "You are reporting drinking that is more than normal social drinking. Normal social drinking for men is considered to be no more than 2 drinks per day or a maximum of 14 drinks per week (for women, 1 and 7 drinks, respectively)." Inform the client of the health risks associated with drinking that exceeds this amount, such as increased probability of liver disease, cardiovascular disease such as stroke, cognitive impairment, pancreatic disease, and accidental injuries. Clearly recommend a menu of change options: "I recommend to all my clients who drink more than normal that they either abstain, cut down, or seek treatment." For clients who report symptoms of dependence such as tolerance, compulsion to drink, inability to stop, or drinking to avoid withdrawal, you may want to recommend only abstinence or treatment. Decide on a plan and monitor progress. Ask the client if he or she is ready to make any of these changes. If the client is ready, formulate a concrete plan of action. Attempt to make any treatment referrals before the client leaves. Agree to monitor progress on this issue along with any other plans being made. If the client is not ready, ask if he or she would be willing to seek more information, for example by seeing a specialist for a more detailed assessment of drinking.

Table 1

EFFECTIVE INGREDIENTS OF BRIEF INTERVENTIONS (FRAMES)

Feedback
- Structured assessment of the personal costs and benefits of changing or not changing
- Ask about the "good things" then the "less good things"

Responsibility
- "It's up to you, no one can change for you"
- Implicitly empowers the client

Advice
- Ask permission to give advice
- Suggest some behavior change

Menu
- Giving clients choice enhances commitment
- Offer alternative goals (e.g., stop, cut down, or no change)
- Offer alternative strategies (e.g., treatment, AA, self-change)

Empathy
- Clarify and amplify the client's experience
- Avoid imposing your own views

Self-efficacy
- Reinforce hope and optimism about the client's ability to change
- Reframe past failures as successive approximations of the goal

(adapted from Miller and Rollnick, 1991)[35]

Brief Interventions:

Brief interventions are for the clinician who has more time and interest in promoting change in alcohol use. Brief interventions have been used in a variety of settings, both as a stand-alone treatment and a means of enhancing the effects of subsequent treatment[54] Brief interventions typically last anywhere from one to four sessions. **The most widely known model of brief interventions is motivational interviewing.[35] Motivational interviewing relies heavily on Rogerian principles of empathic listening, unconditional positive regard and belief in the inherent power of persons to change.[35]** The therapist primarily uses open-ended questions followed by various forms of reflective listening and summaries designed to elicit reasons to change from the client. While the therapist avoids confronting the client, the goal of therapy is for the client to realize, on his or her own, that excessive drinking and associated problems are not consistent with their core values and aspirations. Detailed training manuals[35,55] and workshops (see www.motivational-interviewing.org) are available for clinicians to learn motivational interviewing. Motivational interviewing strategies have been adapted to use with a wide range of clients in a number of different settings[35,56] including persons with brain injury.[57] The Ohio Valley Center for Brain Injury Prevention and Rehabilitation (www.ohiovalley.org) has published education and training materials specifically for persons who want to use motivational interviewing strategies to help clients with TBI. A recent randomized controlled study conducted with hospitalized trauma patients showed that a single motivational interviewing session resulted in almost a 50% reduction in drinking and a 50% reduction in readmissions for trauma one year after initial treatment.[58]

The effective elements of brief interventions have been summarized by the acronym FRAMES (See Table 1).[39] **These key elements are *Feedback, Responsibility, Advice, Menu of options, Empathy and Self-efficacy.*** Typically, based on results of an assessment, the client is provided with personally relevant feedback that includes the impairment or risks associated with past and future drinking. The therapist emphasizes the client's personal responsibility for change, provides clear advice to make a change in drinking, and gives a menu of alternative strategies for changing problem drinking. This information is provided with empathy and understanding, not confrontation, to reinforce the client's hope, self-efficacy, or optimism.

Motivational interviewing dovetails with recent research on client stages of change. The transtheoretical stages of change model is an empirically based model that characterizes motivation to change as a spiral continuum from precontemplation (not considering change), through contemplation (ambivalent about

Table 2
TRANSTHEORETICAL STAGES OF CHANGE

Precontemplation
- Unaware or underaware of problems and not considering change
- More surprised than defensive

Contemplation
- Some awareness of problem
- Ambivalent, weigh pros/cons of change

Determination
- Thoughts and feelings reflect readiness, but do not guarantee actions will be made
- Action likely to be made within a few months

Action
- Does something to initiate change
- First behavioral signs of change

Maintenance
- Actions to sustain change are needed
- May require strategies that are different from initiation of change

Relapse
- Avoid imposing your own views
- Resumption of problem behavior is normal, but may trigger demoralization
- Preparing for relapse is helpful

(adapted from Prochaska, DiClemente & Norcross, 1992)[36]

change), determination (getting ready for change), action (making behavioral changes), and maintenance (see Table 2).[36] The model postulates that client stage of change can help predict outcomes and that matching therapist strategies to the client's stage of change can improve outcomes (see Table 3).

For example, the therapeutic goal for precontemplators is to raise their awareness, not challenge them to change. The motivational interviewing therapist is trained to use open-ended questions, reflective listening, and affirmations in response to resistance; to provide personally relevant information; and to subtly raise doubts in the client's mind about whether he or she is truly satisfied with the current pattern of alcohol use. Research suggests that moving a client from precontemplation into contemplation increases by 50% the chance of changing behavior over the next year.[36]

The therapist helps contemplators resolve ambivalence by exploring the pros and cons of their alcohol use, eliciting reasons for change, and highlighting discrepancies between life goals and the consequences of drinking. The therapist avoids taking sides, but rather helps these individuals weigh reasons for changing against reasons for not changing. On the other hand, when patients are in the action phase, the motivational interviewing therapist activity can be directed at consolidating reasons for change, selecting among various change strategies, devising a detailed change plan, and building on the patient's prior change attempts. For persons in the maintenance phase, interventions can focus on helping prevent or minimize the effects of relapse.

Table 3
SELECTED STAGE-BASED THERAPEUTIC STRATEGIES

Precontemplators

- Give feedback in matter-of-fact manner
- Reflect, even exaggerate resistive statements
- Emphasize the client's personal responsibility and freedom of choice
- Clarify the consequences of the client's behavior in a nonjudgmental manner
- Avoid argumentation; when you begin to argue, change strategies or discontinue
- When resistance is generated, cut losses and revisit the issues at another time

Contemplators

- Elicit the client's primary incentives for change
- Have the client reflect on the good things and less good things about his or her behavior
- Don't take sides; instead, reflect
- Give advice tentatively, e.g., ask for the client's permission first
- Give menu of options, have the client choose from possible goals and strategies
- Emphasize the client's responsibility and freedom
- Boost self-efficacy (e.g., by reframing past failures as successive approximations)

(adapted from Miller Rollnick, 1992)[55]

Facilitating Referrals

In many cases the rehabilitation professional may decide to focus on simply referring at-risk persons to outside specialists, whether it is for formal treatment, further evaluation, or perhaps to attend Alcoholics Anonymous meetings. However, convincing clients to follow through with a referral is no easy endeavor. Traditionally, adherence to referrals has been quite poor, around 10%–14% in some studies.[47] Fortunately, a science is developing around how to improve adherence to referrals.[47] To improve referrals, counselors can use many of the same strategies described under giving advice and brief interventions. The overarching goal is to collaborate with the client as an equal partner in the process of exploring options and making decisions.

To begin with, the counselor can summarize the potential risks (e.g. health, recovery, rehabilitation funding) that may be associated with ongoing at-risk drinking. Feedback should be conveyed in a supportive, nonjudgmental manner, avoiding using terms such as "alcoholic" or "alcoholism." Adopt the neutrality of a consultant by stating that (e.g., "The data suggest . . ." or "People with your pattern of results typically . . .") Next, check with the client regarding understanding and opinions about the feedback. Attempt to

find common ground and agreement before considering advice. Questions such as "What concerns you most about these data?" can help identify key reasons for change. Ask for permission before offering advice and reemphasize the client's freedom of choice (e.g., "No one can make you change or do it for you.). Whatever you do is up to you." Normalize ambivalence and uncertainty. Offer the client more than one option and include not changing as one possible choice. Have prepared concrete ways of responding to common choices, such as the phone numbers of intake workers in some local treatment programs (see SAMHSA web page treatment center locator; www.samhsa.gov), booklets on the place and time of local AA, Rational Recovery, or Moderation Management meetings, web addresses of alcohol self-help groups (e.g., www.moderation.org), and handouts on how to try to change drinking on one's own (see NIAAA web page www.niaaa.nih.gov). If possible, help clients take action, for example by making phone calls to establish direct contact with referral sources and set up appointments. Helping people seek help is not "enabling." If the client chooses no change or if resistance increases around trying to make a referral, reflect their ambivalence, demonstrate respect for the choice of doing nothing for now, and ask for permission to bring up the subject at a later date. Some clients respond to the idea of self-monitoring their drinking for a while and perhaps defining what they think is a "safe" drinking range that they should not exceed. Subsequently, if they exceed this level the counselor has an opportunity to revisit the question of whether any other change is indicated.

In referring clients for specialized substance abuse treatment, the question arises, "What treatments or treatment programs are best for people with disabilities?" Unfortunately, the demand for substance abuse treatment in the United States far exceeds the supply. Moreover, there is frequently little reliable information available on a given treatment program and less on the ability of programs effectively to serve people with disabilities. Initially, referrals may need to be made almost without guidance. Later, the counselor will get feedback from clients about which programs are most effective and accommodating.

Many believe that AA is not effective for persons with TBI.[13] However, it can be difficult to find treatment programs in the community that offer something else,[59] and AA, used in conjunction with professional counseling, does seem to be effective.[60] **Whenever clients are interested in using AA, it seems prudent to encourage this type of self-help in conjunction with professional counseling.** To this end, the National Head Injury Foundation[13] rewrote the 12 steps in more concrete terms and produced a model educational letter to introduce AA sponsors to the special issues among persons with alcoholism and TBI.[13]

Since many programs rely heavily on group-based psychoeducational treatment, some thought should be given to the question of whether the client has the cognitive capabilities to learn in that environment. It may be useful to adopt an advocacy role and help the client request specific accommodations such as less group-based treatment, more individual counseling, written information to reinforce key points, and help clarifying some of the more abstract concepts.

Case Example:

The alcohol screen (AUDIT) was imbedded into a larger battery of tests. Emphasize client's control and responsibility at the outset. *The italicized type is a sample of counselor notations.*

> ***The alcohol screen (AUDIT) was imbedded into a larger battery of tests. Emphasize client's control and responsibility at the outset.***
>
> **Counselor:** So, Mr. Smith—thanks for completing the questionnaires I gave you last week. I want to talk with you about the results over the next couple of times we meet. (Discuss one or more other topics first) . . . Next, I want to give you feedback from your answers to the questions about alcohol. As I told you before, it is my job to give you feedback about your answers. It is your job to decide if you have any concerns or want to make changes. I won't tell you what to do.
>
> **Client:** Yeah, I thought you were going to bring this up—what does this have to do with getting back to work, anyway?

The client is pretty defensive, probably in precontemplation, I'd better go slow and "roll with resistance." The most I could do today is to have him entertain the idea alcohol may be harming him. I can use reflection that exaggerates his point a little.

Counselor: So it really doesn't make any sense to talk about alcohol when you are here to get back to work.

Client: Well, if I were an alcoholic it would make sense, but I'm no alcoholic.

The client is concerned about labels; I'd better validate his concerns.

Counselor: You are saying that if you had big problems with alcohol it would make sense to discuss it, but not unless there were major problems.

Client: Right.

Side with the client's impression that he has no problems and focus on the data.

Counselor: So this might go pretty quickly. If you don't have any concerns about your drinking after we review your answers, we can just move on.

Client: Okay.

Counselor: Let's look at your answers then. . .

Focus on the positive, on the absence of pathology, to build trust and minimize the likelihood that the client's prediction that you will blame and label him.

Counselor: On the first measure, you reported you drink only about 2–3 times per week, clearly not every day, or not even most days.

Client: Right . . . mostly weekends, Friday and Saturday nights.

Counselor: It also looks like you never have trouble stopping drinking and are actually very responsible about your alcohol use. I mean that you have never failed to do what was expected of you because of your drinking.

Client: Right, I am a darned good worker. My drinking has never stopped me from putting in a good day's work. I show up even when I am feeling pretty rough from the night before.

Pass up the inclination to point out that the client admitted getting drunk. Summarize all the good points.

Counselor: So you drink only a few times per week, you can stop when you want to, you never drink in the morning, and alcohol has never gotten in the way of doing a good job at work. Does that seem about right to you?

Client: Yeah.

Giving additional feedback

Counselor: Now you said that when you do drink you have about 5–6 drinks.

Client: Right

Counselor: That would mean you typically have somewhere between 10–18 drinks per week, a bit more than 50% of American males who consume about 4 drinks per week or less. How does that fit with your impression?

Client: All right, I guess.

