COUNSELOR WORKBOOK

A TRAINING MANUAL FOR
SUBSTANCE USE DISORDER COUNSELORS
4TH EDITION

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INTRODUCTION

This *Counselor Workbook* is intended for use by counselors working in U.S. Navy substance use disorder treatment programs. It was developed as an additional resource for counselors who are under the supervision of a clinical preceptor. While the objective of this Workbook is counselor skill and knowledge development, the primary focus is on the *Addiction Counseling Competencies* as outlined in the *Treatment Assistance Publication (TAP) 21,* published by the Substance Abuse and Mental Health Services Administration (SAMHSA). *TAP 21* organizes the knowledge, skills, and attitudes required for professional practice across four Transdisciplinary Foundations and eight Practice Dimensions. It was first written in 2011 and updated in 2016 under previous CPP contracts. As a product of the contracts, its content belongs to the U.S. Navy. This 2024 edition utilizes some of the 2011 and 2016 content, with updates befitting current best practices.
The format for the Workbook is as follows:

Part I: Before You Begin

Part I will review the subject matter and skills you studied and practiced while a student at the Navy Drug and Alcohol Counselor School (NDACS). Resources that you received at NDACS or that are available in the public domain that will be referred to throughout this book will be identified here.

Part II: Transdisciplinary Foundations

Part II will provide an overview of the Transdisciplinary Foundations listed in TAP 21. These topics will be discussed only briefly, based on an assumption that the student has some knowledge of these subjects. Suggestions for further reading and learning activities will be made. The learning activities are divided into activities for interns and advanced activities for more seasoned counselors. They will be notated as "Basic" or "Advanced" for each activity to alert counselors and preceptors to what activities may be appropriate for the level of development of the counselor.

Part III: Case Study and Practice Domains

Part III will provide detailed information and learning activities related to the eight Practice Domains. Individual chapters will cover the eight domains. These chapters use activities, assignments, and self-study questions to guide and maximize your learning. Counselors are encouraged to review all completed assignments with their preceptor.

Part IV: Supplemental Chapters

Part IV includes additional resources for further reading and exploration of special subject matters.

This Workbook also reflects the treatment delivery system being used in the Navy. This delivery system includes a continuum of substance use disorder care that reflects the Patient Placement Criteria developed by the American Society of Addiction Medicine (ASAM PPC). At the time of this writing, the third edition of the ASAM PPC was being followed per military instructions, although the 4th edition was released in November 2023. Readers are referred to any updates to military instructions that may modify approaches to treatment. Theories and clinical approaches consistent with the *VA/DoD Clinical Practice Guidelines for the Management of Substance Use Disorders (SUD)* will be explored. Content that goes beyond the scope of services offered by many Navy Substance Abuse Rehabilitation Programs (SARP) is presented for counselors preparing for reciprocal levels of certification with the International Certification & Reciprocity Consortium (IC&RC).

This Workbook is intended for use as a self-directed study guide in conjunction with guidance from a clinical preceptor. You are encouraged to use these activities as part of the Individual Development Plan (IDP) you develop with your preceptor. Your preceptor is a living resource for you to use in gaining competence in the functions and skills outlined here. Use this Workbook as a challenge to reach your maximum level of counselor skills.

PART I: BEFORE YOU BEGIN

Background

The Navy Drug and Alcohol Counselor School (NDACS) offers a highly structured clinical training program for active-duty Navy personnel who are seeking to become drug and alcohol counselors and to work in the Navy's Substance Abuse Rehabilitation Programs (SARPs). Upon completion of the school, counselor interns are assigned to duty at one of more than 50 Navy SARPs, where they will continue to grow and develop their skills as counselors. The Clinical Preceptorship Program provides ongoing training, mentoring, and clinical supervision to SARP counselors throughout their tenure at Navy programs. Following delivering a minimum of 2000 clinical hours, intern counselors may apply to be certified as an Alcohol and Drug Counselor Level I (ADCI). Advanced certification levels may be obtained following subsequent years of training and ongoing supervision.

The U.S. Navy Certification Board (USNCB) is a member of the International Certification & Reciprocity Consortium (IC&RC). As a member board, the Navy has agreed to follow certification standards that have been set by professionals across the profession of addiction treatment. Certification through the Navy board helps to ensure that counselors have obtained the knowledge, skills, and competencies that have been set as minimum standards of care by the profession.

Navy Drug and Alcohol Counselor Course of Study

This Workbook is written for use by the counselor who has completed the course of study at the NDACS. Therefore, there are some assumptions made regarding the knowledge base that a counselor intern and ADCI counselor bring to the practice and continued training as a counselor in a Navy SARP. At the time of this workbook update, NDACS is developing an extended curriculum which may expand the subjects covered during the program.

Subject matters that are studied in NDACS include the following:

1. The counseling domains of the alcohol and drug counselor
2. Navy Continuum of Care, ASAM PPC-3R, and DSM-5-TR diagnostic criteria
3. Twelve-Step (12-Step) programs
4. Principles of effective communication
5. Stress management
6. Theories of human development
7. Counseling theories and skills
8. Group dynamics and facilitation
9. Biopsychosocial and spiritual aspects of dependence
10. Family aspects
11. Cultural aspects to counseling
12. Sexuality, HIV/AIDS, and sexually transmitted diseases
13. Posttraumatic stress disorder and secondary trauma
14. Co-occurring disorders
15. Cross-addiction and compulsive gambling
16. Relapse prevention
17. Clinical writing and documentation
18. Professional development of substance use disorder counselors

Many of these subjects will be addressed again in this Workbook. You may find it helpful to refer to the materials you studied while in school. In addition, your preceptor may give you other reading and training materials to review.

Counseling Competencies

As part of SAMHSA's *Technical Assistance Publication (TAP)* Series, *TAP 21* outlines the knowledge, skills, and attitudes that define competency for substance use disorder counselors. The IC&RC and other credentialing bodies incorporate the competencies detailed in this document into their credentialing requirements. You will need to refer to the *TAP 21* frequently throughout this Workbook. The manual may be accessed at:
https://www.samhsa.gov/resource/ebp/tap-21-addiction-counseling-competencies-knowledge-skills-attitudes-professional

SAMHSA has a variety of other materials available on many special populations and treatment issues. Several manuals from the *Treatment Improvement Protocol (TIP)* series and the *TAP* series will be referred to in this Workbook. Most can be downloaded to your computer at no cost. You are encouraged to take advantage of this valuable resource as you build your professional library.

Certification Portfolio

Regardless of whether you will only spend a few years working as a counselor in the Navy or if you will pursue a counseling career when you leave active duty, it is valuable to maintain a professional development portfolio. Components of a portfolio include a list of credentialing requirements for your area of work, a place to document clinical supervision by a preceptor and/or other professionals, and evidence of ongoing training and education that you receive during your counseling career. You are encouraged to work with your preceptor to develop and maintain your portfolio.

PART II: TRANSDISCIPLINARY FOUNDATIONS

Chapter 1 Understanding Addiction

Purpose of This Chapter

This chapter provides the list of the *TAP 21* Competencies for Transdisciplinary Foundation #1: Understanding Addiction (*TAP 21*, 2006, p. 9–10). Each competency is listed, along with source material and suggestions of activities related to the competency. It is assumed that you will have some base knowledge in these areas after completing your NDACS schooling. You and your preceptor together can identify which competencies will require additional study for you to meet the standards for certification.

Competency 1

Understand a variety of models and theories of addiction and other problems related to substance use.

Knowledge

- Terms and concepts related to theory, etiology, research, and practice.
- Scientific and theoretical basis of models from medicine, psychology, sociology, religious studies, and other disciplines.
- Criteria and methods for evaluating models and theories.
- Appropriate applications of models.
- How to access addiction-related literature from multiple disciplines.

Attitudes

- Openness to information that may differ from personally held views.
- Appreciation of the complexity inherent in understanding addiction.
- Valuing diverse concepts, models, and theories.
- Willingness to form personal concepts through critical thinking.

Activities

1. Write a one-page essay on how strongly you support the treatment model used by the Navy SARP programs and why. Review with your preceptor. (Basic)
2. Write a dialogue of how you would respond to a patient who said, “I can control my drinking using will power.” Review with your preceptor. (Basic)

3. Role play with another counselor or your preceptor this scenario: What is alcoholism and what do I have to do to get better? Have your partner play a patient asking these questions. (Basic)

4. Prepare a presentation on one or two models or theories for the treatment of substance use disorders including a realistic patient case of how a SARP counselor would work with this patient according to the model or theory. Present to your preceptor and/or fellow counselors in a group supervision meeting. (Advanced)

5. Locate 2-3 peer-reviewed research articles from the past 5 years related to the complexity of treating substance use disorders and apply the research findings to the Navy SARP programs. Answer the questions, "How do these findings apply to Navy SARP programs? How are the Navy SARP programs addressing these findings? Are there ways that the SARP program could meet these emerging needs of patients?" Review with your preceptor. (Advanced)

Competency 2

Recognize the social, political, economic, and cultural context within which addiction and substance abuse exist, including risk and resiliency factors that characterize individuals and groups and their living environments.

Knowledge

- Basic concepts of social, political, economic, and cultural systems and their effect on drug-taking activity.
- The history of licit and illicit drug use.
- Research reports and other literature identifying risk and resiliency factors for substance use.
- Statistical information regarding the incidence and prevalence of substance use disorders (SUDs) in the general population and major demographic groups.
- *Attitudes*
- Recognition of the importance of contextual variables.
- Appreciation for differences between and within cultures.

Activities

1. Review the chapter on alcohol and illicit drug use in the most recent report: *Department of Defense Survey of Health Related Behaviors Among Active Duty Military Personnel*. It is available on the Internet. Discuss with your preceptor. (Basic)
    - Five things you were surprised to find in the survey.
    - Five things you need to learn more about to be prepared to meet the needs of your patients. Make a plan with your preceptor to gather more information.

2. Now that you have been working in the field for a time, what social, political, economic, and cultural factors do you see at your SARP and how have you been able to adapt your counseling to accommodate the varying needs of patients? What cultural strengths as well as barriers have you encountered? Discuss with your preceptor. (Advanced)

Competency 3

Describe the behavioral, psychological, physical health, and social effects of psychoactive substances on the person using and significant others.

Knowledge

- Fundamental concepts of pharmacological properties and effects of all psychoactive substances.
- The continuum of drug use, such as initiation, intoxication, harmful use, abuse, dependence, withdrawal, craving, relapse, and recovery.
- Behavioral, psychological, social, and health effects of psychoactive substances.
- The effects of chronic substance use on patients, significant others, and communities within a social, political, cultural, and economic context.
- The varying courses of addiction.
- The relationship between infectious diseases and substance use.

Attitudes

- Sensitivity to multiple influences in the developmental course of addiction.
- Interest in scientific research findings.

Activities

1. Prepare a slide presentation on SUDs using the six knowledge descriptors above as your basic outline. Your target audience is patients in treatment at a Navy SARP. Review the presentation with your preceptor. (Basic)
2. Research and consult with other clinic professionals to prepare a presentation on medications commonly used in treating SUDs at your SARP clinic as well as commonly occurring medical and other mental health conditions. Identify side effects, ability to abuse prescribed medications, medication mechanism of action in the body, and contraindications. Review the presentation with your preceptor and fellow counselors. (Advanced)

Competency 4

Recognize the potential for SUDs to mimic various medical and mental health conditions and the potential for medical and mental health conditions to coexist with addiction and substance abuse.

Knowledge

- Normal human growth and development.
- Symptoms of SUDs that are similar to those of other medical and/or mental health conditions and how these disorders interact.
- The medical and mental health conditions that most commonly exist with addiction and SUDs.
- Methods for differentiating SUDs from other medical or mental health conditions.

Attitudes

- Willingness to reserve judgment until completing a thorough clinical evaluation.
- Willingness to work with people who might display and/or have mental health conditions.
- Willingness to refer for treating conditions outside one's expertise.
- Appreciation of the contribution of multiple disciplines to the evaluation process.

Activities

1. Review your training materials and notes from NDACS. Prepare a list of questions and/or issues you would want to pursue in response to the following statements and review with your preceptor. (Basic)
    a. He doesn't have a drinking problem. It's normal for 20-year-olds to party.
    b. The patient just had a baby. It's normal to feel depressed after giving birth. It's all those hormones.
    c. The patient has chronic pain after injuring his back when the IED hit his vehicle in Iraq. He doesn't drink. We can't expect him to stop using his pain medication.
2. Now that you have been working in the field awhile, how has your perception changed regarding a.-c. in question 1? What challenges do you experience treating patients with these issues? How do you collaborate with other healthcare professionals to treat these patients? Discuss with your preceptor. (Advanced)

Resources

See the bibliography in *TAP 21* on pages 11–12.

NDACS training outlines and reading material.

SAMHSA publications on various addiction and treatment topics:
https://www.samhsa.gov/kap/resources

Chapter 2 Treatment Knowledge

Purpose of This Chapter

This chapter provides the list of the *TAP 21* Competencies for Transdisciplinary Foundation #2: Treatment Knowledge (*TAP 21*, 2006, p. 15–17). Each competency is listed, along with source material and suggestions of activities related to the competency. It is assumed that you will have some base knowledge in these areas after completing your NDACS schooling. You and your preceptor together can identify which competencies will require additional study for you to meet the standards for certification.

Competency 5

Describe the philosophies, practices, policies, and outcomes of the most generally accepted and scientifically supported models of treatment, recovery, relapse prevention, and continuing care for addiction and other substance-related problems.

Knowledge

- Generally accepted models, such as but not limited to:
- Pharmacotherapy,
- Mutual help and self-help,
- Behavioral self-control training,
- Mental health,
- Self-regulating community,
- Psychotherapeutic, and
- Relapse prevention.
- The philosophy, practices, policies, and outcomes of the most generally accepted therapeutic models.
- Alternative therapeutic models that demonstrate potential.

Attitudes

- Acceptance of the validity of a variety of approaches and models.
- Openness to new, evidence-based treatment approaches, including pharmacological interventions.

Activities

1. Download the *Quick Guide for Counselors Based on TIP 49* (see Resources). Identify which medications in this guide may be used by Navy physicians. Write out a scenario of how you would explain to a patient why you think they might benefit from taking the medication. (Basic)

2. Choose one of the models listed under Competency 5 that you would like to learn more about. Using reading materials you have or through online sources, prepare a 10-minute presentation you can give to your team on that model. (Basic & Advanced)

3. Create a case conceptualization based on a real patient using one of the models listed under Competency 5. Include the following in your case conceptualization: basic background of the patient, identified model(s) used to conceptualize the patient, how you would work with this patient based on the model in both individual and group counseling (as applicable), and anticipated outcomes for treatment. (Advanced)

Competency 6

Recognize the importance of family, social networks, and community systems in the treatment and recovery process.

Knowledge

- The role of family, social networks, and community systems as assets or obstacles in treatment and recovery processes.
- Methods for incorporating family and social dynamics in treatment and recovery processes.

Attitudes

- Appreciation for the significance and complementary nature of various systems in facilitating treatment and recovery.

Activities

1. Download *TIP 39: Substance Abuse Treatment and Family Therapy* (see Resources). Read the section on "Integrated Treatment: Benefits, Limitations, and Levels of Involvement with Families." Discuss with your preceptor the level of family involvement in your program and if anything more can or should be done for families. (Basic)
2. Act out a role play with your preceptor on talking with a patient about his plans for not drinking at his upcoming trip home on leave. (Basic & Advanced)
3. Act out a role play with your preceptor on talking with a patient's family member about substance use and family roles. (Advanced)

Competency 7

Understand the importance of research and outcome data and their application in clinical practice.

Knowledge

- Research methods in the social and behavioral sciences.
- Sources of research literature relevant to the prevention and treatment of addiction.

- Specific research on epidemiology, etiology, and treatment efficacy.
- Benefits and limitations of research.

Attitudes

- Recognition of the importance of scientific research to the delivery of addiction treatment.
- Openness to new information.

Activities

1. The National Institute on Drug Abuse (NIDA) and the Substance Abuse and Mental Health Administration (SAMHSA) teamed to form a Blending Initiative. The purpose of this initiative is to translate research information into material that is useful to treatment practitioners. Follow this link and explore the resources available: https://archives.nida.nih.gov/nidasamhsa-blending-initiative.
2. Addiction Technology Transfer Centers (ATTCs) are another resource that works to translate research into practical tools. Go to www.attcnetwork.org and look at the materials they have available. (Basic)
3. Sign up for at least one research email notification system to stay current on the latest research. (Basic)
4. Locate and read 1-2 recent (past 5 years) research articles on addiction treatment and present the findings, including limitations of the research, from the articles to your preceptor and/or fellow counselors. (Advanced)

Competency 8

Understand the value of an interdisciplinary approach to addiction treatment.

Knowledge

- Roles and contributions of multiple disciplines to treatment efficacy.
- Terms and concepts necessary to communicate effectively across disciplines.
- The importance of communication with other disciplines.

Attitudes

- Desire to collaborate.
- Respect for the contribution of multiple disciplines to the recovery process.
- Commitment to professionalism.

Activities

1. Make a list of the members of the interdisciplinary team at your SARP. Include three attributes' members of that discipline bring to patient care. If you do not know what they can offer, find out by meeting with that team member. Review with your preceptor. (Basic)
2. While sitting in a team meeting, keep track of acronyms or terms used by members of other disciplines with which you are not familiar. Find out what those terms mean through researching professional literature or by speaking with that team member. (Basic)
3. Now that you have been working at your SARP for a while, reflect on how your SARP integrates into the greater Navy medical center at your site. Discuss with your preceptor your reflections and how SARP can/does work collaboratively with your interdisciplinary team as well as the greater Navy medical center at your site. (Advanced)

Resources

See the bibliography in *TAP 21* on page 17.

NDACS training outlines and reading material.

AA Big Book: https://www.aa.org/the-big-book

Twelve Steps and Twelve Traditions:
https://www.aa.org/twelve-steps-twelve-traditions

CSAT (2009) *Quick Guide for Counselors: Based on Treatment Improvement Protocol 49: Incorporating Alcohol Pharmacotherapies Into Medical Practice.*
https://store.samhsa.gov/product/Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA10-4542

CSAT (2004) *Treatment Improvement Protocol 39: Substance Abuse Treatment and Family Therapy.* https://store.samhsa.gov/product/treatment-improvement-protocol-tip-39-substance-use-disorder-treatment-and-family-therapy/PEP20-02-02-012

Chapter 3 Application to Practice

Purpose of This Chapter

This chapter provides the list of the *TAP 21* Competencies for Transdisciplinary Foundation #3: Application to Practice (*TAP 21*, 2006, p. 18–26). Each competency is listed, along with source material and suggestions of activities related to the competency. It is assumed that you will have some base knowledge in these areas after completing your NDACS schooling. You and your preceptor together can identify which competencies will require additional study for you to meet standards for certification.

Competency 9

Understand the established diagnostic criteria for substance use disorders and describe treatment modalities and placement criteria within the continuum of care.

Knowledge

- Established diagnostic criteria, including but not limited to current *Diagnostic and Statistical Manual of Mental Disorders (DSM)* standards and current *International Classification of Diseases (ICD)* standards.
- Established placement criteria developed by various states and professional organizations.
- Strengths and limitations of various diagnostic and placement criteria.
- Continuum of treatment services and activities.

Attitudes

- Openness to various treatment services based on patient need.
- Recognition of the value of research findings.

Activities

1. Review the current *DSM* diagnostic criteria for SUDs. Write a list of questions you continue to have regarding the criteria. Are you ready to apply them with a patient? Review with your preceptor. (Basic) If you have been working in the field awhile, what are the most common diagnoses you see at your SARP? What diagnostic challenges do you still encounter? Which diagnoses are you more comfortable with or less comfortable with applying to patients? Review with your preceptor. (Advanced)
2. After you have completed three screenings at your new assignment, look again at the *DSM* diagnostic criteria. Consider the average age of your treatment population. Do you see any limitations to these criteria? Discuss with your preceptor. (Basic) If you have been working in the field awhile, what limitations have you noticed over time at your SARP? How have you navigated these limitations? Discuss with your preceptor. (Advanced)

3. Review the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC-3R; see Part III, Chapter 2, Assessment). Write a list of questions you have regarding the criteria. Are you ready to apply them with a patient? Review your questions with your preceptor. (Basic) If you have been in the field awhile, what challenges do you experience when applying the ASAM Criteria? What questions do you have applying the ASAM Criteria to your patients? Discuss with your preceptor. (Advanced)

Competency 10

Describe various helping strategies for reducing the negative effects of substance use, abuse, and dependence.

Knowledge

- Various helping strategies, including but not limited to:
  - Evaluation methods and tools,
  - Stage-appropriate interventions,
  - Motivational interviewing,
  - Involvement of family and significant others,
  - Mutual-help and self-help programs,
  - Coerced and voluntary care models, and
  - Brief and longer term interventions.

Attitudes

- Openness to various approaches to recovery.
- Appreciation that different approaches work for different people.

Activities

1. Take the list of helping strategies listed above. Brainstorm a list of every strategy you know under each category. For example, what assessment tools did you learn to use in NDACS? Write down your list. Are you surprised at all you have learned? Are there some areas in which you could identify very few or no strategies? Identify which chapters under Part III, Case Study and Practice Domains, will help you learn more. Review with your preceptor. (Basic) If you have been working in the field for a while, review helping strategies with your preceptor that you would like to or need to develop further. (Advanced)

2. Act out a role play with your preceptor using motivational interviewing techniques with a patient who is ambivalent about entering into treatment. (Advanced)

Competency 11

Tailor helping strategies and treatment modalities to the patient's stage of dependence, change, or recovery.

Knowledge

- Strategies appropriate to the various stages of dependence, change, and recovery.

Attitudes

- Flexibility in choice of treatment modalities.
- Respect for the patient's racial, cultural, economic, and sociopolitical backgrounds.

Activities

1. Look at the class schedule at your SARP, or the SARP where you send patients to treatment. Identify which classes seem to be most appropriate for patients in the Precontemplation, Contemplation, and Action stages of change. (Basic) Look at your caseload of current patients and identify which stage of change each patient is currently in and identify strategies that may help them in that stage. Discuss with your preceptor. (Advanced)
2. Consider you screen a patient who had an alcohol-related incident 6 months ago and is just now being screened. Somewhere in changing duty stations, his paperwork was lost and has just now caught up with him. Based on the history he reports, you would likely have recommended treatment for him right after the incident occurred. Since then, he reports he has stopped drinking on his own and that his life is stable across all ASAM dimensions. What can you offer this patient? Should you offer him anything? How will you diagnose him? What options do you have in the Navy system? (Basic)

Competency 12

Provide treatment services appropriate to the personal and cultural identity and language of the patient.

Knowledge

- Various cultural norms, values, beliefs, and behaviors.
- Cultural differences in verbal and nonverbal communication.
- Resources to develop individualized treatment plans.

Attitudes

- Respect for individual differences within cultures.
- Respect for differences between cultures.

Activities

1. Look through the literature available for patients at your SARP. Does it reflect different cultures? Would people of various cultural backgrounds find your waiting room a welcoming place? (Basic)
2. Review the materials you received at NDACS on various cultures. Which cultures do you think you need to learn more about? Check the SAMHSA website to see what additional information you can find. Discuss with your preceptor. (Basic)
3. Now that you have been working in the profession for a while, what cultural patterns have you noticed at your SARP regarding the cultural backgrounds of patients as well as the cultural environment at your SARP? What challenges have you had working with patients at your SARP from different cultural backgrounds? How did you handle those challenges? If you had it to do over again, how would you handle it differently? Discuss with your preceptor. (Advanced)

Competency 13

Adapt practice to the range of treatment settings and modalities.

Knowledge

- The strengths and limitations of available treatment settings and modalities.
- How to access and make referrals to available treatment settings and modalities.

Attitudes

- Flexibility and creativity in practice application.

Activities

1. Think about what you now know about the Navy treatment model. What would you do if you thought a patient's needs could not be adequately met by the Navy? Are there other options? If you had to refer a patient to a civilian provider, what would you want that provider to know about the Navy and your patient to make an adequate referral? (Basic)
2. Think about a recent patient that you screened or treated where you felt their needs were not adequately met by the Navy. Discuss and brainstorm with your preceptor how that patient's needs could have been handled differently by the Navy and/or referred to additional support outside the Navy. (Advanced)

Competency 14

Be familiar with medical and pharmacological resources in the treatment of SUDs.

Knowledge

- Current literature regarding medical and pharmacological interventions.
- Assets and liabilities of medical and pharmacological interventions.
- Health practitioners in the community who are knowledgeable about addiction and addiction treatment.
- The role that medical problems and complications can play in the intervention and treatment of addiction.

Attitudes

- Open and flexible with respect to the potential risks and benefits of pharmacotherapies to the treatment and recovery process.

Activities

1. Return to the *Quick Guide for Counselors for TIP 49* that you downloaded for Competency 5. Read the guide and write a list of at least three questions you have regarding the use of medication in substance abuse treatment. Discuss with your preceptor. (Basic)
2. Return to your NDACS material on medical consequences of substance use. Identify two medical conditions you would like to learn more about. Discuss research strategies with your preceptor and your findings. (Basic) Create a presentation to share your findings with your SARP colleagues. (Advanced)
3. Act out a role play with your preceptor where you explain risks and benefits of pharmacotherapies or medical consequences of substance use to a patient. (Advanced)

Competency 15

Understand various insurance and health maintenance options available and the importance of helping patients access those benefits.