Counselor: You also said that at some point someone was concerned about your drinking or suggested you stop or cut down.

Client: Oh, that doctor who took care of me after the car crash said he didn't want me to drink, but I tried drinking again after a while and it didn't seem to hurt anything.

Counselor: So nothing disastrous has happened. What was your doctor concerned about, anyway?

Client: Something to do with my head injury, I guess.

I'd better reflect back the client's unconcern and

find out what he knows before giving information.

Counselor: It sounds like you are not really that concerned about how alcohol use could affect your brain injury recovery. Tell me what you know about how alcohol can affect your recovery.

Client: Nothing, I guess—I just thought something really bad would happen and it never did.

Ask permission before giving information.

Counselor: Remember, I am not going to tell you what to do, but do you want any information about how alcohol can affect recovery from brain injury?

Client: Sure, I guess . . .

(see Appendix 1 for information on alcohol and brain injury) Explain in matter-of-fact terms. Use impersonal language such as "Research suggests that brain injury recovery can continue for more than two years and that people can improve their chances of maximal recovery by abstaining from alcohol . . ."

Counselor: What do you think about what I said?

Client: I didn't know alcohol could hurt my recovery. But I feel fine and still haven't had anything bad happen.

End with a balanced summary. Don't ask, "What do you want to do?" This assumes that the client wants to make some sort of behavioral change. Reflect, reflect, and summarize. Reemphasize the client's control and tie back to his key values.

Counselor: So, on one hand, you can control your drinking and you have not noticed anything terrible happening as a result of drinking since your brain injury. On the other hand, you drink a bit more than average, still have potential for more brain injury recovery, and you acknowledge the possibility that drinking could affect recovery. It's really up to you to decide if drinking is important enough to risk having less recovery. That comes down to a person's values. No one can make that decision for you . . . Where does this leave you?

Client: I'm not sure.

End the discussion before the client feels pressured to change now and gets defensive. He's at least contemplating the possibility his drinking may not be 100% safe. Reinforce any positive expressions of concern he has made.

Counselor: Well, you have been very open-minded today, listening to feedback and information. You seem content with your drinking now, with no real reasons to change. Should we move on to another subject and talk about this more the next time we meet?

Client: Okay.

Conclusion

One way to provide better alcohol-related services for persons with disabilities is by improving access to effective treatment. Rehabilitation professionals can promote access to treatment by bringing empirically based alcohol screening and brief interventions into the medical, vocational, rehabilitation and independent living settings in which people with disabilities are usually seen. Rehabilitation professionals can take several practical and relatively brief steps to promote better outcomes in the area of substance abuse. We can raise awareness of the issue by advocating for universal screening for alcohol problems in our rehabilitation programs. We can become more familiar with current thinking in the area of addictive behavior and help dispel myths among our colleagues regarding these problems. We can learn brief counseling techniques designed to facilitate self-change or improve the probability of successful referral into treatment. By taking these steps we can help make treatment of substance abuse problems a routine part of comprehensive rehabilitation services.

Appendix I
ALCOHOL AFTER TRAUMATIC BRAIN INJURY

Alcohol and brain injury recovery

- Recovery from brain injury continues for at least 1–2 years after injury.
- Alcohol seems to slow or stop brain injury recovery, possibly by interfering with neurons making new connections with each other.
- Not drinking is one way to give the brain the best chance to heal.

Alcohol, brain injury, and seizures

- Traumatic brain injury puts survivors at risk for developing seizures (epilepsy).
- Alcohol lowers the seizure threshold and may trigger seizures.
- Not drinking can reduce the risk of developing post-traumatic seizures.

Alcohol and the risk of having another brain injury

- After one brain injury, survivors are at higher risk (3 to 8 times higher) of having another brain injury.
- Drinking alcohol puts survivors at even higher risk for having a second brain injury.
- Not drinking can reduce the risk of having another brain injury.

Alcohol and mental functioning

- Alcohol and brain injury have similar effects on memory, mental speed, balance and thinking.
- Alcohol seems to magnify the negative effects of brain injury.
- Alcohol may affect brain injury survivors more than it did before the injury.
- The negative mental effects of alcohol can last from days to weeks after drinking stops.
- Not drinking is one way to maximize your mental abilities.

Alcohol and sex

- Alcohol reduces testosterone production in males.
- Alcohol reduces sexual desire in men and women.
- Alcohol reduces sexual performance in men (erection and ejaculation).
- Alcohol reduces sexual satisfaction in men and women.
- Abstinence from alcohol improves sexual ability and sexual activity in men and women.

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

5. The rate of lifetime alcohol abuse or independence among persons with TBI or SCI is about:

A. 10%

B. 25%

C. 50%

D. 75%

6. In order to reduce clients denial and resistance about their alcohol problems, the counselor should:

A. Confront the client with the facts of their drinking problems

B. Use empathic listening

C. Advise the client to attend AA

D. Work on having the client accept that they are an alcoholic

7. Which of the following is an acronym for an alcohol screening measure?

A. FRAMES

B. DRINK

C. AUDIT

D. SMASHED

8. All of the following statements about advice and brief interventions are correct, *except*:

A. They are never as effective as longer forms of treatment

B. People who are not alcohoism specialists can learn to use them

C. They can influence drinking one year after the intervention

D. They can be tailored to the client's stage of change

Directions in Substance Abuse Counseling
Volume 6 Lesson 3

Using Critical Thinking to Improve Outcomes in Substance Use Disorder Counseling

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Introduction

One of the most overlooked aspects of substance use disorder (SUD) counselor training is critical thinking. According to the literature, counselors give little attention to their reasoning processes, including those used to evaluate the scientific basis and validity of information they use in practice.[1,2] Many workshops and college courses focus on the emotional state of the counselor, but little, if any, time is spent on the art of thinking critically.

This subject does not appear to be well represented in the literature, either. When a colleague and I made an informal survey of 25 recently published academic books on topics relevant to SUDs counseling, we failed to find one that addresses the issues of learning and reasoning. In fact, none of these books even mentioned the phrase, "critical thinking." When a multi-billion dollar business, such as that which is generated by SUDs, fails to examine the process of idea development, it subjects SUD practitioners to a poor public perception of our accountability and competence.

The subject of critical thinking is important because (1) **good clinical decision making requires solid reasoning skills,**[3] **and** (2) **the quality of SUD counselor decisions and critical reasoning skills correlate well with the quality of treatment that clients receive.**[2] Improvement in the thinking processes of the counselor will result in

improved outcomes for clients. Such improvements reduce the risk of counselor-induced resistance to therapy, because they cause the counselor to replace critical and dogmatic postures with the invigorating results of critical thinking.[2,4] Thus, the SUD counselor has everything to gain by becoming a critical thinker and need only sacrifice a few dead-end thought patterns to do so. This lesson will provide the reader with some of the foundations of critical thinking, describe specific fallacies or heuristics, identify levels of critical thinking, and present questions that are designed to foster the practice of critical thinking. It is intended to guide SUD counselors toward developing more introspective thinking habits by helping them identify and correct any current faulty thinking habits and demonstrating how these improvements will enhance the quality of assessment, counseling, and evaluation of clients. By the end of the lesson, practitioners should be able to:

- **Identify key elements of critical thinking.**
- **Identify elements of noncritical thinking that they use in their daily practice.**
- **Begin a process of correcting their own noncritical thinking processes to improve services to their clients.**

Critical Thinking in a Nutshell

Although no clear definition of **critical thinking** could be identified in the literature, it may be considered a **purposeful way for the counselor to explore all of his or her assumptions regarding each client and to review alternative was of meeting the client's needs in an objective and earnest fashion.** Such an exploration can be carried out without bias toward any particular outcome.[5]

The process of critical thinking is described in several articles. Cogan[6] defines critical thinking as "*. . . the reliable, reasoned determination of whether to believe, disbelieve or suspend judgment about the truth of any statement*" (p. iii). Paul defines critical thinking as disciplined, self-directed, and designed to help the thinker master numerous intellectual skills and abilities.[7] Thus, critical thinking is, essentially, the task of thinking about thinking, with the purpose of developing better, clearer, and more accurate and defensible ideas.

Moore and Parker define critical thinking as "*. . . the careful, deliberate determination of whether we should accept, reject, or suspend judgment about a claim —and of the degree of confidence with which we accept or reject it.*"[7 (p. 4)] A claim is a statement that is either true or false. Claims are generally true, and as anyone who has read the literature of the field of alcohol/drug rehabilitation can attest, SUD counselors do make a lot of claims. Many authors are quick to point out that there are no easy ways to help anyone accept a claim. Evaluating a claim requires many skills, including the ability to listen and/or read the claim very carefully, to judge the value of arguments that are made about the claim, to find covert agendas, and to determine the consequences of the claim.[9] **Many SUD workers accept certain claims concerning the nature of addiction at face value. For example, some practitioners accept the claim that anyone with an addiction has a character flaw called denial. Although this claim is heard far and wide, it lacks supportive evidence.[4,10] Still, many counselors make this assumption without first considering the effects of their assumption on the counseling process.** Such assumptions can influence the counselor to select certain counseling strategies over others and appear to be obstinate and resistant to the client. Thus, noncritical thinking can bias both the assessment and intervention segments of a therapeutic encounter. In turn, this can lead to very poor counseling outcomes.

Properties of Critical Thinking

Several authors have suggested that **critical thinking requires characteristics such as humility, honesty, objectivity, integrity, perseverance, and self-discipline.[2,7]** For example, critical thinkers generally present their ideas in a humble manner. They do not suggest that they have found the truth about any counseling strategies, let alone the dynamics of addiction. These thinkers tend to be courteous, if not modest, in the tone of their writing and in their personal presentations. **They also have a great deal of integrity: their presentations are honest and sound. They persevere in seeking the best possible answers to difficult and**

thorny questions by spending a great deal of time doing research to find information that will strengthen an argument or bring evidence against it. Some of these individuals are tenacious in their pursuit of an intriguing idea, not letting go until they have processed that idea to its fullest so that they and their trusted colleagues are satisfied that they have reached a firm conclusion. Lastly, they are disciplined in their professional lives. Rather than being stilted or rigid in their approach to their work, they usually have broad, workable plans to complete their projects and examine new materials and research findings.[11] This does not make them perfect, but they are usually not known to be procrastinators.

Critical thinkers who work in the SUD field can identify specific elements in their thought processes, including the purpose of their thinking, the precision with which questions must be designed to answer such purposeful questions, the method of interpreting the answers they obtain (within the counselor's own point of view), **and the method of evaluating of the relevance of the data they obtain** (i.e., the selection and use of appropriate computational procedures to clarify an issue).[11] Thus, counselors who think critically can tell if their perception of a client's problems is based on a disease-based, analytic, cognitive, or solution-focused model. They can also closely examine the relevant facts and figures they will use to shed light on an issue. Lastly, they are aware of the conclusions and assumptions they are making and the implications and consequences of those conclusions.

Unfortunately, many SUD practitioners cannot do this, (i.e., distinguish a client's problem within a larger context). Many are not even aware of such issues. Thus, they are not mindful of the assumptions they make about treatment and find themselves blindly coming to certain conclusions (e.g., that everyone who presents for SUD treatment is in denial to some degree). This can have serious consequences for their clients.

Critical thinkers constantly assess their strengths and weaknesses to improve their skills. They usually do not "rest on their laurels" or rely solely on their past experiences. Such habits tend to lead to stagnation, making them unreceptive to fresh ideas and new approaches to their clients. Self-assessing SUD professionals are aware of their limitations, as well as their abilities. These self-assessors are usually never satisfied with mediocrity; they want to be the best at what they do. Behind this drive to improve are the best interests of their clients.

There is a balance that permeates the critical thinker's whole system of thinking. Such thinkers are courageous and fair in their manner of thought. They do not shy away from injustice, whether it involves the SUD field in general or a poorly proposed theoretic conclusion about addiction. Perhaps their greatest trait is their sensitivity to the many ways in which thinking can become distorted, prejudiced, and otherwise made defective. This ability allows them to develop well-reasoned responses to and explanations of very difficult arguments that exists in the SUD field.

Critical thinkers are able to consider all aspects of an argument; thus, they are courageous and fair in their manner of thinking. Perhaps their best trait is their sensitivity to the many ways in which the thought processes of the most well-intentioned individuals can be distorted, resulting in misleading, prejudiced, and otherwise defective conclusions. Critical thinking allows the individual to develop well-reasoned responses to complex questions.

Thinking Errors—A Sampling of Heuristics

Unfortunately, critical thinking carries with it a host of mind-traps, including heuristics, into which the SUD counselor can fall.