Knowledge

- Existing public and private payment plans, including treatment orientation and coverage options.
- Methods for gaining access to available payment plans.
- Policies and procedures used by available payment plans.
- Key personnel, roles, and positions within plans used by the patient population.

Attitudes

- Willingness to cooperate with payment providers.
- Willingness to explore treatment alternatives.
- Interest in promoting the most cost-effective, high-quality care.

Activities

1. Contact a counselor in your local treatment community (your preceptor can help you find someone) and discuss what role they play in discussing payment plans and insurance with their patients and how insurance reimbursement influences counselors' jobs. (Basic)
2. Create a resource guide of available community providers/resources in your area that patients may access or be referred to. Include eligibility criteria for accessing the resources (including if insurance is accepted) and if there is a financial cost for using them. (Basic & Advanced)

Competency 16

Recognize that a crisis may indicate an underlying SUD and may be a window of opportunity for change.

Knowledge

- The features of crisis, which may include but are not limited to:
  - Family disruption,
  - Social and legal consequences,
  - Physical and psychological,
  - Panic states, and/or
  - Physical dysfunction.
- Substance use screening and assessment methods.
- Prevention and intervention principles and methods.
- Principles of crisis care management.
- Posttraumatic stress characteristics.
- Critical incident debriefing methods.
- Available resources for assistance in the management of crisis situations.

Attitudes

- Willingness to respond and follow through in crisis situations.

- Willingness to consult when necessary.

Activities

1. Download *Treatment Improvement Protocol 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment* (CSAT, 2009). https://store.samhsa.gov/product/TIP-50-Addressing-Suicidal-Thoughts-and-Behaviors-in-Substance-Abuse-Treatment/SMA15-4381
   Read the list of *Ten Points to Keep You on Track* on pages 6–7 of *TIP 50*. Discuss with your preceptor. (Basic)
2. Write a list of three other things, besides suicide ideation, which might constitute a crisis during a patient's treatment. Make a list of questions you need to answer to deal with these issues, such as what you need to know, how might it affect the course of treatment, what options are available to deal with the crisis, what other disciplines do you need to consult. (Basic)
3. Review a case scenario with your preceptor involving suicidal ideation and any other crises situations identified in question 2. Discuss with your preceptor how you would handle each scenario. If you have already encountered any of these crisis situations, reflect on how you handled it when it occurred and what you would do differently in the future. (Advanced)

Competency 17

Understand the need for and the use of methods for measuring treatment outcome.

Knowledge

- Treatment outcome research literature.
- Scientific process in applied research.
- Appropriate measures of outcome.
- Methods for measuring the multiple variables of treatment outcome.

Attitudes

- Recognition of the importance of collecting and reporting on outcome data.
- Interest in integrating research findings into ongoing treatment design.

Activities

1. Review SAMHSA's *TIP 46, Substance Abuse: Administrative Issues in Outpatient Treatment that* provides extensive information on outcomes monitoring in Chapter 6 (CSAT, 2006). The document can be ordered on the SAMHSA website or retrieved electronically at http://www.ncbi.nlm.nih.gov/books/NBK25680. (Basic)

2. Find out if your site is collecting any outcome data. If so, how is the data being used? Schedule a team meeting to discuss how you might modify services in response to the data. (Advanced)

Resources

See the bibliography in *TAP 21* on pages 25–26.

NDACS training outlines and reading material.

Diagnostic and Statistical Manual of Mental Disorders (DSM)

International Classification of Disorders (ICD) manual

Center for Substance Abuse Treatment. *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series 50. DHHS Publication No. (SMA) 09-4381. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009.

Chapter 4 Professional Readiness

Purpose of This Chapter

This chapter provides the list of the *TAP 21* Competencies for Transdisciplinary Foundation #4: Professional Readiness (CSAT, 2006, p. 27–34). Each competency is listed, along with source material and suggestions of activities related to the competency. It is assumed that you will have some base knowledge in these areas after completing your NDACS training. You and your preceptor together can identify which competencies will require additional study for you to meet the standards for certification.

Competency 18

Understand diverse cultures, and incorporate the relevant needs of culturally diverse groups, as well as people with disabilities, into clinical practice.

Knowledge

- Information and resources regarding racial and ethnic cultures, lifestyles, gender, and age as well as relevant needs of people with disabilities.
- The unique influence the patient's culture, lifestyle, gender, and other relevant factors may have on behavior.
- The relationship between substance use and diverse cultures, values, and lifestyles.
- Assessment and intervention methods that are appropriate to culture and gender.
- Counseling methods relevant to the needs of culturally diverse groups and people with disabilities.
- The Americans with Disabilities Act and other legislation related to human, civil, and patients' rights.

Attitudes

- Willingness to explore and identify one's own cultural values.
- Acceptance of other cultural values as valid for other individuals.

Activities

1. **Supplemental Chapter 7** offers three questionnaires, developed by Peter Bell, which assess attitudes regarding culture, ethnicity, and diversity. Complete one or more of these questionnaires. Discuss your professional and personal development in cultural competency with your preceptor. Map out a course for additional training on your IDP. (Basic & Advanced)
2. Using available search engines, develop a list of federal statutes of which you need to be aware to provide treatment in a manner that protects the rights of all individuals. Review the list with your preceptor. (Basic)

3. Review the list of Harvard tests regarding cultural competence at the link below. Take several tests and review your results. Focus on populations you may not be familiar with or that you find challenging. Review your results with your preceptor and add goals to your IDP for any growth areas needed. (Advanced)
   https://implicit.harvard.edu/implicit/takeatouchtestv2.html

Competency 19

Understand the importance of self-awareness in one's personal, professional, and cultural life.

Knowledge

- Personal and professional strengths and limitations.
- Cultural, ethnic, or gender biases.

Attitudes

- Openness to constructive supervision.
- Willingness to grow and change personally and professionally.

Activities

1. Ask your SARP director or preceptor to show you the report that was completed on your training at NDACS. Discuss the strengths and weaknesses identified on that evaluation with your preceptor, where you are today in those areas, and what areas need further attention. (Basic) If you have been in the field for a while, reflect on how far you have come in your skill development and discuss with your preceptor where you are today with your skills, strengths, and further growth areas. Create a plan with your preceptor for addressing growth areas. (Advanced)
2. Read the article *Tips to navigate workload and prevent burnout* at https://ct.counseling.org/2022/12/tips-to-navigate-workload-and-prevent-burnout/. Choose one new self-care activity and track your use for a month. (Basic)
3. The Professional Quality of Life (ProQOL) is a quality of life test designed to measure the negative and positive effects of helping others who have experienced trauma. It includes sub-scales for compassion satisfaction, burnout, and secondary traumatic stress. https://proqol.org/proqol-measure. Complete the test and discuss your results with your preceptor. (Advanced)

Competency 20

Understand the addiction professional's obligations to adhere to ethical and behavioral standards of conduct in the helping relationship.

Knowledge

- The features of crisis, which may include but are not limited to:
  - Family disruption,
  - Social and legal consequences,
  - Physical and psychological panic states, and/or
  - Physical dysfunction.
- Substance use screening and assessment methods.
- Intervention principles and methods.
- Principles of crisis case management.
- Posttraumatic stress characteristics.
- Critical incident debriefing methods.
- Available resources for assistance in managing crisis situations.

Attitudes

- Willingness to conduct oneself in accordance with the highest ethical standards.
- Willingness to comply with regulatory and professional expectations.

Activities

1. Review the ethical standards of alcohol and drug counselors you received at NDACS. Answer the following questions and discuss with your preceptor. (Basic)
   a. Is there anything in this list of ethical standards that surprised you?
   b. In your class on ethics at NDACS, what did you learn that was new?
   c. Have you faced any ethical dilemmas so far in your counselor role? If so, did you seek supervision?
2. Develop a logbook of ethical questions. For 1 month, jot down any questions on ethics that come up and share these with your preceptor in supervision. Consider continuing the use of the log as a method of tracking supervision and training on ethics. (Basic & Advanced)
3. Reflect on your time working at your SARP as well as any previous SARPs and identify 2-3 ethical dilemmas that you have experienced. Discuss with your preceptor how you handled those situations, what you learned, what you would've done differently, and how you would handle a similar situation in the future. (Advanced)

Competency 21

Understand the importance of ongoing supervision and continuing education in the delivery of patient services.

Knowledge

- Benefits of self-assessment and clinical supervision to professional growth and development.
- The value of consultation to enhance personal and professional growth.
- Resources available for continuing education.
- Supervision principles and methods.

Attitudes

- Commitment to continuing professional education.
- Willingness to engage in a supervisory relationship.

Activities

1. Write a few paragraphs or a list of bullets answering the following questions. Then review them with your preceptor. (Basic & Advanced)
    a. What was I told to expect from supervision/Preceptorship while at NDACS?
    b. What has been my experience with supervision/Preceptorship so far?
    c. What would I like to be different in supervision/Preceptorship?
    d. How would I like to engage in supervision/Preceptorship going forward?
    e. Benefits and challenges of supervision/Preceptorship that I've experienced.

Competency 22

Understand the obligation of the addiction professional to participate in prevention and treatment activities.

Knowledge

- Research-based prevention models and strategies.
- The relationship between prevention and treatment.
- Environmental strategies and prevention campaigns.
- Benefits of working with community coalitions.

Attitudes

- Appreciation of the inherent value of prevention.
- Openness to research-based prevention strategies.

Activities

1. Meet with your SARP director or department head and discuss what role SARP counselors play in prevention at your location. Discuss how prepared you are to participate at that level. Identify what additional knowledge/skills you will need. Ask your preceptor to include those on your IDP when appropriate. (Basic)

2. Over your time in SARP, how has prevention been conducted? What has your role in prevention been over time? Are there any additional skills you still need to develop further around prevention? Discuss with your preceptor and update your IDP with any skills needing further development. (Advanced)

Competency 23

Understand and apply setting-specific policies and procedures for handling crisis or dangerous situations, including safety measures for patients and staff.

Knowledge

- Setting-specific policies and procedures.
- What constitutes a crisis or danger to the patient and/or others.
- The range of appropriate responses to a crisis or dangerous situation.
- Universal precautions.
- Legal implications of crisis response.
- Exceptions to confidentiality rules in crisis or dangerous situations.

Attitudes

- Understanding of the potential seriousness of crisis situations.
- Awareness of the need for caution and self-control in the face of crisis or danger.
- Willingness to request help in potentially dangerous situations.

Activities

1. Read Competency 86, Crisis Intervention, Part III, Chapter 8, and complete the related activities. Review this material with your preceptor. (Basic & Advanced)

2. Make a list of crisis events in your life. Consider the event and the strengths and weaknesses you demonstrated in responding to the crisis. Discuss your preparation to deal with a crisis in your role as an alcohol and drug counselor with your preceptor. If needed, add activities to your IDP to strengthen your preparedness. (Basic & Advanced)

Resources

See the bibliography in TAP 21 on pages 32-34.; NDACS training outlines and reading material; Corey, M.S. & Corey, G. (2020). *Becoming a Helper* (8th ed.). Boston, MA: Cengage Learning.

PART III: CASE STUDY AND PRACTICE DOMAINS

Chapter 1 Clinical Evaluation: Screening

Purpose of This Chapter

This chapter reviews the Practice Dimension of Clinical Evaluation by focusing on its first component: screening.

The learning objectives directly correlate with Competencies 24–32, as listed in the *TAP 21* (pages 39–44) and IC&RC Domain II: Evidence-Based Screening and Assessment. Each competency is accompanied by a set of knowledge, skills, and attitudes that define the standard.

Learning Objectives

- Establish rapport, including management of a crisis situation and determination of need for additional professional assistance. (24)
- Gather data systematically from the patient and other available collateral sources, using screening instruments and other methods that are sensitive to age, developmental level, culture, and gender. (25)
- Screen for psychoactive substance toxicity, intoxication, and withdrawal symptoms; aggression or danger to others; potential for self-inflicted harm or suicide; and co-occurring mental disorders. (26)
- Assist the patient in identifying the effect of substance use on their current life problems and the effects of continued harmful use or abuse. (27)
- Determine the patient's readiness for treatment and change as well as the needs of others involved in the current situation. (28)
- Review the treatment options that are appropriate for the patient's needs, characteristics, goals, and financial resources. (29)
- Apply accepted criteria for diagnosis of SUDs in making treatment recommendations. (30)
- Construct with the patient and appropriate others an initial action plan based on patient needs, patient preferences, and resources available. (31)
- Based on the initial action plan, take specific steps to initiate an admission or referral and ensure follow-through. (32)

Introduction

Screening is defined by *TAP 21* as the "process through which counselor, patient, and available significant others review the current situation, symptoms, and other available information to

determine the most appropriate initial course of action, given the patient's needs and characteristics and the available resources within the community" (CSAT, 2006, p. 39).

The screening process includes determining whether a patient has a SUD and, if so, the extent and severity of the patient's disorder. The screening function requires the counselor to interview the patient and consider many factors before recommending the patient for admission to treatment at the appropriate level of care. The screening process is also a time for the counselor to orient the patient to the screening and assessment process. It is important for the counselor to describe the screening process to the patient and help the patient understand what will happen during the screening process.

The screening process itself may not be very time-consuming. Screening can be viewed as a brief process of gathering information, determining the patient's readiness for treatment, determining eligibility for treatment, recommending appropriate treatment options, and initiating the process of admission or referral to another program.

Screening is often the first face-to-face encounter the counselor has with the patient; therefore, it is important that the counselor takes a welcoming stance, establishes rapport, and responds to the patient with an understanding of their readiness for treatment and change. It is important that the counselor be sensitive to the patient's potential anxiety and discomfort while maintaining an awareness of how intimidating standard screening procedures may seem to many patients, particularly patients who have never engaged with behavioral health in the past.

As previously mentioned, screening is the point at which the counselor begins the process of gathering information. This also includes documenting information about the patient on various forms. It is very important that the counselor maintain eye contact, conduct the screening as a two-way conversation, and avoid merely asking questions and documenting answers. A counselor sitting behind a desk reviewing and writing on a screening form may not only be intimidating to the patient, but also can be a hindrance to the counseling process. The counselor must know the kind of information that is relevant, how to ask questions to elicit the important information, and how to record the information to benefit the patient and other treatment staff.

Since each patient brings their own variables, it is recommended that the counselor adopt a systematic approach for the screening interview to ensure that consistent data are gathered from each patient screened. There are a number of instruments and questionnaires available to professionals in the alcohol and drug field. It is important that the counselor know and understand the eligibility criteria for services offered in their treatment program as well as those at available referral resources.

THE INTRODUCTION OF RYAN: A CASE STUDY

Ryan is a 25-year-old E-4 corpsman assigned to the base medical clinic. He was referred to the SARP following his arrest for a DUI. He was initially reluctant to keep his appointment at the SARP and expressed his concern over what such a step may mean regarding his future career in the Navy. He has been in the Navy for 7 years, always receives positive fitness reports, and enjoys his work as a corpsman. He has shared with you that he would like to stay in the medical field and is interested in completing his bachelor's degree and then going on to nursing school. He is married, has no children, but is close with his wife's family who live nearby. This includes her parents and her older brother, who is married and has three children. He considers his brother-in-law to be his best friend. He and his wife are very close to her family. Since his brother-in-law is currently deployed (he is also in the Navy), he has become a father figure to the children, especially to his 7-year-old nephew.

Building Rapport (24)

Understanding the importance of building rapport is a key factor in the screening process. At the initial contact with a counselor, the patient may experience a variety of feelings and emotions, including intimidation, shame, and fear. The counselor must maintain and display understanding of the patient's emotional state. Rapport building begins from the first contact that the patient has with the behavioral health clinic. It is important for counselors to be mindful of the way they answer the phone, how patients are scheduled for appointments, the waiting room environment, and how the patients are greeted when they arrive for initial appointments.

How the counselor develops rapport with the patient will set the tone for the remainder of the patient's experience in treatment. The patient's contact with the counselor during screening may be their first attempt to seek help or, at the very least, the first opportunity for the counselor to provide some needed emotional support and guidance.

The manner in which the counselor approaches the patient will go a long way toward how much information the counselor derives from the interview. It is during the screening interview that the counselor can make the first impression that will dictate how the patient views the treatment process in the future. Building rapport with the patient is paramount to developing a relationship of trust that will allow ease in the exchange of important information. The following techniques blended in your interviewing style will encourage and empower the patient.

Eye contact: If the interview is a person-to-person meeting, look the patient in the eye and maintain eye contact. For many people, this establishes a sense of interest and concern. However, there are some cultures that have different customs about eye contact; be aware of these differences to prevent offending the patient or having your eye contact misunderstood. Typing on a computer and/or

Can you think of any words or terms that, when interpreted by some patients, might be offensive to them?

taking notes can impede a counselor's ability to maintain eye contact. When typing or taking notes during a screening, the counselor should begin the screening interview with an orientation of what will happen during the screening and discuss informed consent documents without taking notes in order to maintain eye contact and ensure the patient is comfortable before initiating notetaking.

Cultural consideration: Cultural consideration and knowledge of your patient's background are important. When woven throughout the fabric of all the skills in the interviewing process, this element can help develop a trust-building relationship in a subtle way. Knowledge and understanding of a patient's ethnic, racial, and identified culture, as well as the understanding of perceived gains experienced by using alcohol or drugs, should be part of the counselor's awareness of the patient.

Gender difference: Gender issues have significant impact on patients. How a patient identifies their gender has implications related to their experiences of stigma, discrimination, community, mental health, and substance use. Sensitivity to the needs of female patients, patients who identify as non-traditional gender identities (i.e., nonbinary, gender fluid, gender neutral, bigender, etc.), and transgender patients and the specific problems that they may encounter is important. Awareness of cross-gender relationships between male counselors and female patients is also an area of concern. Typically women, nontraditional gender identities, and transgender patients have been victims of ridicule and stigmatization because of behavior associated with alcohol and drug misuse. Consideration of this fact can facilitate the development of a more secure and productive relationship.

What are some unspoken cues the counselor may communicate?

Verbal language: Know what is appropriate and acceptable to say to the patient. Language is a fluid matter and does not always mean the same thing for each of us. Counselors must be sensitive to language they use with patients. Counselors should also avoid using language wrought with clinical jargon or vocabulary that may not be understandable to the patient.

Body language: A counselor's awareness of their physical presentation to the patient is important. It is critical that the counselor senses and monitors any unspoken cues. A counselor's body posture and facial expressions communicate nonverbal messages to the patient and need constant monitoring to ensure appropriate communication is occurring.

Confidentiality/disclosure: Informing the patient of the counselor's requirements for confidentiality and disclosure is best handled in the early stage of the relationship and is part of the informed consent process. Other components of informed consent include reviewing paperwork that the patient signs with the patient to ensure understanding. Providing the patient with an overview of the counseling process, patient-counselor relationship boundaries, purpose and process of the screening, and confidentiality are some of the items that should be covered during the informed consent process that begins during the first session with a patient. Understanding the requirements

and limits of confidentiality eliminates the potential misunderstanding of what is and is not privileged information.

As the counselor gathers information in the interview process, it would benefit both patient and counselor to describe the chain of information. Tell the patient the purpose for gathering the information, to whom and where it will go, and how it will be used.

CASE STUDY 1.1

How would you begin to establish rapport upon meeting a client such as Ryan for the first time?

Motivational Interviewing

Understanding and using the basic concepts of Motivational Interviewing (MI) will greatly assist the counselor in the screening process, rapport building process, and helping motivate the patient to engage in treatment. MI considers the stage of change (precontemplation, contemplation, preparation, action, maintenance, relapse) that the patient is currently in and attempts to motivate the patient to move to the next stage of change. Miller and Rollnick (2013) present the basic principles of MI with the acronym "OARS." The four components of OARS are as follows:

Open-ended questions. The point of open-ended questions is that they are not answered with a brief reply or a "yes" or "no" reply; therefore, the patient is encouraged to do most of the talking. Examples of open-ended questions are: "Tell me about your alcohol use," "Describe what it was like growing up in your house as a child," or "How have you tried to stop or cut down on your substance use?" During the early phase of an interview, it is important for the counselor to establish an atmosphere of acceptance and trust in which the patient will explore their problems. The counselor should listen, and the patient should talk. Open-ended questions unlock the door for the patient to explore. How the counselor responds to the patient's initial answers will influence what happens.

Affirm the patient. It can be helpful for the patient to hear support by means of verbal affirmation. Reflective listening can be affirming, but direct affirmation by means of positive statements and feedback has a place in counseling. Affirmation can be in the form of compliments and statements of appreciation and understanding, such as "I appreciate you coming in today," "That must have been an incredibly difficult situation to experience," or "It sounds like you are very resourceful."

Reflective listening. When the counselor listens to what the patient says, there is a point at which the counselor considers what the patient means and chooses the most likely interpretation of the statement. With reflective listening, the counselor includes the realization that what they believe or assume people mean is not necessarily what the patient means. Reflective listening is a way for the counselor to check, rather than to assume, that they know what is meant. Reflective listening involves making a statement that is a guess about what the person means such as, "It sounds like you were disappointed," "On the one hand you want to stop drinking and on the other hand, you only

spend time with other people that drink alcohol," or "You're feeling anxious about your upcoming birthday party and wondering if you can maintain sobriety."

Summarization. Periodic summaries can link together and reinforce what has been said during the counseling interview. Summary statements can show that the counselor has been listening carefully and prepare the patient to move on. They allow a patient to hear their own motivational statements and are helpful to use at the end of a session to reinforce the important parts of the session for the patient to remember. Summaries can be helpful in expressing a patient's ambivalence. A summary is one way to allow a person to examine the positives and negatives simultaneously. For example, "We've talked today about your pattern of alcohol use and how it has significantly increased in the past 3 months after your relationship split. You've tried cutting back and stopping on your own but haven't been able to stop drinking for more than 2 days at a time, so you are motivated now to seek help outside of yourself to see if you can stop as you've recognized some negative consequences recently related to your alcohol use."

By adopting the MI approach into a personal counseling-style therapeutic frame of reference, the counselor takes another step in the effort to build rapport and trust with the patient. Note also that MI is not a psychotherapeutic theory; it is an approach that can be used with any theory. As with any technique or change, it is important to practice and become familiar with the use of MI to be comfortable with the changes yourself. More techniques and principles for motivating patients toward change are introduced in subsequent chapters. The counselor should read Miller and Rollnick (2013) for more in-depth information about these techniques and the rationale behind using them.

CASE STUDY 1.2

In your interview with Ryan, you sensed some initial tension on his part, but found that by attempting to form a connection with him, much of the tension seemed to dissolve. This enabled you to gather more information from him, including the fact that he returned from a deployment lasting 6 months. You also learned that, since his return from deployment, he has spent much time with his nephew. He explained that when his father was a child, his grandfather was killed in Vietnam. He knows how devastating this was for his father, who had no other father figures to support him during his childhood.

How would you go about probing further to learn more about this and the possible impact his father's situation had on Ryan's own childhood?

Crisis Intervention

The process of crisis intervention requires the counselor to establish rapport rapidly at the beginning of the interview. The patient must feel that they have a knowledgeable ally who will see the patient through the crisis.

The counselor, working efficiently, needs to gather relevant data, assess the risk of danger to the patient and others, and become informed about current problems triggering the crisis. The counselor must also determine when medical or psychiatric intervention is warranted. If the patient is assessed as needing medical or psychiatric intervention, the counselor should make immediate arrangements.

If the crisis is of an emotional nature, determine what the current symptoms are, what the precipitating event was, and get a brief history of the emotional problem. The following comments may be helpful in deciding if there is an emotional crisis:

- Describe your current mood.
- Describe your eating and sleeping habits.
- Tell me about the changes in your lifestyle.
- Have you ever thought of hurting yourself on purpose?
- Have you ever considered suicide?

The counselor must also assess the patient's ability to cope with the crisis. This can be done by reviewing the patient's personal strengths and support network. It will be in the patient's best interest if, during the screening process and resulting action plan, an understanding of the context of the crisis is factored into the assessment and response. The plan should reframe the crisis into a solvable problem and potential growth situation. It is important that the plan decrease the pressure on the patient with a solution that helps increase the level of functioning and empowers the patient.

During the process of planning a response to the crisis, the counselor must weigh the advantages and disadvantages of each response option. The counselor may need to consult and coordinate with other providers in the clinic to brainstorm response options and/or coordinate the response once an option is identified. When the options have been discussed, the most workable option can be chosen. Then an action plan can be developed. Once a plan is agreed on, the counselor must use the appropriate support system. Contact can be made to the necessary support individuals, such as medical personnel, who can help carry out the plan of action. The counselor should make a plan of follow-up with the patient within a few days to confirm actions and progress.

Gather patient Data (25) and Screen for Psychoactive Substance Toxicity, Intoxication, and Withdrawal Symptoms; Potential for Danger to Self or Others; and Co-occurring Mental Disorders (26)

Using the MI approach, the counselor will be in a better position to connect with the patient on their level of motivation for change. This, in turn, will more likely lead to gathering information that is accurate and relevant to the screening interview. The counselor may also choose to use validated

screening instruments and, if so, must be adept at interpreting them. (See screening tools at the end of this chapter.)

CASE STUDY 1.3

During your interview with Ryan, you learn that he has begun drinking daily since he returned from deployment. He usually stops for a few drinks with friends after work. In fact, it was on his way home after a few drinks when he was pulled over for a DUI.

How would you assess Ryan for a substance use disorder? Would you consider using any screening instruments? If so, which ones?

You decide to conduct an Alcohol Use Disorder Identification Test (AUDIT) with Ryan and his tallied score is 15.

What does a score of 15 on the AUDIT indicate? How will you use this information?