Heuristics are short-cuts or errors in thinking.[12] They are favored assumptions, and everyone uses them. They are based on inexact rules for resolving problems. Thus, heuristics lead to systematic errors in reasoning and, thus, biases in thought. Interestingly, individuals who use heuristics often are not the ones who are perplexed by problems. Rather, they feel that they know exactly how to respond to bewildering problems. By simply dipping into their supply of heuristics to find a response, they feel that their conclusions are right and above question.[12]

People resort to heuristics for several reasons. **One reason lies in the human propensity to economize—to save time and effort in the way we think.** Such economizing may have overtones of self-protection

(i.e., it suggests that we want everything to depend on a central variable);[13] this would make it easier for us to understand the world and feel reassured that things are under control. Without such mental economy, we would have to wade through intimidating and complex sets of data, (including the data contained in SUD literature.[13] To avoid such unpleasantness, and to retain a sense of control, we resort to heuristics.

The subject of heuristics is illustrated further by the observation that many SUD treatment regimens have become automatic, habitual, and routine and are based on essentially the same basic philosophies and strategies. Suggestions of other forms of treatment are often met with doubt, if not scorn, possibly due to a reliance on heuristics. In other words, the counselors believe that they already have the right therapeutic formula, and that the effectiveness of the treatments already in use is indisputable.

Shermer indicated other reasons for adhering to fallacious beliefs. For one thing, they are comforting and consoling.[14] Moreover, they provide immediate gratification and are simple to use. This is in contrast to the amount of labor that is required to process information thoroughly by means of complex thinking.

As we have seen, it is natural for the mind to reduce complex ideas into simple ones or to subsume new ideas within the familiar and the old. It is not natural to want to constantly rethink the systems, routines, and habits that have been formed over the years. The task of rethinking old routines and habits is often considered threatening,[7] and when people feel threatened by views that are different from their own, they tend to rely more on heuristics to support the conclusions that are already in place.

This concept can be personalized by examining some of your own ideas and how you came to accept them. Take a minute to write down a prized concept or two that you hold about yourself or a SUD-related topic. It can be anything from what you attribute the causes of addiction to, how effective a counselor you consider yourself to be, your concept of the biopsychosocial model, or how well you believe you can accurately assess new clients. Review your concept(s) as you proceed through the next section, which covers common heuristics, and try to determine whether your prized concept is built upon any errors in thinking.

Common Heuristics:

The following heuristics—which are derived primarily from the works of Capaldi,[15] Sutherland,[16] Schnick and Vaughn,[17] Gilovich,[18] and Conway and Munson[19]—are a few of the dozens that you may encounter every day as a SUD professional. **They are divided into roughly three groups, based on** (1) **reasoning fallacies,** (2) **fallacies intended to maintain a claim, and** (3) **fallacies intended to defend a claim.** It is not necessary to memorize this list, but it could be beneficial to refer to it once in a while.

Reasoning Fallacies

Hasty generalizations—Drawing a conclusion before you have sufficient facts. ("So you drank a six-pack of beer 4 months ago at a ball game. You've got to be an alcoholic.")

Availability error—The tendency to judge something or someone by the first thing that comes to mind (e.g., coming from a codependency workshop and tagging the first client you see following the workshop as being codependent.)

Saint/Devil effect—Overgeneralizing the personality of someone on the basis of a salient (good or bad) characteristic. (e.g., in describing an SUD job seeker, an inpatient SUD interviewer says, "This interviewee doesn't attend self-help groups, and she smokes. I won't hire her despite her academic credentials.")

Ad populum—Appealing to popular attitudes. ("Everybody I know believes that AA is the most successful form of intervention, so it must be true.")

Making the wrong connection—Wrongly attributing the effectiveness of treatment to certain underlying philosophies and methods. ("You have to be tough with characters like them. That is the only way they get sober.")

Mistaking the cause—Making an error in assigning one of a number of possible causes to the most striking or available characteristic. ("He is angry and obviously depressed.")

Misinterpreting evidence—Lacking a core knowledge of statistics and trusting the results of studies that are based on small and biased samples. ("I don't understand those research journals, so I never read them, but I know they support my therapeutic approach.")

Ad ingnantiam—Making an appeal to ignorance. For example, if something cannot be proven, it is assumed to be true. ("Scientists cannot disprove the disease model, so it has to be true.")

After-the-fact reasoning—Coming to what is considered a true conclusion after an event has taken place. ("I always thought she was a drug addict.")

Ad hominem—Attacking the character of someone who is arguing against you instead of the content of his or her counterargument. (If you can discredit the person, you believe that you discredit the argument.)

Either/or ploy—Dichotomizing an argument in such a way that if you discredit one position, you feel forced to accept another (generally the one put forth by the purveyor of the "either/or" ploy).

Beg the question—Giving the answer to your question in your question. ("I know an alcoholic when I see one, and you're one. Aren't you?")

False dilemma—Presuming that only two alternatives exist when there are actually more than two. ("Either you are an alcoholic or you're not.")

Pooh-pooh—Dismissing a claim by ridiculing it. ("Who would believe those 'repressed memory' people? That is the silliest thing I've every heard.")

Straw man—Misrepresenting an argument so you can criticize it more easily. ("All that book-learning only gives people a head full of useless information. What you need to survive in this field is personal experience.")

Red herring—Drawing attention away from the issue at hand. ("Yes, there are flaws in the traditional American disease model, but it's proved itself and it is better than anything else we have in the field, so I'm sticking with it.")

Oversimplification—Presenting a complicated situation by using simple assertions, to the point of introducing serious inaccuracies. ("The cause of all addiction is repressed anger.")

Fallacies Intended to Maintain a Claim

Obedience—The tendency to comply with little explanation for doing so. ("My program director believes we should do things this way, and I agree.")

Conformity—Acquiescing to the opinion of others because of peer pressure, cultural norms, or out of habit. (See Obedience.)

Belonging to a group—As a group thinks, so will its members. ("Every staff member believes the client is in denial, so he must be.")

Misplaced consistency—Striving to maintain consistency despite having facts that suggest a lack of consistency. ("I don't care what the research says. I'm sticking with the 12-step model.")

Believing that a bold statement is a true claim—Emotions, no matter how strong, cannot serve as evidence. ("I believe with all my heart and soul that the only way to get sober is by doing it the way I did.")

Coincidence—Figuring out how to take credit for success when another equally valid reason for it can be determined. (A SUD counselor says, "Yeah, I was instrumental in his recovery," when in reality, the client's return to a very supportive family environment and his acquisition of a job is just as likely to have contributed as much if not more to his success.)

Representativeness—Remembering one's successes and forgetting the failures.

Emotive words or false analogies—Using strong feeling words or analogies to win support for

your ideas and theories. ("If you don't stop drinking, you are going to die!")

Overreliance on authorities—Constantly using an authoritative base of information rather than an empirical one. ("I never look at journals. I just read the Big Book of Alcoholics Anonymous.)

Fallacies Intended to Defend a Claim

Ignoring the evidence—The tendency to neglect information that can be valuable to a case or contrary to a certain theory. ("So what if the Alcohol Screening Index doesn't say she is an alcoholic? I say she is!")

Distorting the evidence—Making up explanations to account for the behavior of others. ("I've seen lots of cases like this, and they are all related to repressed memories.")

Equating anecdotes with science—Thinking that the story of a single individual is equivalent to evidence that is applicable to all. It isn't. ("Denial is like an impenetrable barrier or wall.")

Overconfidence—Believing we make better judgments than we actually do.

Human intuition—Assuming our "gut feelings" are accurate *because they are gut feelings* when, in fact, they are not.

This list will hopefully help you identify your own fallacies or any of those to which you will be exposed.

The list can also be useful within the therapeutic setting. Clients often have a propensity to use a variety of these heuristics, which could support a state of dysfunction. **If you are going to use elements of critical thinking in the counseling session, first it is important to develop a rapport with the client. Next, do an assessment of the mind-traps which the client has a tendency to use repeatedly. If the rapport is solid, you can then begin to point out to the client that what feels natural for them in terms of thinking may actually be harming them. If the client can begin to see these mental errors, perhaps he/she would be willing to try some thinking alternatives.** Take, for example, the case of Robert S.

Case Vignette:

> **Bob has all the indications of someone who is showing signs of problem drinking. He has been fired from several jobs due to his drinking, and has been arrested twice for driving under the influence of alcohol. He was mandated to counseling and the therapist has noted that Bob has the habit of equating anecdotes with science. He is often heard to say, "My friend has been drinking as long as I have, and he holds a job and doesn't get into trouble." Bob thinks the dynamics of his friend are equivalent to most people, especially himself. In addition, he is overconfident. Bob believes that he continues to make good judgments despite a history that argues otherwise. These can be powerful reasons to support a lifestyle that is not going well.**

The aim of the therapist is to help Bob begin to see that his equating anecdotes with science and his overconfidence is doing him more harm than good. If that is successful, perhaps the counselor can insert thinking alternatives that can better serve Bob. For one, it is important to see that the examples of other people may not apply to him, and that it is well to be confident of one's abilities, but foolish to be cocky.

Developing the Art of Critical Thinking

Other than the simple act of continuous study, there is no magic involved in converting SUD counselors into better critical thinkers. The reference list at the end of this lesson will get you started on a long-term study program. In the meantime, try to determine your current level of critical thinking. Table 1 (on following page) can be used to determine your level of critical thinking along a development scale, using four major categories (Kurfiss, 1985). After completing the table, answer the two sets of questions that follow.

Table 1
LEVELS OF CRITICAL THINKING

LEVEL 1: Dualism / received knowledge

- At this level, individuals believe knowledge is a matter of simply collecting information or data from workshops and books.
- Information is believed to be either correct or incorrect.
- The concept of interpretation is itself perplexing. Often people will become irate or confused, and wonder why other people or authors don't just say what they mean.
- Individuals may resist critical thinking because they begin to see the world as far more complex than they realized.

LEVEL 2: Multiplicity / subjective knowledge

- Here, individuals begin to recognize that doctrines and opinions can and will conflict. In addition, they begin to see that conflict is a legitimate feature of knowledge.
- Unknowns, doubts, and uncertainties are acknowledged.
- Thinking is less dualistic and more multiple, or many-sided.
- At this level, people begin to recognize that knowledge and thinking is complex, but have not yet learned how to operate in it.

LEVEL 3: Relativism / procedural knowledge

- Here, people begin to realize that opinions differ in quality.
- They recognize that good thoughts are supported by good reasons.
- They begin to see that they must evaluate an issue in complex terms, weighing more than one factor in the attempt to develop an opinion.
- Attempts are made to understand another point of view, the reasons behind that view, and the thinking framework.
- They will take deliberate extensions into positions that initially feel wrong or remote.

Level 4: Commitment to relativism/constructed knowledge

- At this level, knowledge learned from others is integrated.
- Individuals begin to capture the interplay of rationality, caring, and responsibility.
- They become passionately engaged in the search for understanding.
- They become committed to nurturing rather than criticizing ideas.
- They seek integrated, authentic lives, and contribute to the empowerment and quality of others.

Ideas to Challenge Ambiguity, Vagueness, and Fallacy

The following questions, which are based on some thoughts put forth by Bates (1995) and Moore and Parker (1995), were designed for the SUD professional to use to critically address some of the issues under discussion.

- Are the SUD-related ideas that you hold, read, or hear clear and specific?
- Do you or your supervisors, fellow counselors, or trainers stick to an issue, or are the arguments that any of you put forth considered irrelevant by your agency?

- Is there a logical sequence to the arguments that you, your supervisors, or other trainers present regarding SUD-related subjects? Is there a point to any argument proposed in your agency? Do you have support for your arguments, (i.e., has the hypothesis put forth by the argument been tested?)
- Is any weight given to competing hypotheses? Are hypotheses eliminated if they fail to explain the findings in question?
- Is the SUD argument complete? Does it reach a conclusion and closure?

Rudiments of Critical Thinking

The following questions are designed for use in assessing the foundation of your current manner of thinking:

- If I were pressed to define a SUD theory, could I do it well?
- How do I know that my ideas about the SUD therapy are reasonable or rational?
- Can I defend my assertions using solid information and data?
- Do I emotionally strike out because of emotional displays and a reliance on heuristics?
- Have I tested my ideas in the past month to see if they are accurate and clear?
- Can I ponder SUD-related ideas in an in-depth manner or just superficially?
- Do I usually assume that I am right, or am I willing to entertain ideas that are opposed to mine and think them through in an intelligent fashion?
- Do I know how to question myself and test my ideas?
- Do I know the terrain, or am I just blindly following someone else's path?

After reviewing your answers, you may think of methods to correct some of your responses. If that has occurred, then your effort to become a critical thinker and produce more efficient results is beginning to pay off.

Conclusion

As indicated in this lesson, the foundation for critical thinking, as it applies to the SUD counselor, consists of the avoidance of common heuristics and the promotion of clear thinking, which can be assessed by using the development table and two sets of questions provided herein. Hopefully, these tools will help the SUD counselor improve his or her thinking processes and become able to apply these skills to the counseling process to bring about better treatment outcomes.