Each SARP utilizes a screening questionnaire that gathers data on drinking and psychoactive drug use history, as well as family, social, employment, behavioral, and mental health history. The use and analysis of much of that information will be discussed in Part III, Chapter 2 as components of the full assessment process. An initial review of that information during the screening allows the counselor to determine if the patient needs to be examined in the medical department for withdrawal symptoms, or by a mental health practitioner for suicidal ideation.

Accurate data interpretation requires knowledge of SUDs and psychiatric disorders. Counselors must be able to conceptualize the data being gathered and to communicate an analysis of the findings, both verbally and in writing. To screen and assess effectively, a counselor must have a good understanding of the following:

- Symptoms of intoxication, withdrawal, and toxicity of psychoactive substances
- Effects of substance use, both physically and psychologically
- Concepts of toxicity screening and reporting
- Diagnostic criteria for mental health disorders
- Signs of potential for violence and suicide risk
- Common symptoms of both SUDs and mental health disorders that often mimic each other

Counselors are referred back to their NDACS training material for information on the above symptoms and diagnostic criteria. Using the list to the left and the screening documents used at your facility, identify which questions on the questionnaire will give you data for each screening category. Review with your preceptor.

CASE STUDY 1.4

Since you have learned that a score or 8 or more on the AUDIT represents "a medium level of alcohol problem," you decide that you need to conduct a full biopsychosocial interview to determine the significance of Ryan's alcohol use and the level of intervention that may be required (Babor, Higgins-Biddle, Saunders, & Monteiro, 2001, p. 20). This will enable you to gather information about Ryan's family history, mental health status, and drinking patterns.

Assist the patient in Identifying the Effect of Substance Use on Their Life (27)

Patients come to substance abuse screenings for a variety of reasons that may include trying to save their careers, stay out of jail, or prevent the end of a relationship. They may not see alcohol or drug use as a cause of their current life problems. This blindness may be due to the defense mechanism of denial, by which they protect their substance use by denying its impact on their life, or because they lack knowledge of the biopsychosocial components of SUDs. Although its purpose is to identify whether a person needs the SARP services, the screening is also the beginning of treatment as the counselor begins to educate the patient and build a therapeutic relationship. Knowing the patient's current understanding of the role of substances in their life will help the treatment team determine the necessity for treatment and level of required care. Asking the patient about their own perspective on how their substance use has impacted their life and if they think they need treatment for substance use are helpful in determining the patient's level of readiness to engage in treatment.

Patient Readiness for Treatment (28)

As a counselor considers treatment options, consideration should be given to the patient's readiness for treatment. A counselor's skill at assessing readiness to change and communicating with the patient in response to their readiness will have a significant impact on the patient's motivation to follow through with treatment. The following are all important concepts to master to effectively determine a patient's readiness for treatment and change:

1. The transtheoretical change theory and its stages of change:
    - Precontemplation
    - Contemplation
    - Preparation
    - Action
    - Maintenance

See Chapter 3 for more information on the Transtheoretical Change Theory and its Stages of Change.

2. The counselor's understanding of the appropriate approach to take at each stage of change and a recognition of the importance of accepting the patient's self-assessment.

3. The counselor's knowledge of MI techniques used to gain an understanding of a patient's ambivalence about changing (Miller & Rollnick, 2013):
    - The importance ruler: "On a scale of 0 to 10, how important is it that you stop drinking?"
    - The readiness ruler: "On a scale of 0 to 10, how ready are you to stop drinking?"
    - The confidence ruler: "On a scale of 0 to 10, how confident are you that if you decided to stop drinking, you could do it?"

4. The role of the family and significant others in supporting change

5. An awareness of all treatment options that can best meet the patient's level of readiness and change

Evaluation instruments are available that can help a counselor determine a patient's readiness for change. One such instrument is the *Stages of Change Readiness and Treatment Eagerness Scale*, known as SOCRATES, developed by Miller and Tonigan (1996). Counselors should discuss the use of tools that measure the readiness to change with their preceptor and treatment team.

Determining Treatment Options (29)

At the conclusion of the screening process, counselors have the opportunity and obligation to review treatment options with the patient. The counselor must be aware of all treatment options, both within the treatment system and the additional resources in the community. In the Navy system, an active-duty patient will be required to follow the treatment recommendations made by the SARP team, or risk administrative separation from the Navy. In other settings, screeners may be able to offer the patient the choice of several different treatment programs. Final determination of choice may be influenced by cost, insurance reimbursement, access to public transportation, availability of an admission spot in a program, etc.

Apply Accepted Criteria for Diagnosis of Substance Use Disorders (30)

Counselors must be familiar with diagnostic criteria as published in the *Diagnostic and Statistical Manual of Mental Disorders* (5th edition, text revision), also called the *DSM-5-TR* (American Psychiatric Association, 2022). This includes accepted criteria for SUDs, and other mental health disorders, such as behavioral disorders. The criteria outlined in the *DSM-5-TR* will enable a counselor to determine the appropriate level of care more effectively and/or refer to the most appropriate treatment facility. The counselor must also be adept at being consistently aware of their own level of competency regarding diagnosis of disorders. The counselor must subsequently know when to seek consultation with another mental health professional. More information on the DSM can be found in Supplemental Chapter 1.

Construct an Initial Action Plan with the Patient (31)

The screening process enables a counselor and patient to begin the process of developing an initial action plan, which may include a referral to another facility or the initiation of treatment in the counselor's facility. The action plan outlines specific steps for either an admission or a referral and is most effective when the plan has been mutually developed and agreed on between the counselor and the patient. It also involves the documentation of the action plan steps and can be seen as the precursor to the patient's treatment plan.

See Chapter 3 for more information about developing the patient's treatment plan.

Initiate Admission to Treatment or Referral (32)

Once the initial plan has been determined, the counselor must follow through with the admission or referral process. Depending on the treatment setting, the counselor who completes the screening may continue with a complete assessment and serve as the treatment counselor. In other settings, management of the patient's care may be given to another staff member. Whether the patient is continuing in treatment at the same site or being referred elsewhere, the competent counselor will ease the transition by ensuring that all required documentation is completed. When necessary, counselors will need to obtain permission from the patient to release confidential information. See Chapters 4 and 5 for more information about releasing confidential information.

Summary

Screening involves the gathering of information from a patient to determine if they need services for treating SUDs, or a referral for alternative care. As the initial phase in a patient's involvement in treatment, the attitude and responsiveness of the counselor to the concerns and questions of the patient will go a long way in setting the course for an effective treatment course. Counselors are encouraged to approach screening through the eyes of the patient, who may be scared, angry, tired, or hopeless, and help them start on the road to better health.

Learning Activities
1. Role play an initial patient session with your preceptor to demonstrate the establishment of rapport.
2. Review and practice (or role play with another counselor) using standard forms for screening.
3. Observe a screening interview by a credentialed counselor and review it with your preceptor.
4. Conduct a screening interview while being observed by your preceptor.

5. Review three recent screenings done by yourself or another counselor at your clinic and critique them. What was done well? What are areas for improvement? Discuss with your preceptor. (Advanced)
6. Observe another counselor at your clinic conduct a screening and debrief with them afterwards. Discuss your observations with your preceptor. (Advanced)

Self-Study Questions

1. Define screening.

2. List three techniques a counselor can use to encourage and empower a patient while establishing rapport during screening.

3. List and describe the four principles of Motivational Interviewing (MI) that are represented by the acronym "OARS."

4. Is Motivational Interviewing (MI) a psychotherapeutic theory or an approach that can be used with any theory?

5. List at least four immediate actions a counselor must take during the process on crisis intervention.

6. List at least five factors a counselor must understand to effectively screen a patient.

7. Describe two Motivational Interviewing (MI) techniques that can help the counselor understand a patient's ambivalence about making a change.

8. List the five stages of change as outlined by the transtheoretical change theory.

9. Describe the process of developing an initial action plan. What can be included? Who develops it? What is it seen as a precursor to?

Self-Study Answers

1. Screening is the process through which counselor, patient, and available significant others determine the most appropriate initial course of action, given the patient's needs and characteristics and the available resources within the community.

2. Techniques a counselor can use to encourage and empower a patient while establishing rapport during screening include the following:

   - Make eye contact
   - Be sensitive to cultural differences
   - Be aware of appropriate and acceptable language to use with a patient
   - Be aware of messages a counselor's body language may give
   - Explain the nature of confidentiality requirements in a counseling relationship

3. The four principles of Motivational Interviewing (MI) that are represented by the acronym "OARS" are:

   - Open-ended questions to gather accurate information
   - Affirmations of what the patient is saying
   - Reflective listening to assure the patient they are being understood
   - Summaries to show the patient that they are being heard and to help the patient see their ambivalence

4. Motivational Interviewing (MI) is an approach that can be used with any theory.

5. Immediate actions a counselor must take during the process on crisis intervention include any of the following:

   - Help the patient feel that they have a knowledgeable ally
   - Gather relevant data to assess any risk of danger
   - Learn what triggered the crisis
   - Determine when a medical or psychiatric intervention is necessary
   - Assess the patient's ability to cope with a crisis
   - Develop an action plan with the patient

6. To screen a patient effectively, the counselor must have a good understanding of the following factors:

   - Symptoms of intoxication, withdrawal, and toxicity of psychoactive substances
   - Effects of substance use both physically and psychologically
   - Concepts of toxicity screening and reporting

- Diagnostic criteria for psychiatric disorders
- Signs of potential for violence and suicide risk
- Common symptoms of both SUDs and psychiatric disorders that often mimic each other

7. Two Motivational Interviewing (MI) techniques that can help the counselor understand a patient's ambivalence about making a change are:

   - The importance ruler: "On a scale of 0 to 10, how important is it that you stop drinking?"
   - The confidence ruler: "On a scale of 0 to 10, how confident are you that if you decided to stop drinking, you could do it?"

8. The five stages of change as outlined by the transtheoretical change theory are:

   - Precontemplation
   - Contemplation
   - Preparation
   - Action
   - Maintenance

9. The development of an initial action plan may include a referral to another facility, the initiation of treatment in the counselor's facility, and/or an outline of the specific steps for either an admission or a referral. The initial action plan should be mutually developed and agreed on between the counselor and the patient. It is seen as the precursor to the patient's treatment plan.

Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)

Patient: _____ Date: _____ Time: _____

Pulse/HR: _____ Blood Pressure: _____

NAUSEA AND VOMITING: Ask "Do you feel sick to your stomach? Have you vomited? Observation.

0 – no nausea or vomiting
1 – mild nausea with no vomiting
2
3
4 – intermittent nausea with dry heaves
5
6
7 – constant nausea, frequent dry heaves, and vomiting

TACTILE DISTURBANCES: Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.

0 – none
1 – very mild itching, pins and needles, burning, or numbness
2 – mild itching, pins and needles, burning, or numbness
3 – moderate itching, pins and needles, burning, or numbness
4 – moderately severe hallucinations
5 – severe hallucinations
6 – extremely severe hallucinations
7 – continuous hallucinations

TREMOR: Arms extended and fingers spread apart. Observation.

0 – no tremor
1 – not visible, but can be felt fingertip to fingertip
2
3
4 – moderate, with patient's arm extended
5
6
7 – severe, without extending arms

AUDITORY DISTURBANCES: Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.

0 – not present
1 – very mild harshness or ability to frighten
2 – mild harshness or ability to frighten
3 – moderate harshness or ability to frighten
4 – moderately severe hallucinations
5 – severe hallucinations
6 – extremely severe hallucinations
7 – continuous hallucinations

PAROXYSMAL SWEATS: Observation

0 – no sweat visible
1 – barely perceptible sweating, palms moist
2
3
4 – beads of sweat obvious on forehead
5
6
7 – drenching sweats

VISUAL DISTURBANCES: Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.

0 – not present
1 – very mild sensitivity
2 – mild sensitivity
3 – moderate sensitivity
4 – moderately severe hallucinations
5 – severe hallucinations
6 – extremely severe hallucinations
7 – continuous hallucinations

ANXIETY: Ask "Do you feel nervous?" Observation.

0 – no anxiety, at ease
1 – mildly anxious
2
3

HEADACHE, FULLNESS IN HEAD: Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness.

0 – not present
1 – very mild
2 – mild

4 – moderately anxious, or guarded, so anxiety is inferred 5 6 7 – equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions	3 – moderate 4 – moderately severe 5 – severe 6 – very severe 7 – extremely severe
AGITATION: Observation. 0 – normal activity 1 – somewhat more than normal activity 2 3 4 – moderately fidgety and restless 5 6 7 – paces back and forth during most of the interview, or constantly thrashes about	ORIENTATION AND CLOUDING OF SENSORIUM: Ask "What day is this? Where are you? Who am I?" 0 – oriented and can do serial additions 1 – cannot do serial additions or is uncertain about date 2 – disoriented for date by no more than 2 calendar days 3 – disoriented for date by more than 2 calendar days 4 – disoriented for place/or person

Total CIWA-Ar Score: _____
Rater's Initials: _____
Maximum Possible Score: 67

This assessment for monitoring withdrawal symptoms requires approximately 5 minutes to administer. The maximum score is 67. Patients scoring less than 1 do not usually need additional medication for withdrawal.

Adapted from Sullivan, Sykora, Schneiderman, Naranjo, & Sellers (1989)

CAGE Assessment

C Have you ever tried to **C**ut back on your use?

A Have you ever been **A**nnoyed/**A**ngered when questioned about your use?

G Have you ever felt **G**uilt about your use?

E Have you ever had an **E**ye-opener to get started in the morning?

The CAGE Assessment is a quick questionnaire to help determine if an alcohol assessment is needed. If you answer yes to two or more of these questions, then an assessment is advised.

Adapted from Ewing (1984)

Alcohol Use Disorders Identification Test (AUDIT): Interview Version

Read questions as written. Record answers carefully. Begin by saying, "Now I am going to ask you some questions about your use of alcoholic beverages during the past year." Explain what is meant by alcoholic beverages by using local examples of beer, wine, vodka, etc. Code answers in terms of *standard drinks*. Place the answer number in the box at the right.

1. How often do you have a drink containing alcohol?

0 – Never *(Skip to Questions 9–10)*
1 – Monthly or less
2 – 2–4 times a month
3 – 2–3 times a week
4 – 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

0 – 1 or 2
1 – 3 or 4
2 – 5 or 6
3 – 7, 8, or 9
4 – 10 or more

3. How often do you have six or more drinks on one occasion?

0 – Never
1 – Less than monthly
2 – Monthly
3 – Weekly
4 – Daily or almost daily
Skip to Question 9 if the total from Questions 2 and 3 = 0

4. How often during the last year have you found that you were not able to stop drinking once you had started?

0 – Never
1 – Less than monthly
2 – Monthly
3 – Weekly
4 – Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

0 – Never
1 – Less than monthly
2 – Monthly
3 – Weekly
4 – Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

0 – Never
1 – Less than monthly
2 – Monthly
3 – Weekly
4 – Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

0 – Never
1 – Less than monthly
2 – Monthly
3 – Weekly
4 – Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

0 – No
2 – Yes, but not in the last year
4 – Yes, during the last year

5. How often during the last year have you failed to do what was normally expected from you because of drinking? 0 – Never 1 – Less than monthly 2 – Monthly 3 – Weekly 4 – Daily or almost daily	10. Has a relative, friend, doctor, or other health worker been concerned about your drinking or suggested you cut down? 0 – No 2 – Yes, but not in the last year 4 – Yes, during the last year
	Record total of specific items here:

Adapted from Babor, Higgins-Biddle, Saunders, & Monteiro (2001)

Risk Level	Intervention	AUDIT Score*
Zone I	Alcohol Education	0–7
Zone II	Simple Advice	8–15
Zone III	Simple Advice AND Brief Counseling and Continued Monitoring	16–19
Zone IV	Referral to Specialist for Diagnostic Evaluation and Treatment	20–40

*The AUDIT cut-off score may vary slightly depending on the country's drinking patterns, the alcohol content of standard drinks, and the nature of the screening program. Clinical judgment should be exercised in cases where the patient's score is not consistent with other evidence, or if the patient has a prior history of alcohol dependence. It may also be instructive to review the patient's responses to individual questions dealing with dependence symptoms (Questions 4, 5, and 6) and alcohol-related problems (Questions 9 and 10). Provide the next highest level of intervention to patients who score 2 or more on Questions 4, 5, and 6, or 4 on Questions 9 or 10.

The Drug Abuse Screening Test

The following questions concern information about your involvement with drugs. Drug abuse refers to (1) the use of prescribed or "over-the-counter" drugs in excess of the directions, and (2) any non-medical use of drugs. Consider the past year (12 months) and carefully read each statement. Then decide whether your answer is YES or NO and check the appropriate space. Please be sure to answer every question.

	YES	NO
1. Have you used drugs other than those required for medical reasons?		
2. Have you abused prescription drugs?		
3. Do you abuse more than one drug at a time?		
4. Can you get through the week without using drugs (other than those required for medical reasons)?		
5. Are you always able to stop using drugs when you want to?		
6. Do you abuse drugs on a continuous basis?		
7. Do you try to limit your drug use to certain situations?		
8. Have you had "blackouts" or "flashbacks" as a result of drug use?		
9. Do you ever feel bad about your drug abuse?		
10. Does your spouse (or parents) ever complain about your involvement with drugs?		
11. Do your friends or relatives know or suspect you abuse drugs?		
12. Has drug abuse ever created problems between you and your spouse?		
13. Has any family member ever sought help for problems related to your drug use?		
14. Have you ever lost friends because of your use of drugs?		
15. Have you ever neglected your family or missed work because of your use of drugs?		
16. Have you ever been in trouble at work because of drug abuse?		
17. Have you ever lost a job because of drug abuse?		
18. Have you gotten into fights when under the influence of drugs?		
19. Have you ever been arrested because of unusual behavior while under the influence of drugs?		
20. Have you ever been arrested for driving while under the influence of drugs?		
21. Have you engaged in illegal activities in order to obtain drugs?		
22. Have you ever been arrested for possession of illegal drugs?		
23. Have you ever experienced withdrawal symptoms as a result of heavy drug intake?		
24. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)?		
25. Have you ever gone to anyone for help for a drug problem?		
26. Have you ever been in a hospital for medical problems related to your drug use?		
27. Have you ever been involved in a treatment program specifically related to drug use?		
28. Have you been treated as an outpatient for problems related to drug abuse?		
TOTAL SCORE*		

A score of "1" is given for each YES response, except for items 4, 5, and 7, for which a NO response is given a score of "1." Cutoff scores of 6 through 11 are considered to be optimal for screening for substance use disorders. Using a cutoff score of 6 provides excellent sensitivity for identifying patients with substance use disorders. However, using a cutoff score of <11 may more accurately identify the patients who do not have a substance use disorder. Over 12 is definitely a substance abuse problem.

Adapted from Gavin, Ross, & Skinner (1989)

Chapter 2 Clinical Evaluation: Assessment

Purpose of This Chapter

This chapter reviews the Practice Dimension of Clinical Evaluation by focusing on its second component: Assessment.

Learning Objectives

- Select and use a comprehensive assessment process that is sensitive to age, gender, racial and ethnic culture, and disabilities. (33)
- Analyze and interpret the data to determine treatment recommendations. (34)
- Seek appropriate supervision and consultation. (35)
- Document assessment findings and treatment recommendations. (36)

The learning objectives directly correlate with Competencies 33–36, as listed in the *TAP 21* (pages 46–48) and IC&RC Domain II: Evidence-Based Screening and Assessment. Each competency is accompanied by a set of knowledge, skills, and attitudes that define the standard.

Introduction

Assessment is defined by *TAP 21* as an "ongoing process through which the counselor collaborates with the patient and others to gather and interpret information necessary for planning treatment and evaluation of patient progress" (CSAT, 2006, p. 46).

This chapter discusses the actions of the counselor in conducting the interview as a component of the assessment process to provide a diagnosis and prescribe treatment. The decisions that are made as a result of a valid assessment are similar in nature to those a physician makes in prescribing medications *after* conducting an exam. Anything else would be suspect.

Comprehensive Assessment Process (33)

The most comprehensive assessment is a formal assessment, often taken with a detailed list of questions based on a biopsychosocial model. It involves looking at all components of the patient's life and investigating what needs exist in each domain.

The following are the areas or domains covered in a biopsychosocial interview based off Perkinson (2008) and expanded:

- **Demographic data:** Describe the patient's age, gender identity, marital status, sexuality, race, ethnicity, culture, spirituality/religious affiliation, etc.
- **Education/occupational history:** How far has the patient gone in school, work, and military career?

- **Chief complaint:** Why is the patient seeking help?
- **Developmental history:** Includes significant information regarding the patient's growth and development (What happened growing up? Did they meet developmental milestones as a child? Learning challenges? What was it like growing up in their house? Who lived with them growing up?)
- **Medical history:** Describes hospitalizations, illnesses, treatment history, and medication.
- **Family history:** Covers information about parents, siblings, and other significant figures, childhood trauma, including the family's history with alcohol and drugs. A verbal history about the patient's family may reveal information about family dynamics and if there is a history of addiction with any other family members. What are the patient's current relationships like with family members?
- **Mental status:** Describes attitude, orientation, mood, thought processes, concentration ability, and memory. Has there been any mental health treatment in the past? Previous mental health diagnoses? Trauma history? In addition, assesses for any suicidal or homicidal ideation.
- **Substance use/abuse pattern:** Covers past and present patterns, past treatment history, periods of sobriety. Take a drinking/drug history and, if needed, use an additional assessment tool to determine the extent of the patient's potential alcohol or drug problem. (See the assessment tools in Chapter 1.)
- **Social history:** Covers past and present significant relationships, both romantic and non-romantic. Who does the patient spend most of their time with? Is their social environment supportive of recovery or not? Is there a current romantic relationship and dynamics of that relationship if so? Past marriages? Children? Current or past egal involvement related to substance use?

The assessment also includes a determination of the patient's stage of change and a process of integrating it with information gathered from the biopsychosocial model and any other assessment tools used. Information gathered during the screening process is also used in the assessment process.

CASE STUDY 2.1

As you conduct your biopsychosocial interview, you gather information about Ryan's family history, mental health status, and his drinking patterns. As you probe further, you discover that Ryan's father had a serious problem with alcohol, was divorced by his mother, and died about 5 years ago due to medical complications of his drinking. He attributes his father's drinking and other behavior problems to the fact that he lost his father as a child. As tensions diminish, Ryan continues to open up and talk freely about his own family of origin, as well as the concerns he has for his nephew. You sense that there is something else going on with Ryan that he seems to be avoiding by talking about people in his life and not about himself.

You are beginning to suspect that Ryan is reluctant to talk about something that is bothering him. How would you approach Ryan as a means of getting him to share what he may be holding back?

Analyze and Interpret Data (34)

At this time, the counselor should review the information already gathered and determine what further information is needed. According to Perkinson (2008), it is best to start with the patient's childhood and to proceed with a summary of everything you have seen and heard.

It has also been recommended (Perkinson, 2008) that the counselor give an impression of the patient's status in each of the six problem areas identified by the American Society of Addiction Medicine (ASAM) Patient Placement Criteria (3rd edition, revised) or ASAM PPC-3R (2013). These problem areas, also known as dimensions, can be used in analyzing assessment information to make treatment placement decisions. Using these problem areas, the counselor can assess the severity of the patient's problem with alcohol and/or drugs and determine the intensity of treatment. These dimensions are outlined in **Table 2.1** below. In addition, the Navy incorporates a seventh dimension, Operational Commitments, into its assessment process. This dimension considers military operational status and can override the urgency of Dimensions 1–6, based on the needs of the military.

Table 2.1: ASAM Assessment Dimensions

1. Acute intoxication and/or withdrawal potential
2. Biomedical conditions and complications
3. Emotional/behavioral/cognitive conditions and complications
4. Readiness to change
5. Relapse/continued use potential/continued problem potential
6. Recovery environment
7. Operational commitments (military specific)

A major goal for the counselor is learning to match the level of functioning with the level of service. Assessment is an ongoing process; levels of care vary as patient needs vary. Levels of care, as outlined later, are defined by intensity, structure, and frequency. ASAM details a list of questions to ask patients to assess the severity of their problems in determining levels of care (ASAM, 2013). The questions listed with each dimension are as follows:

Dimension 1: Acute Intoxication/Withdrawal Potential. What risk is associated with the patient's current level of acute intoxication? Is there a significant risk of severe withdrawal symptoms or seizures based on the patient's previous withdrawal history, amount, frequency, and recency of discontinuation or significant reduction of alcohol or other drug use? Are there current signs of withdrawal? Is there a history of serious, life-threatening withdrawal? Does the patient have support to assist in ambulatory detoxification, if medically safe?

Dimension 2: Biomedical Conditions and Complications. Are there current severe health problems or physical illnesses, other than withdrawal, which need to be addressed or that may complicate treatment? Are there chronic conditions that affect treatment?

Dimension 3: Emotional/Behavioral/Cognitive Conditions and Complications. Is the patient in immediate danger of harm to self or others? Are there current psychiatric illnesses or psychological, behavioral, or emotional problems that need to be addressed or that complicate treatment? Are there chronic conditions that affect treatment? Do any emotional/behavioral problems appear to be an expected part of addiction illness or do they appear to be autonomous? Even if connected to addiction, are they severe enough to warrant specific mental health treatment?

Dimension 4: Readiness to Change. Does the patient feel ambivalence or feel treatment is unnecessary? Does the patient feel coerced into treatment? How ready is the patient to change? If willing to accept treatment, how strongly does the patient disagree with others' perception that she has an addiction problem? Does the patient appear to be compliant only to avoid a negative consequence, or does she appear to be internally distressed in a self-motivated way about her alcohol/other drug use problems?