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

9. A heuristic is:

A. A thinking error

B. A rationalization for drug abuse

C. A permanent state of confusion

D. All of the above

10. Which of the following best describes core characteristics of critical thinking?

A. A refined intuition based on years of experience

B. An ability to passionately appeal to colleagues and clients

C. Honesty, objectivity, integrity

D. Independence of thought, marked by an aloof and pensive manner

11. In an argument, a client begins to attack you and not the content of your proposals, he/she would be utilizing the heuristic of:

A. Obedience

B. Ad hominem

C. Distorting the evidence

D. Over-relying on authorities

12. Which of the following will most likely contribute to the development of critical thinking?

A. Using this lesson as a frame of reference for establishing and maintaining objectivity about oneself and one's work

B. Holding tight to your own heuristics

C. Switching to an entirely new way of thinking about the world

D. All of the above

Directions in Substance Abuse Counseling
Volume 6 Lesson 4

Women, Drugs, and AIDS: Implications for Rehabilitation Counselors

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Introduction

Women in general, especially women with AIDS and a history of substance abuse, present gender-specific challenges to service providers and treatment programs, including issues concerning gynecological health and pregnancy, social role expectations, mode of infection transmission, culture, stigma, and the clinical progression of both the disease and the addiction.[1,2] Compared to men, women are more likely to present with polysubstance use, women who abuse alcohol are frequently affected by liver damage and have a higher mortality rate, and women substance abusers are generally more likely to blame the onset of their problematic substance use on a specific stressful circumstance. In addition, the abuse begins later for women than for men, although women manifest symptoms of substance abuse and start treatment at about the same time as men.[3–6]

Individuals who use substances to excess are likely to experience impaired judgement, which may result in their engaging in more high-risk sexual activities and, thus, increase their exposure to HIV and risk of contracting AIDS.[7,8] Concomitant use of alcohol and other drugs (AOD) has been directly linked to AIDS in women, because AOD use often disinhibits behaviors that can lead to unsafe needle-sharing and sexual practices, as well as inadequate hygienic care.[9] Furthermore, women with substance abuse problems tend to have had a rape experience (i.e., unprotected sex), which exposed them to the risk for sexually transmitted diseases.[10]

The majority of new HIV infections in the United States are related to drug use (by sharing contaminated needles or through sexual contact with an injected substance user). This phenomenon has become particularly problematic; AIDS is now the fourth leading cause of death among women aged 15 to 44 years.[11]

This lesson contains information that will enhance the knowledge and competency of rehabilitation counselors in addressing a host of issues that are unique to women with both substance abuse and HIV/AIDS. In particular, this lesson will discuss the stages of recovery, which range from access and assessment through treatment and follow-up.

After completing this lesson, the practitioner will be able to (1) define terms associated with AIDS and substance abuse, (2) identify psychosocial, cultural, and physical characteristics of substance abuse and AIDS, (3) identify signs and symptoms of AIDS and substance abuse, (4) understand treatment issues for women substance abusers with AIDS, and (5) understand the key phases of a service delivery approach for women with a dual diagnosis of AIDS and substance abuse.

Definitions

The language and terminology of the field of substance abuse and AIDS education is derived from an amalgam of medical, social, and psychological terms. The breadth of substance abuse and AIDS terminology is vast and varied and beyond the scope of this lesson.

Abuse-Related Terms:

Addiction

***Addiction* is defined in many ways throughout rehabilitation counselling literature.** In the United States, the definition has its origins in the field of alcoholism therapy and has been incorporated into medical practice as the disease model.[12] **Basically, addiction is the presence of physical symptoms of withdrawal or tolerance.[13] It manifests as persistent and repetitive behavioral patterns in which one or more of the following criteria are present: progression, preoccupation, perceived loss of control, and negative long-term consequences.**[14] Addiction may also be defined as a process that occurs along a continuum of behaviors and consequences that range from nonproblematic to highly problematic. Different individuals have different origins of addiction, lengths of time of addiction, and oscillation patterns along the continuum.[13]

Abuse

***Abuse* of a substance implies that the substance is used the extent that the mood, behavior, and ability of the user to functionis negatively affected.**[13] The negative effects of substance abuse may involve impaired psychological, physical, social, or occupational functions.

Substance Dependence Disorder

The term ***substance dependence disorder*** can be applied to the effects of every class of addictive substances, except caffeine. While the symptoms of dependence are similar across various categories of substances, some symptoms are less salient for certain classes, and in a few instances, many symptoms do not apply (e.g., withdrawal symptoms are not specific to hallucinogen dependence). **The diagnosis of a substance dependence disorder requires the presence of a maladaptive pattern of substance use that results in distress or clinically significant impairment and involves at least three of the following symptoms** (all of which must appear within the same 12-month period): **tolerance; withdrawal; use of the substance longer than intended; unsuccessful attempts to control or reduce consumption; spending excessive amounts of time using or procuring the substance; reduced involvement in important social, occupational, or recreational activities; and continued use despite the presence of recurrent physical or psychological problems.**[15]

HIV-Related Terms:

Human Immunodeficiency Virus (HIV)

***HIV* infection is a manifestation of a sequence of predictable phases that culminate in a severe deficit of immune competency that is life threatening.** The virus infects, functionally impairs, and depletes lymphocytes.[16] An infection with this virus may lead to AIDS.

Acquired Immune Deficiency Syndrome (AIDS)

***AIDS* refers to the presence of life-threatening opportunistic infections, neoplasma, wasting and specific HIV-related neurologic disease.**[17] Normally

opportunistic infections or tumors would not have a chance to thrive if the body's defenders, the T4 cells, were performing properly.[18] Opportunistic infections thrive because the protective functions of the immune system are radically diminished or lost.

Lymphocytes

The blood cell that is most greatly compromised by HIV is the *lymphocyte*, which is a type of white blood cell. Lymphocytes can be further divided into T and B lymphocytes (*T* for the cells that originate in the thymus gland, which lies just under the sternum or breastbone, and *B* for those that originate in the bone marrow). The T cells are divided further into helper cells (T4) and suppressor cells (T8). The main problem faced by a persons with AIDS is the loss or impairment of T-helper cells and the subsequent reduction in the ratio of T4 to T8 cells.[18]

Epidemiology

Everyone is at risk for AIDS, although this disease is acquired through specific behaviors and exposures. **Infection most commonly occurs through vaginal or rectal sexual intercourse without condoms or by sharing unsterilized drug injection instruments.**[18] Health care workers are at increased risk by means of needle sticks or exposure to contaminated blood. For infection to occur, there must be an opening or break in the skin or protective membranes. **The risk for HIV infection is also increased by pregnancy, birth, and transfusion. A woman's immune system may become depressed during pregnancy; thus, pregnancy may accelerate the course of HIV/AIDS-related illness.** Consequently, drug-using pregnant women experience a high rate of infection, premature labor, and fetal loss.[18]

Signs and Symptoms of the AIDS–Substance Abuse Connection

Early signs of HIV infection in women are often overlooked and underrecognized by health care professionals.[19] Women may seek health care for vague complaints that are actually related to impaired immunologic functioning. Also, women usually first seek treatment at a later stage of disease progression than men.[10] The signs and symptoms presented are explained by the predominant concepts related to AIDS-related complexes (ARC). As Reichert and MacGaffie stated, "The most common symptomatology related to ARC include fatigue, memory loss, weight loss, fevers, lymphadenopathy, new growths above and below the skin, thrush, shingles, dry cough, persistent diarrhea, easy bruisability, and unexplained bleeding."[20]

HIV disease is described by four clinical phases: primary HIV disease; chronic asymptomatic disease; chronic symptomatic disease; and advanced disease, or AIDS. As Keeling states: "Primary HIV disease is characterized by a short, minor, seldom recognized illness occurring just after infection and before antibody tests turn positive. **Chronic asymptomatic disease is marked by a lengthy but variable period during which clinical silence masks progressive immunologic deterioration. Chronic symptomatic disease is defined by constitutional symptoms, specific minor complications involving skin and mucous membranes, and continued immunologic decline;** it is limiting and sometimes disabling, but rarely severe or life-threatening. **Advanced disease is distinguished by the presence of life-threatening opportunistic infections, neoplasms, wasting, or specific HIV-related neurologic disease.**[21] The dual diagnosis of AIDS and substance abuse presents both overlapping and distinct symptomologies. It is often necessary to distinguish neurocognitive impairments caused by AIDS from those caused by substance abuse during the determination of treatment protocol.

CNS Disorders in HIV vs. Substance Abuse:

Evidence of central nervous system disease in AIDS is often extremely subtle and may show up only as mild, short-term memory loss.[18] For example, a person may not be able to remember phone numbers or may have to write notes to remind herself about things she did not have to be reminded of before. The amnesia spells (blackouts) that are characteristic of acute substance abuse are not characteristic of AIDS; when seen in patients with AIDS, they indicate the presence of a chemical dependency problem.[18,22] **The memory**

deficits that are associated with AIDS frequently progress, regardless of treatment. In contrast, the memory deficits that are associated with substance abuse will improve with abstinence from the substance,[18] although improvement is limited in cases of severe neurocognitive impairment related to alcohol abuse (e.g., Wernicke-Korsakoff syndrome).[23] Mild expressive aphasia (failure to understand language) or global loss of affect (a generalized lack of response to one's environment) are sometimes seen in persons with AIDS, but usually subside in a chemically-dependent person after the person has been detoxified.[18] **Acute anxiety and depression are very common with AIDS and substance dependency, but both respond to appropriate counseling and medication.**[18,22,23]

Acute psychiatric manifestations of cerebritis (inflammation of the brain that results in altered mental or neurological functioning, including psychotic states) are sometimes present in persons with AIDS and may be extremely difficult to distinguish from the encephalopathy (brain disease) caused by many drugs or other substances.[18] In such cases, it is best to make such a distinction after the effects of the psychoactive substances have worn off. However, it is better to err on the side of caution and check for opportunistic infections of the brain.[18,23]

Gynecological Disorders in HIV vs. Substance Abuse:

For women, a gynecological examination may reveal the earliest symptoms of HIV disease. **Vaginal candidiasis, vaginal yeast infections, pelvic inflammatory disease, abnormal pap smears, and genital warts are common early indicators of HIV.**[6] **Although these conditions are seen in the general population, the physician should suspect HIV if the infections are recurrent or severe and recommend testing.**[24] Women substance abusers and users with HIV/AIDS also have such complications as sexually transmitted diseases, hepatitis, anemia, urinary tract infections, and malnutrition.[25] Female substance users also often have irregular menses.[26]

Psychosocial Dimensions of AIDS and Substance Abuse

AIDS and substance abuse are not just somatic diseases; they also require extensive psychosocial interventions. Chemically dependent women with HIV/AIDS have compound difficulties.[9] Often they must deal with the following issues: stigmatization; social isolation; grief due to loss of health, sexuality, body image, and childbearing potential; low self-esteem; unstable employment; residential instability; emotional stressors; discrimination due to economic status; and, if a member of a racial minority group, racism.[16,27] **Consequently, depression is high among chemically dependent women with AIDS.**[28] Some women also face legal problems related to drugs or prostitution.[29] Furthermore, women with HIV have little or no reason to know one another and are less likely than men to have peers to turn to for advice, support, or information.

Women with seropositive status contend with other psychological problems including guilt regarding their past behavior and viewing the illness as a punishment, anger at their fate, feelings of hopelessness, uncertainty regarding the illness, and fears of death and dying. Intimacy is another concern and women may feel sexually dirty and unloved.[10] In addition, women must contend with issues of moral indignation and societal chauvinism.[9,26] "Singularly, or collectively, the psychological issues may be profound."[9] Keeling[17] stresses that "we cannot manage the epidemic, or its impact on individuals, outside its social and cultural context."