Dimension 5: Relapse/Continued Use/Continued Problem Potential. Is the patient currently under the influence of alcohol or drugs? Is the patient in immediate danger of continued severe distress and drinking/drug-taking behavior? Does the patient have any recognition of, understanding of, or skills with which to cope with addiction problems to prevent relapse or continued use? What severity of problems and further distress will potentially continue or reappear if the patient is not successfully engaged in treatment at this time? How aware is the patient of relapse triggers, ways to cope with cravings to use, and skills to control impulses to use?

Dimension 6: Recovery Environment. Are there any dangerous family members, significant others, living situations, or school/working situations that pose immediate threats to the patient's safety, well-being, or sobriety? Does the patient have supportive friendships, financial resources, or educational/vocational resources that can increase the likelihood of successful treatment? Are there legal, vocational, social service agency, or criminal justice mandates that may enhance the patient's motivation for engagement in treatment?

Dimension 7: Operational Commitments (military specific). What are the command's upcoming commitments and deployment schedule? Will these plans impact the service member's availability for a particular level of care?

In addition to the assessment information gathered by the primary counselor, it is appropriate for other members of the medical command to participate in the process. If there is information that indicates possible psychological impairment, certain tests may be necessary. If there is a question of any physiological problems, a physician or other specialist may be consulted and asked to join in the assessment process.

CASE STUDY 2.2

During your interview, you learn that Ryan was deployed in a non-combat zone attached to a medical clinic, however, there was a training accident where several service members were severely wounded, and one killed that he had worked closely with in a previous command. As a corpsman, he served a Marine command during the deployment and experienced trauma by assisting in the treatment of the severely wounded Marines. He also saw the body of the Marine that was killed whom he knew well. You suspect that Ryan may be experiencing posttraumatic stress disorder (PTSD) and are beginning to think that this may be directly related to his drinking. Although you have not experienced working with a patient with PTSD before, you are aware that, with other patients you have seen, co-occurring disorders have bi-directional effects on individuals who have substance use disorders. You are beginning to suspect that Ryan's deployment experience is having a serious impact on him.

The use of dimensions to make decisions about patient placement and/or treatment planning requires gathering information on each dimension from other staff members and from the results of screenings and assessments. This information, along with the answers to the questions listed above under each dimension, could be helpful in making patient placement decisions.

ASAM Levels of Care

In ASAM PPC-3R, there are five levels of care designed to meet an individual patient's needs. In the process of assessment, it is important that counselors become familiar with the ASAM criteria and levels of care. Using the ASAM PPC-3R model will help ensure that patients are being recommended the level of care most appropriate to their needs. It is important to note that this model has flexibility in that levels of care for the patient can be changed to best match the patient's needs with the appropriate level of care. It is also important that counselors develop the skills necessary to prepare patients to make the transition to a particular level. The levels outlined below are current as of the revision of this workbook, however, could change based on updates made to the ASAM criteria/ patient placement and Navy instruction.

The five levels of care are described below:

Level 0.5: Early Intervention. Early intervention programs are designed to increase the participant's knowledge and awareness of alcohol and to assist him in making healthy decisions about any further use of alcohol. Level 0.5 gives participants information to enable them to make behavior changes and avoid problems with alcohol. An example of this level of care is the structured program *Prime for Life®*, a 16 hour course for personnel who have exhibited a pattern of alcohol misuse.

Level I: Outpatient Services. Outpatient services are designed to treat individuals who show maladaptive patterns of alcohol use. Patients are seen by qualified personnel during regularly scheduled sessions, with the goal of achieving permanent changes in a patient's alcohol-use behavior. Outpatient services are characterized as organized, low-intensity, nonresidential treatment that can address lifestyle, attitudinal, and behavioral issues. Duration and frequency of contact are based primarily on individual need. Patients are typically seen anywhere from 1 to 9 hours a week. Weekly individual counseling and continuing care groups are examples of Level I services.

Level II: Intensive Outpatient. Intensive outpatient programs (IOPs) involve highly structured day or evening treatment programs that provide the essential education and treatment components necessary for patients to develop a successful recovery program. This program introduces the basic building blocks for an abstinent lifestyle and allows patients to apply learned skills within their normal home environment while they are in treatment. This program also facilitates the patient's acceptance and adjustment to having a serious problem with alcohol. IOPs held in Navy SARPs are examples of Level II care.

Level III: Clinically Managed/Medically Monitored Residential/Inpatient Services. Clinically managed residential and medically monitored services are structured, 24-hour treatment programs that provide safe and stable treatment environments for patients whose prognosis requires such structure. Patients who need a positive recovery environment are given the opportunity to develop sufficient recovery skills while living in a patient community. This level of care is a clinically managed/medically monitored setting that treats those who require a planned, 24-hour regimen but do not require 24-hour medical care. The Navy has several Level III programs but often refers to civilian treatment programs for Level III care as well based on geographical availability.

Level IV: Medically Managed Intensive Inpatient Treatment. Medically managed residential services are structured 24-hour, hospital-based treatment programs that provide safe and stable treatment with 24-hour medical care. The focus of treatment at this level is medical management. Patients are being treated for medical or mental problems that cannot be successfully treated in a Level III program. Acute care in a Navy hospital due to a serious

substance use-related medical problem or for detoxification prior to admission to a less intensive level is an example of Level IV care.

Table 2.2 was developed to illustrate the interrelationships between the dimensions and levels of care. This grid may be used as a tool for making connections between the dimensions and levels of care. Also note the "Assessment by Dimension" document at the end of this chapter.

Table 2.2: Patient Placement Criteria Grid

		TREATMENT LEVELS			
		Level 0.5 Early Intervention (IMPACT)	**Level 1 Outpatient (OP)**	**Level II Intensive Outpatient/ Partial Hospitalization (IOP/PH)**	**Level III (Residential)**
ASAM PLACEMENT AND TREATMENT DIMENSIONS	**WITHDRAWAL**	No significant risk	No significant risk	Minimal risk of withdrawal	Minimal risk of withdrawal
	BIOMEDICAL	None or very stable	None or very stable	If bio-medical problems other than withdrawal exist, it is noninterfering.	If bio-medical problems other than withdrawal exist, it is noninterfering, but requires monitoring
	EMOTIONAL/ BEHAVIORAL	None or very stable	If emotional/ behavioral problems present, requires minimal structure and support	Emotional/behavioral problems may interfere; requires more structure and support.	Emotional/behavioral problems interfere; requires 24-hour milieu
	READINESS TO CHANGE	Willing to participate (Precontemplation through determination)	Amenable to treatment, willing to participate, motivated to work recovery plan (Maintenance)	Acknowledges problems, but resistance is high enough to require a structured program (Precontemplation, contemplation, and preparation)	Resistance so high, despite negative consequences, that residential treatment required
	RELAPSE/ CONTINUING PROBLEM POTENTIAL	Able to achieve program goals in an educational setting to change current patterns	Able to cope with cravings and/or pursue treatment goals with minimal support and structure	Able to cope with cravings and/or pursue treatment goals with close monitoring and support	High likelihood of use without close monitoring in a 24-hour setting
	RECOVERY ENVIRONMENT	Supportive environment and/or skills to cope	Supportive environment or skills to cope	Coping skills or environment require additional support	Unable to cope with recovery environment; needs 24-hour milieu
	NAVY SPECIFIC	Availability	Availability	Availability	Availability

Diagnostic Criteria

You are now familiar with the levels of care, dimension descriptions, and placement criteria for each level of care along each dimension. The following discussion integrates this approach with that of diagnoses based on the criteria listed in the *DSM-5-TR* (American Psychiatric Association, 2022). Supplemental Chapter 1: Substance Use Disorders and DSM-5 Diagnostic Criteria provides a history of the Diagnostic & Statistical Manual, as well details the diagnostic criteria of Alcohol Use Disorder (AUD).

DSM-5-TR Criterion 1 for substance use disorder is one example of these criteria: "The substance is often taken in larger amounts or over a longer period than was intended" (APA, 2022, p. 546). The degree of severity relates to how often the substance is used and how large the quantity of the substance is. For instance, if the patient drinks six to eight beers instead of two to three beers when out with friends once a week, he may meet the criterion, but the degree of severity would be moderate; however, if the patient goes out drinking with friends once or twice a week and frequently does not stop until intoxicated—at 12 beers, for example—he would meet Criterion 1 and would evidence a high degree of severity. Since the degree of severity is significant clinical data, it is important to help counselors go beyond simply determining if a *DSM-5-TR* criterion has been met.

CASE STUDY 2.3a

While taking Ryan's alcohol history, you learn the following information:

- Since returning from deployment 3 months ago, he has been drinking at least 5 days a week.
- He drinks five to six beers when he drinks and more if he does not have to work the next day.
- He drinks more than he intended to two to three times a month.
- He feels guilty about his drinking at least once a week because it has cut down on the frequency of his visits with his nephew.

The ASAM PPC-3R dimensions are compatible with the *DSM-5-TR* criteria for substance use disorder but organize patients' clinical data in a different way. The treatment dimensions provide a framework, not just for determining a diagnosis, but also for identifying problem areas. As with the *DSM-5-TR* criteria, it is most helpful to discuss these problem areas in terms of severity.

In practical application, the counselor will assess the patient on each of the eleven *DSM-5-TR* criteria for alcohol use disorder. The counselor will then go further with the assessment by considering the degree of severity on each criterion. While doing this, the counselor will assess the severity of problems on all six ASAM dimensions. The result is a unique profile for each patient. Developing such

a profile is useful in assisting the counselor to begin a clinical formulation, while conveying meaningful information to the patient and other relevant treatment staff members. Information on the severity of the disorder, as well as the ASAM dimensions augments and further individualizes the clinical formulation.

Note that the counselor initially determines the most appropriate level of care for the patient based on the six dimensions identified by ASAM. Only after considering the clinically most appropriate level is a decision made to modify it due to operational considerations. It is important for the counselor to consider the possible impact of up or downgrading a level of care recommendation based on operational commitments.

CASE STUDY 2.3b

What level of care would you recommend for Ryan? Why?

Seek Appropriate Supervision and Consultation (35)

Clinical supervision and consultation are readily available to Navy counselors. This may include supervision by a credentialed clinical supervisor on staff, a psychiatrist or other medical professional at your local command, and your preceptor. It also includes input from peers through case consultation or group supervision. All these resources are excellent sources of supervision or consultation; however, your preceptor is part of a Navy-wide program and has been briefed on and is fully aware of all Transdisciplinary Foundations and Practice Dimensions outlined in *TAP 21*.

Clinical supervision has been defined as "a disciplined tutorial process wherein principles are transformed into practical skills with four overlapping foci: evaluative, supportive, administrative, and clinical" (Powell & Brodsky, 2004, p. 9). Your preceptor, therefore, is a source for further skill development by providing an interpersonal tutorial relationship centered on the goals of skill development and professional growth by learning and practicing.

The assessment process is one of the most challenging tasks for a counselor to master. It is a skill that is developed over time—one that requires much experiential learning and practicing. It is also a skill that is rarely learned without the support or consultation with others. Counselors who succeed in their professional growth are those that recognize the need for consultation or assistance from a preceptor, supervisor, or medical professional.

Knowing when to seek supervision or consultation will most readily occur when counselors recognize and accept their own personal and professional limitations. By seeking supervision or consultation, the counselor has a better chance of incorporating information learned into assessment findings and being able to form meaningful conclusions and recommendations that are in the best interest of the patient. It is vitally important that counselors discuss their diagnostic impressions and treatment recommendations with other professionals such as preceptors.

Document Assessment Findings and Treatment Recommendations (36)

Documentation is an essential part of addiction treatment. Treatment facilities, such as Navy SARPs, and treatment systems have their own protocol and forms to use in the documentation of patient care. It is important that in documenting assessment findings and recommendations, counselors follow proper protocols and procedures, understand the appropriate terminology and abbreviations, and provide legible documentation. clear documentation. Most documentation is completed in the Navy electronic health record and each SARP often have differing expectations around documenting assessment findings. SARP counselors complete their assessment documentation then the Licensed Independent Practitioner (LIP) reviews it and signs off on any diagnoses given to the patient.

Documentation of assessment findings includes an ability to conceptualize the case by incorporating all relevant information from a screening interview, biopsychosocial assessment, and other assessment tools. Assessment documentation may also include information from a variety of other sources, such as family members, other treatment professionals, or referring treatment programs.

When documenting assessment findings, it must always be assumed that someone else will be reading the documentation and using it in the patient's ongoing care. This could include fellow staff members, as well as referral sources such as other treatment programs or Navy medical personnel. The documentation should be clear, concise, and relevant to the patient's care and well-being. The counselor must also maintain awareness of confidentiality regulations and all legal ramifications regarding documentation of patient information.