Culturally Diverse Populations

All behaviors, including those related to HIV/AIDS and substance use, occur within the context of the individual's social and cultural group.[31,32] Currently, women who are at the highest risk for HIV/AIDS infection have the multiplicative effects of race, class, and gender subordination.[33] AIDS is now a disease of the poor and minorities. **In the United States, AIDS does not affect all women equally.** For example, African-American women (52%) and Hispanic women (31%) are disproportionately affected,[34] while white women are reported to comprise only 27% of women with AIDS.[33] By contrast, the incidence of AIDS among Asians and Pacific Islanders is generally lower than other cultural minorities.[35] Consider the following substance abuse findings about women of color compared to white American women: cirrhosis rates are six times as high for African-American women; Hispanic-

American women use illicit drugs at a higher rate; Native-American women use alcohol at an earlier age, consume alcohol more frequently and in greater quantities, and suffer more serious consequences from excessive alcohol intake; and Asian and Pacific-Islander women have the lowest prevalence of alcohol and drug use, although this varies with acculturation status.[32] **Cultural beliefs, attitudes, and traditions influence the prevalence of substance use and abuse, as well as the amount of interpersonal communication about AIDS.**[32,33,35]

Sensitivity to the social and cultural contexts of specific groups requires that attention to HIV infection, AIDS, and prevention behavior be given in certain key areas, including the following: negative misinformation about the sexuality of women and racial minorities, misconceptions about HIV and AIDS that are held by each group, and the added difficulty of multiple discrimination or stigmatization faced by these groups.[31] To provide optimal services, providers must understand the issues associated with disability and sexuality within each group. Women with disabilities face risk factors similar to those of nondisabled women; however, research suggests that people with disabilities use substances at at least the same rate as those without disabilities.[32,36] The prevalence of substance abuse is higher among lesbians, who also engage in polysubstance use at a relatively high rate.[32,37] Awareness of cultural and social influences on the development of biased attitudes toward gays is as important for understanding the problems of lesbians as is the study of their adjustment, behavior, and reactions to therapy.[38]

Intervention programming for women concerning HIV/AIDS and substance abuse for women must address the individual comprehensively and, therefore, must cover biomedical, psychosocial, cultural, and gender issues. **Croteau and colleagues recommend the following four guidelines for maintaining social and cultural sensitivity in HIV and AIDS programming:** (1) **include targeted group members as full partners in program planning and implementation;** (2) **involve peer leaders;** (3) **include culturally relevant content, media, or settings; and** (4) **foster group pride.**[31]

Treatment for Dually Diagnosed Women

Treatment for women with AIDS and substance abuse is linked to appropriate and timely assessment. **One of the primary indicators of a favorable prognosis is early detection.** Unfortunately, early signs of HIV infection in women are often overlooked.[29] **Similarly, substance abuse in women is often overlooked, ignored, dismissed, or misdiagnosed.**[3,9,32] Because formal substance abuse treatment is time limited and does not address addiction problems thoroughly, women with dual disorders that include addiction (e.g., HIV/AIDS and alcoholism) need continuous treatment —not only for the substance abuse problem, but for the coexisting disorder, as well.[32] **Treatment of substance abuse and AIDS is a long and arduous process that requires a multidisciplinary approach.** It is important to remember that each person must be treated as a unique individual according to the manifestation and stage of both the disease and the addiction.

Treatment Planning for Substance Abuse:

The treatment plan is the foundation for success, providing both the client and interventionist have a structure within which to function.[13] **Due to the gender-specific needs of women, rehabilitation management must focus on an interagency collaboration that addresses social work/welfare, public housing, child care, the legal system, and/or employment.**[9] When designing a plan, the planners must take into consideration the severity of the client's condition, the client's motivation to change, treatment options (e.g., inpatient therapy for detoxification or outpatient therapy for desensitization and job maintenance), the projected length of treatment, client and counselor preferences, cooperation from significant others, and the patient history.[13] Women substance abusers often prefer private therapy or group therapy for women only.[28,32] In addition, the treatment team must consider three types of factors that affect the outcome of substance abuse therapy for women: factors important to her seeking treatment (i.e., lack of child care, legal referrals, socialization barriers); factors important to her completing treatment, (i.e., availability of specialized medical services, housing arrange-

ments, a supportive and trusting environment with little emphasis on confrontation); and factors important to her maintaining recovery (i.e., complete follow-up plan with appropriate linkages, establishment of 12-step philosophy that contributes to recovery for women, establishment of healthy relationships.[13]

Treatment Methods and Modalities for Substance Abuse:

No single modality of care is effective for all women. Women may experience varying degrees of success with different modalities or combinations of modalities at different times. **Generally, treatment for substance abuse includes pharmacological treatment, psychosocial treatment, nontraditional healing techniques** (e.g., acupuncture), **and social learning.**[32] **These methods are often used in combination or sequentially at different stages of the treatment process.** Given the link between substance abuse and HIV/AIDS, the treatment protocol must encompass the appropriate combination of treatment modalities to best serve each woman. At a minimum, the treatment program must provide pre- and posttherapeutic assessment counseling for women who want to be tested for HIV and individual counseling and group support for those who are diagnosed with an HIV infection or AIDS.[32]

Modalities of substance abuse treatment can be classified by setting (e.g., inpatient, residential, or outpatient facility), length of care (short-term or long-term) and philosophical approach (e.g., the medical model or social services model).[32] **The treatment consists of a continuum of services that involve either** (1) **inpatient detoxification, referral for residential treatment and rehabilitation, and referral to outpatient or intensive day treatment; or** (2) **residential treatment and referral to outpatient rehabilitation.** Both processes require continuing care and follow-up.[13,32]

Critical Components of Treatment for Women

The Center for Substance Abuse Treatment recommends that treatment programs designed specifically for substance-abusing women include medical interventions, substance abuse counseling and psychological counseling, health education and prevention activities, life skills training, and access to other social services.[39]

Medical Interventions:

Medical stability is preferred (but not required) for an individual to respond to substance abuse therapy. The following medical issues are especially relevant to female substance abusers:

- **Testing and treatment for infectious diseases, including hepatitis, tuberculosis, HIV infection, and sexually transmitted diseases (STDs).**
- **Screening and treatment of general health problems, including anemia, poor nutrition, hypertension, diabetes, cancer, liver disorders, eating disorders, dental and vision problems, and poor hygiene.**
- **Obstetrical and gynecological services, including family planning, breast cancer screening, periodic gynecological screening (including pap smears), and general gynecological services.**
- **Infant and child health services—including primary and acute health care for infants and children of affected women, immunizations, nutrition services (including assessment for eligibility for the Women, Infants, and Children [WIC] program)—and developmental assessments performed by qualified personnel**

Substance Abuse Counseling and Psychological Counseling:

Counseling must address the emotional, affective, and psychological consequences of substance abuse. Effects on the mind and body should be addressed in unison, as follows:

- **Counseling regarding the use and abuse of substances directly, as well as other issues which may include low self-esteem; race and ethnicity issues; gender-specific issues; disability-related issues; family relationships; unhealthy interpersonal relationships; violence (including incest,**

rape, and other abuse); eating disorders; sexuality; grief related to the loss of children, family, or partners; sexual orientation; and taking responsibility for one's feelings, including feelings of shame, guilt, and anger.

- Parenting counseling, including information on child development, child safety, injury prevention, and child abuse prevention.
- Relapse prevention, which should be a discrete component of each woman's recovery plan.

Health Education and Prevention Activities:

Health education and prevention activities should cover HIV/AIDS; the physiology and transmission of STDs; reproductive health, preconception care, prenatal care, and childbirth; female sexuality; physical and sexual abuse prevention; nutrition; smoking cessation; and general health. Although the public health community has concentrated on the relationship between injected drug use and HIV/AIDS, there is growing evidence of a need to recognize the relationship between the use of any mind-altering substance and high-risk sexual activity.[32]

Life Skills:

The ability of a person to cope with life and survive in today's society requires the possession of certain practical life skills. **It is important for the counselor to be familiar with the following life skills categories in order to better assist women at risk: vocational evaluation; financial management; negotiating access to services; stress management and coping skills; personal image building; parenting issues, including infant and child nutrition, child development, and child-parent relationships; educational training and remedial education services** (these can be provided through access to local general education diploma [GED] programs and other educational services); **English language competency and literacy; and job counseling, training, and referral** (these may be provided by means of case managed or case-coordinated referrals to community programs).

Other Social Services:

Additional support services may be necessary to assist women in following through with rehabilitation therapy. Such services may include transportation to substance abuse treatment and related community services, child care, legal services, and housing.

It is critical that all treatment components be accessible to all women.[32] **A thorough assessment of each woman's social, emotional, cultural, and medical history is the best way of identifying her specific needs.** Treatment must focus on helping individuals develop strengths and coping skills while establishing new behaviors that will prevent the use of chemical substances.[40]

Implications for Rehabilitation

The central premise of a gender-specific approach to prevention and intervention for substance abuse and HIV/AIDS is based on women's social status and sex-related risk of HIV infection for women, which occurs within the context of their relationships with men.[42] As Chen and colleagues succinctly state, "The unequal status of women puts them at severe disadvantage in negotiating sexual encounters and in seeking and utilizing educational and health services."[43] Counselors must also be prepared to talk openly with women about their relationships with respect to sexual abstinence, safe sex, and making choices about sexual practices.[10]

The role of the rehabilitation counselor working with women with AIDS and substance abuse is to decrease adverse effects, improve functional ability, and promote quality of life. Counselors need to have knowledge and experience with issues specific to helping women diagnosed with AIDS (usually at the peak of their careers) articulate new career goals and gain financial support beyond other consumers who comprise the rehabilitation caseload.

Substance Abuse Counseling and Psychological Counseling

Counseling must address advocacy issues on behalf of women who experience domestic violence.[42] These issues may occur sequentially, simultaneously, or recurrently.

As Groomes advises, "The ability to move a person toward quality of life (as defined by the individual with

HIV/AIDS) is enhanced by knowing when to best intervene in a crisis situation, or knowing when to support a particular decision made by the person with HIV/AIDS."[43] To this end, the counselor's ability to enhance the client's quality of life requires a thorough intake interview (i.e., the counselor should ask specific questions about medical conditions, means of support, psychiatric history, and vocational history), an understanding of the vocational interests and past work experience of the client, and educating employers and coworkers about HIV/AIDS and substance abuse.[32,43,44]

Counselors need to be knowledgeable about relationships, poor self concept, and impulsivity to be able to address some of the following issues:

- **Identity disturbances, which are often marked by an unstable concept or sense of self**
- **A pattern of unstable and intense interpersonal relationships that are often marked by alternating extremes of devaluation and idealization**
- **Impulsive behavior that tends to be potentially self-damaging, which may include self-defeating behavior and recurrent gestures that indicate suicidal ideation and intent**

Phase One—Identification:

There is no profile of a "typical" substance abuser, nor is there a composite of what a woman with AIDS looks like. The pattern of substance abuse and the progression of AIDS are different for each woman. The identification of a substance abuse problem can be made by the patient; through a referral by a family member or significant other, or a referral from the medical, social services, or legal system. **Identification does not mean diagnosis, however; it simply means the suspicion or recognition of a pattern of behaviors. During the identification phase, a rehabilitation counselor may administer a screening instrument to determine whether the client should be referred for an assessment.** Many screening instruments can be self-administered (e.g., **CAGE**, [a screening instrument that asks four questions: Have you ever felt that you ought to Cut down in your drinking? Have people Annoyed you by critcizing your drinking? Have you ever felt bad or Guilty about your drinking? Have you ever had a drink first thing in the morning (Eye-opener) to steady nerves or get rid of a hangover?]; the **Drug Abuse Screening Test, or 4Ps** [a four-question screening instrument developed for use in prenatal clinics and integration within large health care systems. The instrument asks four yes/no questions about a patient's alcohol and/or drug use problems during the current *pregnancy*, in her *past*, in her *partner*, and in her *parents*.]). DiNitto and Schwab indicate that failure to detect substance abuse may account for some clients being labeled rehabilitation failures rather than successes.[45] Preferably, women should be referred for a gynecological exam. The following questions can be useful in identifying a woman's current substance-related problems:

- **What types of drugs has she used in the last 24 hours, in what amounts and by what method in the previous month? In the previous three months?**
- **What are her current symptoms? Is she currently experiencing symptoms of withdrawal from drugs?**
- **Is she in need of detoxification? If so, does her physical status warrant inpatient or outpatient detoxification?**[32]

The following questions should be asked to determine if a woman is at risk for HIV:

- **Have you shared needles or syringes to inject drugs or steroids?**
- **Have you had sex with someone who you know or suspect is infected with HIV?**
- **Have you had or do you have a sexually transmitted disease?**
- **Did you receive a blood transfusion or blood products between 1978 and 1985?**
- **Have you had sex with someone who would answer yes to any of the above questions?**

Phase Two—Brief Intervention:

Counselors may initially approach each client with a brief therapy focus.[47] **Brief therapy requires the counselor to be active and direct during counseling sessions, to intervene promptly and early in treatment, and to focus on the here-and-now, helping the client establish specific, time-limited goals to reduce their addiction symptoms and enhance coping abilities that will help the patient remain substance free.**[12,46] Talmon[47] suggests that the counselor facilitate the brief screening by keeping three questions in mind during the interview process: (1) Are you the best counselor for the client? (2) Who is the client? (3) Is there a hidden agenda? Responses to these self-directed questions may assist the counselor in determining if brief therapy is the appropriate approach with the individual or what goals can be realistically achieved within the context of brief therapy. Moreover, establishing a realistic treatment focus may reduce frustration levels for both counselor and client, and assist them in avoiding power struggles. For example, a client who may not be interested in being sober as a long-term goal and is there only because of a court order (e.g., hidden agenda) gives the counselor an opportunity to educate the client about substance abuse and high-risk behaviors and to motivate her to remain abstinent. In turn, this interaction may actually result in the client being more motivated to seek treatment.[46]

Phase Three—Assessment and Diagnosis:

An assessment is made using clinical data regarding the client's substance abuse. **The practitioner should conduct a thorough assessment to identify a pattern of problems related to substance use that does not seem to respond significantly to environmental changes.** If this pattern appears to affect more than one area of consequence (e.g., legal, family, significant others, job, school, medical, or financial consequences) and occurs in different contexts over time, it strengthens the basis for a diagnosis.[47] Rehabilitation counselors do not have the credentials to make a diagnosis, of course. A diagnosis of substance abuse must be made by a physician, psychologist, psychiatrist, or licensed clinical social worker. **A few of the most frequently used assessment instruments with a high reliability are the Addiction Severity Index, the Alcohol Use Inventory, and the Composite International Diagnostic Interview Substance Abuse Module.** Behavioral observations, physiological instruments, and psychometric instruments may also be used.[47]

Phase Four—Education:

The primary purpose of education is to inform the client about the consequences of substance abuse and the ramifications of AIDS. Thus, education is a critical part of the treatment and recovery process. Another important purpose for education is to inform everyone in settings in which the client functions about the consequences of an HIV-positive diagnosis.[6, 46]

Phase Five—Intervention:

Intervention or treatment should be determined by the needs of the individual client. Treatment may be provided in an inpatient or outpatient setting, and the method of treatment may range from pharmacological to nontraditional healing. **Rehabilitation counselors are rarely responsible for the delivery of intervention; however, they are responsible for the coordination of services and, to some extent, case management.** Relapse prevention is a crucial part of intervention and follow-up.[32] The key points to remember regarding intervention include the following:

- **Programming should be comprehensive and holistic.**
- **The cultural needs of the consumer should be met.**
- **Women with dual disorders should receive treatment for both disorders, as deemed appropriate.**
- **Health education and behavior change strategies should be designed to meet the specific circumstances of each woman.**
- **Solutions should address the primary causes of HIV risk among women.**

- **Treatment centers should incorporate premenstrual stress screening, diagnosis, treatment, and/or referral to existing programs.**[3,32]

Phase Six—Rehabilitation Counseling:

Successful rehabilitation clients with substance abuse alone have been differentiated from clients with comorbid substance abuse and HIV/AIDS by the fact that they receive more diagnostic and evaluation services, as well as education and training services.[48] **Clients with AIDS are often disconnected from normal meaningful activities.** For example, they often become unable to work; this may destroy their sense of productivity and of their ability to contribute to their families' well-being or to society and ultimately erode their sense of self-worth.[49] **Glenn[50] offers the following recommendations for effective rehabilitation outcomes: provide consumers, families, and professionals with information about substance abuse prevention and the risks associated with overmedication; help consumers develop skills by providing for their emotional, social, physical, and mental development and incorporate alternative activities—such as recreation, the arts, community involvement, and volunteering—into rehabilitation plans.**

With regard to the vocational impact of HIV/AIDS, Groomes[43] stresses that rehabilitation counselors must be cognizant of the many stigmas that are attached to persons with HIV/AIDS by coworkers and supervisors who are not intelligently informed about the disease. **Therefore, counselors must help clients with AIDS balance the issues surrounding disclosure and fear of loss of confidentiality, loss of social support, and possibly having to decide whether to leave the job and seek a more appropriate position.** These issues are magnified for women.[10,24,32]

Phase Seven—Follow-up:

Given the effects of substance abuse and AIDS on every aspect of a woman's ability to function, continuing care services must be both comprehensive and focused on individual needs. **Counselors must help women identify stressful areas in their lives and learn how to locate and use resources that are designed to help them deal with stress.** Discharge planning should build on treatment efforts that are designed to empower women to handle stress.[32] Follow-up services should include referrals to support groups that are gender-, circumstance-, and diagnosis-specific. Follow-up allows counselors to respond to changes in their clients' physical and mental health, as well as their socioeconomic status during the continuing care phase of recovery.[32] **The rehabilitation counselor should make follow-up procedures part of the rehabilitation process, maintain contact with the consumer as long as necessary, and observe confidentiality.**

Conclusion

Substance abuse and AIDS are major health problems for women. The adverse effects of chronic substance use on the immune system may increase rates of progression from HIV to AIDS. There is growing evidence of a need to recognize the relationship between the use of mind-altering substances and high-risk sexual activity in this population. Critical components of treatment include testing for and treatment of infectious diseases, general health problems, obstetrical and gynecological services, and infant and child health services, as well as counseling that addresses guilt, grief, violence, and low self-esteem.

Rehabilitation counseling can provide women with accurate information and service coordination while negotiating the complex interactions of cultural, biomedical, psychosocial, and vocational factors that impact their quality of life. Approaches that successfully engage and maintain women in treatment utilize a combination of treatment modalities and services that are developed individually for clients from diverse populations and backgrounds. This approach is consistent with the philosophy of rehabilitation: to foster independence, self-worth, and opportunities to contribute to both individual and community improvement.

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

13. Which of the following is *not* part of the definition of the CAGE?

A. Guilt

B. Caution

C. Eye-opener

D. Annoyed

14. Generally, treatment for substance abuse includes:

A. Addressing physical and mental problems independently

B. One modality of treatment

C. Various methods (e.g., pharmacologic, psychosocial, nontraditional healing) used in combination or sequentially at different stages of the treatment process

D. Addressing only physical problems

15. In most cases, memory deficits that are associated with AIDS frequently progress regardless of treatment. Memory deficits associated with substance abuse:

A. Will improve with counseling

B. Will progressively get worse

C. Will show no change with or without treatment

D. Will improve with abstinence from the substance

16. According to the author, which of the following groups has a higher incidence of women affected with AIDS?

A. Asian

B. African American

C. White

D. Hispanic

Directions in Substance Abuse Counseling
Volume 6 Lesson 5

Substance Abuse Treatment for Pregnant and Parenting Women

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Introduction

Substance abuse treatment and research addressing the needs of pregnant and parenting women is a relatively new phenomenon.[1,2] Historically, women who abused alcohol and other drugs, particularly during pregnancy, were greatly stigmatized.[3] Many feared criminal repercussions or the loss of their children if they sought treatment.[4] Within the last two decades gender-specific treatment has evolved philosophically and programmatically.[5] **The field of substance abuse treatment, which previously focused almost exclusively on men and concentrated on behaviors related to substance use, has expanded to encompass treatment programming that addresses the personal and family needs of women.**[6,7]

This lesson discusses issues related to substance abuse in women, highlights gender-specific substance abuse treatment programming, introduces a group therapy treatment model, and describes a loss and grief group therapy model. A case study of one client's experience illustrates the approach taken in a successful loss and grief group. The lesson concludes with a summary of key points.

Substance Abuse in Women

Drug use among women, particularly those of childbearing age, 12–44 years, is a critical health and mental health issue. Women from all racial, ethnic, and socioeconomic groups use both illicit and licit drugs.[8] Estimates from the National Household Survey on Drug Abuse indicate that women in this age group account for approximately 45% of illicit drug use in the United States.[9] While reported substance use rates for women are continually lower than those for men, the differences have lessened over time.[10] Based on extrapolated statistics, approximately 200,000 women died as a result of substance-related illnesses in 1994.[11] Substance use by women has repercussions on family members. It is estimated that more than 1.6 million women using drugs were living with their children. Maternal substance abuse affects the children biologically, through prenatal substance exposure, as well as environmentally.[12] The environmental impact results not only from the drug use itself, but also from factors secondary to drug use, such as inconsistent caretaking and increased violence.[13] The children of women who use drugs are at high risk for emotional, developmental, and academic sequelae.[14]

Although substance-abusing women usually have a drug of choice (i.e., one drug that they use predominantly), current research has identified that many are polydrug users (i.e., they use different drugs in combination). For example, a woman might use both cocaine and alcohol, or heroin and marijuana. **It should be kept in mind that women who abuse drugs may use both illicit substances** (e.g., cocaine, crack, heroin, amphetamines) **and legal substances** (e.g., alcohol, cigarettes, and prescription drugs).[8]

The development of the field of gender-specific treatment has led to research and an understanding of the special needs of defined groups of women, including lesbians and homeless women, as well as women from various cultural backgrounds, such as Native American, African American, European American, Asian American, Latina and Pacific Island women.[15] As our clinical and research understanding of the specific needs of women becomes more defined, interventions appropriate to their needs are increasingly becoming implemented.

Health Status:

Women who abuse substances often exhibit greater health needs, particularly gynecological and obstetrical needs, than women in the general population, and they appear to be predisposed to more medical problems than male substance abusers.[16,17,18] In addition to the direct physiological effects that alcohol and drugs have on women, sexually transmitted diseases (including syphilis, chlamydia, and HIV) and tuberculosis are serious health concerns.[8] The effects of substance abuse on women's health is complex due to a variety of factors. Their poor health is related to unhealthy lifestyles including prostitution and living in violent environments), poor nutrition, and little consistent health or dental care, either prevention or treatment.[17] As a result, they often enter substance abuse treatment in poor physical condition.

Psychosocial Status and Mental Health Issues:

Understanding the psychosocial characteristics of women seeking treatment for substance abuse is important for treatment planning and treatment effectiveness.[19] **Many women enter treatment with dual diagnoses,**[20,21] **which frequently include affective disorders such as depression,**[22,23] mood disorders, and posttraumatic stress disorder.[24] It has been noted in many studies that women in treatment have low self-esteem and this has proven to be an important treatment consideration.[25,26]

Experience of both sexual and physical abuse has been reported as a major characteristic of women in treatment.[27] It is estimated that between 36% and 75% have a history of childhood sexual, physical, or emotional abuse.[27,28,29]

Many women in treatment are pregnant or parenting and this has ramifications not only for the women, but also for their children and families.[30] Familial patterns of substance abuse[31] have been identified in a number of studies. Environmental influences on substance use have been identified, including the effects of intergenerational substance use—which may encompass mother, father, siblings, and grandparents—peer influences; and age of onset. A history of dysfunction in the family of origin often affects the mothers' actions

and relationships with their own nuclear families.[32] In addition to studies that have identified environmental influences, increasing evidence in the alcohol studies literature suggests a genetic predisposition to alcoholism in certain families.[33] Given the multifactorial influences on substance abuse, treatment must be multidimensional. The inclusion of parenting and family issues provides a holistic treatment approach that addresses the multiple needs of substance-abusing women.[34]

Gender-Specific Substance Abuse Treatment Programming

A continuum of treatment models has been developed to address the needs of women in the United States (Table 1), including short- and long-term treatment, outpatient and residential programs, and drug-specific interventions. However, it should be noted that, although the number of programs treating women has increased in the past few decades, there are still not enough programs to meet the identified needs.

Gender-specific treatment programs incorporate relationship issues as a fundamental part of recovery. Treatment programs that address the diverse needs of the substance-abusing population may have a variety of components, including those listed in Table 2.

In a review of the literature, Howell, Heiser, and Harrington[35] report that gender-specific, family-focused, and culturally sensitive programming, provided by multidisciplinary, relationship-oriented staff, are important components of successful programming for women. **Gender-specific treatment shifted from a male approach, which is authoritarian and confrontational, to an approach using the relational model. Acknowledging the integral part that relationships play in the psychological development of women and the need for empathic approaches, has led to fundamental gender-specific programming changes.**[3,36] The relational model uses the "self-in-relation" theory,[37] which places the emphasis on psychological development through connection with others. Women bring to

Table 1
TREATMENT MODELS

- Pretreatment
- Detoxification programs
- Outpatient methadone maintenance programs
- Outpatient treatment
- Residential or domiciliary treatment
- Self-help and support groups

treatment many issues that are fundamental to the relational model. They include women in relationships (as daughters, partners, and parents) and in relation to violence that has been a central part of their lives.[3] As programs for women were implemented, specific needs became apparent. **Primary among them were the practical needs of women with children.** Many women were unable to access treatment without provisions for their children. At first, this generally meant childcare. However, as the effects of drug abuse on the family became more widely recognized,[2] some programs began shifting to an ecological, family-focused treatment approach.[38] **These programs provide prevention and treatment services for the children, as well as for the parents.**[39]

Group Therapy

Therapeutic interventions used in gender-specific drug treatment are increasingly documented in the literature. These include psychotherapy and cognitive, family, and infant mental health therapies, as well as relapse prevention and behavior change techniques.[40] However, rigor-

Table 2
TREATMENT COMPONENTS

- Assessment and diagnosis
- Chemical substitution (i.e., methadone)
- Substance abuse therapy
- Group therapy
- Individual therapy
- Alternative medicine including acupuncture
- Health care
- Family services
- Parenting programs
- Case management
- Infant mental health services
- Educational, vocational, and life skills training

ous scientific studies on effective treatment methodologies are scarce. This can be attributed to the difficulty of implementing applied research procedures in treatment settings with a substance-abusing population and to the newness of the treatment focus on women and their children.[41]

Until the advent of gender-specific treatment, the normative treatment approach was to establish sobriety before beginning to treat psychodynamic issues. The clinical literature increasingly suggests that this approach may not be the most appropriate for women's treatment and that addressing psychological issues should come sooner.[42] **While individual therapy approaches may be a fundamental part of treatment, the value of incorporating a group therapy approach is increasingly apparent.**

Group therapy has been identified as particularly suited to meet the complex needs of women in recovery. This approach is designed to increase knowledge of self and understanding of the other participants in a safe, accepting and trusting environment.[43] The described group approach presented didactic education within a psychotherapeutic context. The women were presented with new concepts and new language within a structure that enabled them to immediately begin to use and practice what they had learned. The language and concepts were designed to help participants identify their feelings and to use them to express themselves. The group context provided them not only with a safe place, but with peers who were able to share their common experiences. Learning that others have experienced similar situations validates the participants' sense of reality and lessens their feelings of loneliness.

Loss and Grief Group Therapy

Loss is a theme commonly identified in the lives of many substance-abusing women. Further clinical assessment often reveals unresolved grief.[44] Broadly defined, loss may include traumatic or dysfunctional events, as well as separation or death.[45,46] Unresolved issues of loss and grief can have negative outcomes. However, it is not clear whether the problematic outcomes are predominantly associated with the loss or trauma, or with the lack of resolution of the issues.[47] Among the identified sequelae are depression;[27,48] post-traumatic stress disorder,[45] drug or alcohol abuse,[48] low self-esteem,[49,50] and difficulty establishing healthy relationships with significant others and with their children.[46]

Unresolved loss and grief issues are associated with drug use and can inhibit or prevent recovery.[51,52] Group therapy, focusing on loss and grief, has been identified as a valuable treatment approach providing the opportunity for women to explore common experiences in a supportive environment.[7,53,54]

Studies on substance abuse treatment for women indicate that those who stay in treatment longer have better treatment outcomes. [30,55,56] In one study of a loss and grief group,[26] it was found that women who participated in the group remained in treatment significantly longer than women who did not participate. **This suggests that participation in the loss and grief group influenced their retention in treatment, potentially enhancing treatment effectiveness,** in addition to any specific benefits that may have been derived from participation in the group.

The treatment program provided a mulitfaceted intake assessment protocol with treatment reviews every three months. At intake, the women were given a battery of biopsychosocial assessments, which included the Substance Abuse Subtle Screening Inventory (SASSI)[57] and the Minnesota Multiphasic Personality Inventory –2 (MMPI-2),[58] as well as a psychosocial history interview. In addition, for both clinical and program evaluation purposes, the women were assessed with The Center for Epidemiological Studies Depression Scale (CES-D),[59] the Hudson Index of Self Esteem (ISE)[60] and the Profile of Moods States (POMS).[61] Parenting attitudes were assessed using the Adult Adolescent Parenting Index (AAPI).[62] These instruments, and others for the children, were given over a two-week intake period by a multidisciplinary team, which included a clinical psychologist, substance abuse counselors, infant mental health specialists, speech and physical therapists, and an educational psychologist. At the end of the intake period, the multidisciplinary team met and developed an initial treatment plan based upon clinical observation, client input, and findings from the assessments. The treatment plan was then implemented and reviewed quarterly.

The loss and grief group was initiated by the infant mental health therapist. She had observed the themes of loss and grief in her sessions and in sessions with other counselors. An overwhelming number of women identified personal traumatic losses in their therapeutic work. It was felt that developing one group which, focused directly on these issues would address treatment needs not covered in other treatment components.

The objectives of the group were to (1) give didactic information on the nature and stages of grief, (2) help each woman to identify her sources of grief, and (3) to provide a safe, supportive place for each woman to tell her story using her new knowledge and language. **A key treatment component was the connection made by many of the women between their earlier losses, loss/separation with their children, and the ways their substance use and relapses were related to lack of resolution of their loss/grief issues.** For example, some women noticed that they experienced a relapse on the anniversary date of a significant loss.

The six-week format included both didactic information on the stages of loss and grief and traditional group psychotherapy. In addition to interpersonal interactions, the group structure included individual writing and reading, and personal written or artistic creations. Individual therapeutic sessions were used to augment group treatment as needed. The sessions had an identified focus. In session one, the overall structure was explained, group norms were developed, and story sharing within a safe environment was modeled. In session two, the emphasis was on acquiring didactic information about loss and grief, including Kubler Ross's[63] stages of grief as related to their personal feelings. Sessions three and four consisted of sharing stories using the knowledge of loss and grief and the language that had previously been introduced. Session five introduced strategies for coping with the grief and loss, and their relationship with substance use. In the final session, the women used their new coping strategies to put closure to the group. At the end of each session, every woman filled out a personal response sheet.

The following case study combines the stories of a number of participants to protect confidentiality. The case follows Katrina through a six-week program, highlighting the program structure and her own insights and development.

Case Study:

This case study describes a loss and grief group implemented at a residential substance abuse treatment program. The grief group met 90 minutes each week for six weeks. This was a voluntary closed group.

Katrina is a 23-year-old African American single mother of Daniel, 6, and Carmaine, 2. She began using cannabis, at age 13, under her older sister's influence, and shortly after began drinking alcohol. When she was 15 years old, she began using crack cocaine, and her addiction level steadily increased until she entered treatment.

Katrina dropped out of high school in the 10th grade and gave birth at age 17. She entered the protective service system with a charge of child neglect due to drug use. She was unsuccessful in outpatient treatment, and her children were placed in foster care. Residential treatment was ordered as a condition of reunification. At treatment entry, Katrina was diagnosed with poly-substance dependence and histrionic personality disorder. Initially, Katrina had a difficult time with the program structure. After 9 months in treatment, she was reunified with her children. A month later she began the grief group.

At the individual presession meeting with the infant mental health specialist, Katrina immediately identified two losses: the separation from her children and her uncle's death. She had been raised without a father and her uncle had assumed this role.

Session One:

At the first session, Katrina tearfully shared the experience of the protective service worker physically remov-

ing her children from her for foster placement. She also talked about not receiving the emotional support as a child. She had not viewed this as a loss until others in the group discussed it in those terms. Finally, she mentioned the death of her uncle. At the end of the session Katrina indicated that she was relieved to be expressing these painful feelings.

Session Two:

As the sessions continued Katrina used the Kubler-Ross (1969) stages of loss and grief to identify her use of denial. She shared the loss of her children and uncle, and admitted that she generally dealt with loss issues by using denial. Katrina related that she refused to think about her uncle when he died, and refused to think about her children when they went into foster care: as it was too painful. Katrina reflected that during each of these incidents, she increased her drug use. She now understood that it was to repress her awareness of what was happening.

Session Three:

Katrina attended the third session, but did not talk. However, she indicated on her response sheet that she had been tearful while others were telling their stories because she could relate to them. She began to realize that she was no longer alone and that the other members could help her through the grief process. She said that she was afraid to grieve.

Session Four:

During the fourth session, Katrina told in detail how she lost custody of her children. They were removed as a result of a drug raid in which she went to jail. At that time, her children went to court-ordered kinship care. When she was released from jail, Katrina picked up her children and went "on the run" with them. A family member convinced her to turn herself in, and she lost them for a second time when they were physically removed from her. Katrina admitted that this group had aroused strong emotions and she remained tearful throughout the session. Katrina brought up that she was having a difficult time in treatment and contemplated leaving. The group questioned her about denial regarding the loss of her children if she left treatment and asked if she was ready to endure another separation from them. She indicated that she would do whatever was necessary to remain with her children.

Session Five:

The fifth session was spent exploring anniversary reactions and how to positively commemorate losses. Katrina actively participated in this session. She talked about her new understanding of grief. She identified how she used a "happy face" to deny the losses she had experienced throughout her lifetime. Aware of her use of denial, she began to question other life experiences, for example, "Why did my mother leave me when I was a teen?" In her response sheet, Katrina indicated that she valued the loss and grief group and was sad to see it end. The group had enabled her to identify her denial and begin to explore the many areas of loss and grief in her life.

Session Six:

In the last session, Katrina commemorated her loss by writing a letter to her children. First, she apologized for their foster care placement. She acknowledged that it was a painful time for all of them. She further explained that the lifestyle she had led during their separation would not have been safe for them. She admitted that she had not been a good parent and said that this was a painful truth. Katrina told her children that she wanted their childhood memories to be happy, secure, and full of love. Finally, she let them know that the separation was not their fault, that she loves them and will continue to work on being the parent they deserve. Katrina shared that this group has allowed her to face her grief and that she understands that grieving is an ongoing process. Katrina indicated that she felt supported by the group and learned to gain support from a group.

Conclusion

Substance abuse is a national health and mental health care concern, and the need to identify effective interventions is paramount. The advent of gender-specific substance abuse treatment in the 1970s not only changed theoretical and philosophical approaches to treatment, but also contributed to a new paradigm in treatment approaches that evolve in response to client

needs. The relational model has guided the implementation of programming that addresses the needs of women. Studies that demonstrate the effectiveness of this paradigm shift are increasing. [26,64]

The identification of critical clinical issues for women that are related to their substance abuse is fundamental to addressing client needs. Gender-specific treatment has increasingly combined these issues with appropriate treatment modalities. Group therapy is one treatment component which is proving effective. Research indicates that factors inherent in this treatment modality itself may facilitate healing. These factors include learning that others have experienced similar traumas, receiving advice, modeling successful behaviors of others, having a sense belonging, and gaining self-understanding and hopefulness.[65]

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

17. Which one of the following statements is correct?

A. The field of substance abuse treatment previously focused almost exclusively on women and not men.

B. Women who abuse substances often exhibit fewer health needs than women in the general population.

C. Women who abuse substances appear to be predisposed to more medical problems than male substance abusers.

D. Women who enter treatment do not usually have any incidence of previous sexual or physical abuse.

18. Gender-specific treatment programming:

A. Is based upon the traditional male treatment model

B. Does not incorporate prevention and treatment services for children

C. Incorporates the relational model in treatment approaches

D. Focuses on substance use issues only

19. The treatment components for women in substance abuse treatment:

A. Focus solely on substance use

B. Has an authoritarian, confrontational underpinning

C. Incorporates life skills training

D. Approaches treatment from a multidisciplinary, multidimensional perspective

20. The use of group therapy in gender-specific substance abuse treatment:

A. Has proven to be fundamental when incorporated into the individual therapy approach

B. Was found to influence the retention of participants in treatment, thus potentially enhancing treatment effectiveness.

C. Is particularly suited to meet the complex needs of women in recovery

D. All of the above

Directions in Substance Abuse Counseling
Volume 6 Lesson 6

Problem Gambling: The Addiction of The New Millennium

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Introduction

A variety of terms have been used in gambling research literature to refer to the difficulties caused by an individual's gambling. Pathological gambling, a disease first recognized by the American Psychiatric Association, is defined as "a recurrent gambling behavior that disrupts all aspects of the gambler's life."[1] *The Diagnostic and Statistical Manual of Mental Disorders*, fourth Edition (DSM-IV),[1] suggests that persons meeting 5 or more of 10 criteria should be classified and treated as pathological gamblers (see Table 1). Alternatively, problem gambling refers to the behavior of individuals who meet fewer than 5 of the DSM-IV criteria. Problem gambling includes patterns of gambling behavior that compromise, disrupt, or damage personal, family, or vocational pursuits.

The objectives of this lesson are to provide the counselor with an understanding of the worldwide proliferation of legalized gambling, the nature and scope of problem and pathological gambling, and specific considerations in the diagnosis, treatment, and prevention of problem gambling. The intent is to make the counselor aware of problem gambling as an economic, social, occupational, and clinical phenomenon, which may coexist with other behavior disorders. The lesson also discusses resources for evaluation, treatment, and ongoing education regarding problem gambling.

The U.S. government has made a significant investment in the intensive study of gambling in recent years,[2,3] and this research constitutes the basis for this lesson. The authors of these studies consolidated and critically reviewed all earlier research that was available. Reading these studies in detail will enable counselors quickly to become familiar

Table 1
AMA CRITERIA FOR A DIAGNOSIS OF PATHOLOGICAL GAMBLING

1. Preoccupation with gambling (e.g., preoccupation with reliving past gambling experiences, handicapping or planning the next venture, or thinking of ways to get money with which to gamble)
2. A need to gamble with increasing amounts of money in order to achieve the desired excitement
3. Repeated unsuccessful efforts to control, cut back, or stop gambling
4. Restlessness or irritability when attempting to cut down or stop gambling
5. Gambling as a way of escaping from problems or of relieving a dysphoric mood (e.g., feelings of helplessness, guild, anxiety, depression)
6. Tendency, after loss of money through gambling, to return another day to get even ("chasing" one's losses)
7. Lies to family members, therapist, or others to conceal the extent of involvement with gambling
8. Commission of illegal acts such as forgery, fraud, theft, or embezzlement to finance gambling
9. Jeopardizing or loss of a significant relationship, job, or educational or career opportunity because of gambling
10. Reliance on others to provide money to relieve a desperate financial situation caused by gambling

with the best and latest information in this relatively immature field, in which a coherent program of scientific inquiry is just beginning to emerge.

The Proliferation of Legalized Gambling

According to the U.S. General Accounting Office,[2] approximately 86% of American adults have gambled sometime in their lives, and 63% report having gambled in the previous year. More people are gambling than ever before,[2] (GAO, 2000) and they are wagering more. In 1997, Americans collectively wagered more than $551 billion. **The estimated profits from legalized gambling totaled about $54.3 billion in 1998** (see Table 2). **In 1999, 48 of the 50 states had some form of legalized gambling; only Utah and Hawaii did not.** Casino-style games are available in 21 states, and 37 states have lotteries. One form of gambling (i.e., state and regional lotteries) is the only for-profit business actually owned by the government.

The expansion of gambling as taken many forms, including state lotteries, convenience gambling, land-based casinos, riverboat casinos, Native American tribal gambling, pari-mutuel wagering, simulcasting and account wagering, and sports wagering. Marketing, public policy, and regulation, or the lack thereof, all play important roles in this expansion. With the advent of new gambling technologies (especially Internet-based technologies), pathological gambling is likely to become even more widespread, and there is increased concern about the impact of both problem and pathological gambling.

Given this situation, a national response to this phenomenon was inevitable. In 1997, the National Gambling Impact Study Commission[3] was charged with conducting a comprehensive study of the social and economic implications of gambling in the United States. Spanning 3 years and costing $8 million, the study reflected the varied and conflicting views of commission members representing every conceivable constituency. It covered the expansion of gambling, regulation and the role of government, clinical manifestations of gambling behavior, Internet gambling, Native American tribal gambling, and the impact of gambling on communities. In this study, pathological gambling was defined as a chronic, progressive failure to resist impulses to gamble. In the United States alone,

Table 2
SOURCES OF $54.3 BILLION IN 1998 GAMBLING INDUSTRY GROSS REVENUE

Casino	41%
Lottery	31%
Tribal	15%
Pari-mutuel	7%
Bookmaking	6%

pathological gambling in this sense affects 1.8 million adults and 1.1 million adolescents in any given year. **Elderly people, poor people, persons in sensitive occupations** (i.e., persons working within the gambling industry) **and people with disabilities may have disproportionately higher rates of pathological gambling, but this has not been verified. Pathological gamblers are believed to be more likely to commit crimes, run up large debts, damage relationships with family and friends, engage in domestic violence and child abuse, and commit suicide.** However, there is no conclusive evidence on whether or not gambling actually causes increased social problems.[2] Tracking systems generally do not collect data on the causes of these incidents, and it is difficult to isolate the contribution of pathological gambling to these problems because such gambling is often accompanied by other behavior disorders.

Assessment

What is available today in the way of assessment and treatment approaches for pathological or problem gamblers? To some extent, one's assessment approach will be grounded in one's view about how disordered gambling behaviors are developed and maintained across the life span. Scientifically speaking, however, the onset and development of pathological gambling remain somewhat of a mystery. **Pathological gambling has been variously described as an impulse disorder, an addiction, a behavioral response to environmental cues, and a manifestation of reward deficiency syndrome. Problem or pathological gambling often appear to occur with other impairments such as substance abuse, mood disorders, and personality disorders.** The earlier one begins to gamble, the more likely one is to become a pathological gambler. Twin studies and recent neuroscience studies suggest that familial factors and the social environment may influence pathological gambling. An assortment of theorized gambling typologies are also available. These include action vs. escape seekers, levels of gambling (0–3), stage theories and other perspectives. The taxonomy from the Committee on Social Economic Impact of Pathological Gambling study[4] is helpful; a modified version of this taxonomy appears in Table 3.

Screening and assessment tools for pathological gambling include psychosocial history, psychometric measures, and biochemical indicators. Yet none of these is as important as a thorough understanding of established diagnostic criteria. As opposed to less excessive forms of gambling, pathological gambling is rather well understood. Clinicians and researchers rely heavily upon the diagnostic criteria listed in the DSM-IV (see Table 1). **In diagnosing pathological gambling, it is important to distinguish it from** (a) **social gambling, which occurs with friends and lasts for a limited period of time with predetermined acceptable losses;** (b) **professional gambling, in which risks are limited and discipline is central; and** (c) **manic episodes, in which gambling exemplifies the loss of judgment characteristic of mania in a person who does not gamble at other times.**

Pathological gambling has other associated features, though they do not rise to the level of diagnostic criteria. Affected individuals are described as competitive, energetic, restless, generous to the point of extravagance, work addicted, superstitious, overconfident, controlling, and power-seeking. They are said to lack insight and believe that money is both the cause and solution to all problems. Pathological gambling is frequently found to coexist with stress-related medical problems, mood disorders, attention-deficit/hyperactivity disorder, substance abuse, and specific personality disorders (antisocial, narcissistic, and borderline). Of individuals in treatment for pathological gambling, approximately 20% are reported to have attempted suicide.

Although the definition of pathological gambling is widely accepted, there is no consensus as to whether it should be classified as a dependent condition (an addiction) **or as a disorder of impulse control.** For the time being, it is classified as the latter, which, among other things, makes reimbursement for treatment of the condition difficult. The validity of treating pathological gambling as a primary disorder independent of other mental illness is the subject of considerable debate.

Diagnosis and assessment are much more "fuzzy" with respect to other levels of gambling severity. Not all gamblers are excessive in their behavior; not all exces-

Table 3
TYPES OF GAMBLING BEHAVIOR

Levels of Gambling Behavior	Characteristics
Pathological Gambling Level 3	Mental disorder characterized by a continuous or periodic loss of control over gambling, a preoccupation with gambling and with obtaining money with which to gamble, irrational thinking, and a continuation of the behavior despite adverse consequences. Meets at least 5 of the 10 DSM-IV criteria for compulsive gambling; referred to as compulsive gambling by lay persons or in the self-help treatment community.
Problem Gambling Level 2	Gambling behavior that results in harmful effects to the gambler, family, significant others, friends, coworkers, etc. Meets fewer than 5 of the 10 DSM-IV criteria.
Problematic, Excessive, or Intemperate Gambling	Refers to any amount of time or money spent gambling that exceeds an arbitrarily defined acceptable level.
Social, Recreational Gambling— Level 1	Gambling behavior for entertainment or social purposes with no harmful effects
0 Gambling	No gambling at all

Source: Modified from Committee on the Social and Economic Impact of Pathological Gambling. *Pathological Gambling: A Critical Review.* Washington, DC: National Academy Press; 1999: 20–21.

sive gamblers are compulsive or pathological in their behavior; and not all pathological gamblers are impaired in every life area. Cases of problem gambling, in which individuals meet fewer than 5 of the criteria for a diagnosis of pathological gambling, may involve "in-transition" gamblers who are moving either toward or away from pathological states.[5] They are not necessarily in an earlier stage of the disorder, because there is no empirical evidence that actual progression of the illness is linear.[6] In fact, "in-transition" gamblers may, alternatively, become pathological, move toward recovery with or without treatment, or languish in this state indefinitely.

Treatment Options

There are but a handful of controlled-outcome studies that address the treatment of pathological gambling. The lack of rigorous research is compounded by the lack of funding, which the federal government has only recently begun address. Two decades of substance abuse treatment have demonstrated that some treatment is better than none, but at this point in time there is no similar validation of the incremental value of treatment for pathological gambling. **Limited research suggests that pathological gamblers who seek treatment generally improve—but the lack of quality research in this field renders this a suggestion rather than a conclusion.** With respect to treatment, the impediments to self-referral, outreach, recruitment, and retention are simply not known. The extent to which treatment needs to be customized for women, adolescents, and persons of varying cultural groups is also not known. It is reasonable to expect that treatment should vary as a function of other patient characteristics as well, including the level of gambling involvement, etiology of the behavior, and presence or absence of coexisting disabilities. **Available treatment options include participation in Gamblers Anonymous, harm reduction,**

motivational enhancement interviewing, pharmacotherapy, aversive therapy, cognitive-behavioral therapy, and contingency management. In addition, similar to other addictive processes such as alcohol use, natural recovery without any treatment intervention (i.e., spontaneous recovery) has been noted to occur among problem and pathological gamblers. However, in the absence of comprehensive assessment tools, matching criteria to maximize the likelihood of placement into appropriate treatment settings, and a system of case management to guide patients through a continuum of available services, we are a long way from being able to match patients with effective treatments. Lack of insurance coverage, stigmatization, and/or the unavailability of treatment in most communities likely complicate the process of seeking treatments.

Given the state of the art of treatment validation for problem gambling, considerable controversy exists over what knowledge, skills, and expertise are required of counselors seeking to provide treatment for problem or pathological gamblers. No experienced counselor would be surprised to learn that a certification process exists; it is managed by the National Council on Problem Gambling. The requirements for National Gambling Counselor Certification include (a) 300 (contact) hours of counselor education, (b) 60 (contact) hours of gambling specific training, (c) a supervised counseling internship, and (d) 2000 hours of supervised experience with gambling clients and their families.

Recommendations for Government Action

The NGSIC[3] recommends that states and other government entities implement a number of measures to address the phenomenon of problem and pathological gambling before lotteries or any other form of legalized gambling be allowed to operate or to continue to operate. Such requirements should be specified in state statutes as applying to state-run lotteries and should also be specified and made applicable for inclusion in tribal government law and tribal-state compacts.

First, the NGSIC recommends that all relevant governmental gambling regulatory agencies require, as a condition of any gambling facility's license to operate, that each applicant:

1. Adopt a clear mission statement as to applicant's policy on problem and pathological gambling;
2. Appoint an executive of high rank to execute and provide ongoing oversight of the corporate mission statement on problem and pathological gambling;
3. Contract with a state-recognized gambling treatment professional to train management and staff to develop strategies for recognizing and addressing customers whose gambling behavior suggests they may be experiencing serious to severe difficulties;
4. Refuse service to any customer, under a state "hold harmless" statute, whose gambling behavior convincingly exhibits indications of a gambling disorder;
5. Provide, to any customer to whom service has been refused (as described above), written information that includes a state-approved list of professional gambling treatment programs and state-recognized self-help groups; and
6. Provide insurance that makes available medical treatment for problem or pathological gambling for facility employees.

In addition, the NGSIC suggests that each state and tribal government enact, if it has not already done so, a gambling privilege tax, assessment, or other contribution on all gambling operations within its boundaries, based upon the gambling revenues of each operation. A sufficient portion of such monies should be used to create a dedicated fund for the development and ongoing support of problem-gambling-specific research, prevention, education, and treatment programs. The funding dedicated for these purposes should be sufficient to implement the following goals:

1. To undertake biennial research by a nonpartisan firm experienced in problem gambling research to estimate the prevalence of problem and pathological gambling among the general

adult population. Specific focus on major subpopulations including youth, women, elderly, and minority group gamblers should also be included, as well as an estimate of prevalence among patrons at gambling facilities or outlets in each form of gambling.

2 To initiate public awareness, education, and prevention programs aimed at vulnerable populations. One such purpose of such programs will be to intercept the progression of many problem gamblers to pathological states.

3 To identify and maintain a list of gambling treatment services available from licensed or state-recognized professional providers, as well as the presence of state-recognized self-help groups.

4 To establish a demographic profile for treatment recipients and services provided, as state and federal laws permit; to develop a treatment outcome mechanism that will compile data on the efficacy of varying treatment methods and services offered; and to determine whether sufficient professional treatment is available to meet the demands of persons in need.

Pathological gambling is a recognized medical disorder, yet most insurance companies and managed care providers do not reimburse for treatment. The commission recommends to states that they mandate that private and public insurers and managed care providers identify successful treatment programs, educate participants about pathological gambling and treatment options, and cover the appropriate programs under their plans. In addition, each state-run or state-approved gambling operation should be required conspicuously to post and disseminate the telephone numbers of at least two state-approved providers of problem-gambling information, treatment, and referral support services. Each gambling facility must implement procedures to allow for voluntary self-exclusion, enabling gamblers to ban themselves from a gambling establishment for a specified period of time.

The NGSIC also endorses volunteer efforts by groups and associations across the United States to deal with problem gambling, especially efforts by practitioners to help problem gamblers. These efforts should include strategically pooling resources and networking, drawing on the lists of recommendations these organizations have presented to the commission, and working to develop uniform methods of diagnosis.

Over the past 25 years, the United States has been transformed from a nation in which legalized gambling was a limited and relatively rare phenomenon into one a nation in which this activity is common and growing. Today, the vast majority of Americans either gamble recreationally and experience few ill effects related to their gambling, or they choose not to gamble at all. Regrettably, some of them gamble in ways that harm themselves, their families and their communities. Pathological gambling has been recognized and classified by the American Psychiatric Association, yet, many individuals still continue to suffer from a condition that is commonly undiagnosed and untreated.

References

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

21. Which of the following groups is believed to experience disproportionately higher rates of pathological gambling than the general population?

A. Elderly people

B. People with disabilities

C. Pesons of lower socioeconomic status

D. All of the above

22. Which one of the following levels characterizes problem gambling?

A. 0

B. 2

C. 3

D. 1

23. With which of the following has pathological gambling been frequently found to coexist?

A. Substance abuse

B. Personality disorders

C. Mood disorders

D. All of the above

24. How is pathological gambling classafied in the DSM-IV?

A. Disorder of impulse control

B. Dependent condition

C. Mood disorder

D. Addiction

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