Summary

The process of assessment involves the continued gathering of information from the patient and other sources. While the screening determines whether the patient needs substance use disorder (SUD) treatment, the assessment determines the severity of the SUD and the necessary level of intervention. The assessment process requires that counselors synthesize all available information, determine the severity of the SUD, and conceptualize the treatment needs of the patient. The ASAM dimensions serve as a guiding tool to ensure all vital information is gathered and evaluated. A thorough assessment will provide a framework for the treatment plan that will be developed next.

Learning Activities
1. Review the portions of the case study found in this chapter and answer all questions that appear with it. Discuss with your preceptor what additional information you would need to complete an accurate assessment on this patient and what appropriate assessment tool(s) you would recommend for gathering this information. (See sample assessment tools found at the end of Chapter 1.)
2. Review the criteria for substance use disorder as presented in the *DSM-5-TR*.

3.	Review material in this chapter on the ASAM PPC-3R and determine the appropriate level of care for the patient in the case study. Support your recommendation in a discussion with your preceptor.
4.	Observe a biopsychosocial assessment conducted by another counselor or role play with your preceptor. Use the tools used by your SARP to document your information.
5.	Using the information collected in Step 4, analyze, and interpret the data collected.
6.	(Advanced) Look back on the screenings/assessments you completed when you first got out of NDACS. Discuss how you have grown in your interviewing and assessment skills with your preceptor.

Self-Study Questions

1. Define assessment.

2. List eight areas or domains covered in a biopsychosocial interview.

3. After conducting a biopsychosocial interview, the counselor should review the information gathered and determine _____ to effectively analyze and interpret the data.

4. List the six dimensions that can be used in analyzing assessment information to make treatment placement decisions, as outlined in the ASAM PPC-3R.

5. When considering the appropriate level of care based on the severity of a patient's substance use disorder, the counselor should seek the _____ restrictive level of intervention first.

6. Why is it important to obtain a history of substance use and misuse within the patient's family?

7. List at least three important reasons why it is particularly important that counselors seek consultation and/or supervision while grasping the skills and competencies of conducting assessments.

8. List the reasons why documentation is an essential part of addiction treatment.

Self-Study Answers

1. Assessment is an ongoing process through which the counselor collaborates with the patient and others to gather and interpret information necessary for planning treatment and evaluation of patient progress.

2. The eight domains of a biopsychosocial assessment are:
   - Demographic data
   - Education/occupational history
   - Chief complaint
   - Developmental history
   - Medical history
   - Family history
   - Mental status
   - Substance use/abuse pattern

3. After conducting a biopsychosocial interview, the counselor should review the information gathered and determine ***what further information is needed*** to effectively analyze and interpret the data.

4. The six dimensions that can be used in analyzing assessment information to make treatment placement decisions, as outlined in the ASAM PPC-3R, are:
   - Acute intoxication and/or withdrawal potential
   - Biomedical conditions and complications
   - Emotional/behavioral/cognitive conditions and complications
   - Readiness to change
   - Relapse/continued use potential/continued problem potential
   - Recovery environment

5. When considering the appropriate level of care based on the severity of a patient's substance use disorder, the counselor should seek the ***least*** restrictive level of intervention first.

6. A verbal history about the patient's family may reveal information about family dynamics and if there is a history of addiction with any other family members.

7. The following are some of the reasons why it is important for counselors to seek supervision and/or consultation while grasping the skills and competencies of conducting assessments.

   - The assessment process is one of the most challenging tasks for a counselor to master.
   - Assessment is a skill that is developed over time.
   - Assessment is a skill that requires much experiential learning and practicing.
   - Assessment is a skill that is rarely learned without the support or consultation with others.
   - Counselors who succeed in their professional growth are those who recognize the need for consultation or assistance from a preceptor, supervisor, or medical professional.

8. Documentation is an essential part of addiction treatment for the following reasons:

   - Documentation shows that proper protocols and procedures are followed.
   - Documentation gives counselors a means to conceptualize the case by incorporating all relevant information.
   - Documentation is a means of collecting information from a variety of other sources, such as family members, other treatment professionals, or referring treatment programs.
   - Documentation provides a record for other relevant treatment personnel for use in the patient's ongoing care.

Assessment by Dimension

The use of dimensions to make decisions about patient placement and/or treatment planning requires gathering information on each dimension during screenings and assessments. A variety of instruments are used to assist in patient placement decisions. Listed below are questions intended to serve as a guide for counselors as they gather information associated with each dimension. In each dimension, space is left for the counselor to add questions that they believe will assist in this endeavor.

Dimension 1: Acute Intoxication/Withdrawal Potential

Have you ever had, or do you currently have, any problems after you stopped drinking, such as hand tremors, seizures, or hallucinations?

When was your last drink?

Have you ever been in a hospital for drinking?

Can you get through the week without using alcohol?

What questions can you add to gain information associated with this dimension?

1.
2.
3.

Dimension 2: Biomedical Conditions and Complications

What current medical conditions or problems do you have (hypertension, liver disease, chest pain, diabetes, etc.)?

Have you ever been in a hospital because of your drinking?

Have you ever been injured in an accident or a fight because of your drinking?

Have you ever been in a hospital for medical problems related to your drinking?

What questions can you add to gain information associated with this dimension?

1.
2.
3.

Dimension 3: Emotional/Behavioral/Cognitive Conditions and Complications

Are you currently experiencing crying spells?

Are you currently experiencing, or have you recently experienced, appetite loss, weight loss, or significant weight gain?

Have you recently experienced difficulties in falling asleep, staying asleep, or awakening too early?

Are you currently having feelings of helplessness or hopelessness?

Have you had thoughts of hurting yourself or another person in the past 6 months?

Have you ever been physically, sexually, or emotionally abused?

What questions can you add to gain information associated with this dimension?

1.
2.
3.

Dimension 4: Readiness to Change

Do you feel you have a drinking problem?

If yes, do you want help with this problem?

Are you being coerced or mandated into the assessment and any treatment that follows?

Have you ever been involved in a treatment program for alcohol abuse/addiction?

What questions can you add to gain information associated with this dimension?

1.
2.
3.

Dimension 5: Relapse Potential/Continued Use/Continued Problem

Do you feel you are a normal drinker?

Do you feel you can stop drinking and stay stopped, continuing to abstain?

Do you ever feel bad about your alcohol use?

Do you ever feel that continued use would be a threat to your safety or your well-being?

Do you try to limit your alcohol use in certain situations?

What questions can you add to gain information associated with this dimension?

1.
2.
3.

Dimension 6: Recovery Environment/Operational Schedule

Do you feel your environment will support you in getting help?

Do you feel your living environment poses immediate threats to your safety or well-being?

Do your friends or relatives know or suspect that you misuse alcohol?

Does your spouse ever complain about your drinking?

Have you ever been in trouble at work because of alcohol use or misuse?

What questions can you add to gain information associated with this dimension?

1.
2.
3.

Chapter 3 Treatment Planning

Purpose of This Chapter

This chapter reviews the Practice Dimension of Treatment Planning and its importance in the process of the treatment of substance use disorders.

Learning Objectives

The learning objectives directly correlate with Competencies 37–48, as listed in the *TAP 21* (pages 55–62) and IC&RC Domain III: Evidence-Based Treatment, Counseling, and Referral. Each competency is accompanied by a set of knowledge, skills, and attitudes that define the standard.

- Use relevant assessment information to guide the treatment planning process. (37)
- Explain assessment findings to the patient and significant others. (38)
- Provide the patient and significant others with clarifications and additional information as needed. (39)
- Examine treatment options in collaboration with the patient and significant others. (40)
- Consider the readiness of the patient and significant others to participate in treatment. (41)
- Prioritize the patient's needs in the order that they will be addressed in treatment. (42)
- Formulate mutually agreed-on and measurable treatment goals and objectives.
- Identify appropriate strategies for each goal. (43)
- Coordinate treatment activities and community resources in a manner consistent with the patient's diagnosis and existing placement criteria. (44)
- Develop with the patient a mutually acceptable treatment plan and method for monitoring and evaluating progress. (45)
- Inform the patient of confidentiality rights, program procedures that safeguard them, and the exceptions imposed by regulations. (46)
- Reassess the treatment plan at regular intervals or when indicated by changing circumstances. (47)

Introduction

Treatment Planning is defined by *TAP 21* as a "collaborative process through which the counselor and patient develop desired treatment goals; describes measurable, time-sensitive action steps toward achieving those goals with expected outcomes; and reflects a verbal agreement between a counselor and patient. At a minimum, an individualized treatment plan addresses the identified

substance use disorder(s), as well as issues related to treatment progress, including relationships with family and significant others, potential mental conditions, employment, education, spirituality, health concerns, and social and legal needs" (CSAT, 2006, p. 55).

The treatment planning process includes a set of problems with short- and long-term goals negotiated with the patient. It is a document written in terms clear to the patient that includes methods and resources to be used during and beyond treatment. The creative counselor can use the treatment plan to help the patient to think "outside the box" and to encourage the patient to view problems differently.

Problems and goals are linked by specific objectives and interventions that are written in behavioral terms. This gives both the patient and counselor a clear understanding of who, what, where, when, and how. The process also involves in-depth communication between the patient and counselor and, therefore, has the potential of enhancing the therapeutic relationship.

Counselors can play a significant role in guiding the patient through the change process by tying treatment planning to the stages of change. As the patient changes, so must the treatment plan. Treatment planning is a dynamic process that involves ongoing review and revision.

Effective treatment planning is tuned to the unique needs of each patient. The basis of a treatment plan is an assessment of the individual's presenting problem, physical health, and emotional and behavioral status. It is a unique plan based on the patient's individual problems and needs, as well as on identified strengths and limitations. The plan must be *patient*-driven, as opposed to *program*-driven.

Each patient's treatment plan should look distinctively different from those of other patients. The one-size-fits-all approach (the program-driven approach to treatment planning) not only ignores the uniqueness of each patient, but also takes away any sense of ownership of one's treatment plan. This sense of ownership is essential in creating a sense of empowerment for the patient in their quest to meet goals. This, in turn, can lead to a high degree of self-efficacy, empowerment, and motivation.

A preliminary treatment plan is formulated based on the information accumulated during the screening and assessment process. The plan must also consider, by way of the assessment, the dimensional criteria discussed in Chapter 2. When reviewing the dimensions for a patient, the counselor may ask, "Where is this patient's biggest risk regarding each dimension?" This will give helpful clues in identifying problems that are not only unique to the individual, but also dimension-driven.

Dimension-driven problem statements allow the counselor and patient to develop goals that are tailored to be dimension-specific. This will support placement decisions in addition to demonstrating clearly, upon resolution of goals, when a patient is ready either to move to another level of care along the treatment continuum or to be discharged. To assess for proper placement, continued stay, transfer, or discharge, dimensional criteria must be constantly assessed. Periodic review and revision of the treatment plan should be conducted based on changes in the patient's

condition, treatment level, and dimensional criteria. Identifying dimension-specific problems can enhance this review process.

Use Assessment Information to Guide Treatment Planning (37)

In many ways, treatment planning is a continuation of the clinical evaluation. It involves gathering information gleaned during screening and assessment with the goal of integrating that data into a "road map" or plan for the patient. It is the "engine" that drives treatment and is most effective when it becomes a dynamic individualized plan.

Interpret Information

As an initial stage in the treatment planning process, interpretation must be free of bias with a primary focus on the patient's individualized needs and desires. This includes understanding the patient's stage of change and level of readiness regarding treatment. Treatment failures can occur when a counselor unknowingly attempts to connect a patient at an incorrect stage of change with treatment goals and interventions that they are not ready for based on their stage of change.

Collaborate

The process of mutually developing a treatment plan is often the first step of a shared journey between the patient and counselor. By forming a positive working relationship, the patient and counselor can work together to formulate goals and objectives in behavioral terms. Writing goals in behavioral terms gives the counselor and the patient a set of goals that are measurable. It also increases the likelihood that the patient has agreed to "do something." This gives the patient acceptable alternatives for treatment that will increase the chance of a positive outcome. An effective treatment planning process also adapts treatment approaches to the patient's attitudes, lifestyle, economic situation, and values, considering any special population with which they are identified.

Examine Treatment Options

Not only must a counselor have knowledge of resources to use for successful treatment, but they must also be able to explain the activities, resources, and methods being proposed for the patient's treatment. This requires both an understanding of the patient's identified issues and an awareness of the wide variety of treatment options to consider in developing an individualized treatment plan.

Confirm Readiness

As stated earlier, a patient's stage of change and level of readiness are key indicators of what approach a counselor takes to be effective at connecting with the patient. Knowledge of motivational processes and the stages of change are necessary to effectively gain the patient's acceptance of treatment while eliciting their preferences for treatment.

Explain Assessment Findings to Patient and Significant Others (38)

Patients have a right to understand the outcome of the assessment process and the recommendations for a treatment plan. The counselor should strive to translate the clinical findings into terms that will help the patient understand the purpose behind each component of the plan.

Patients have a right to know why a particular activity is included in the treatment plan. For example, a patient who has a chance to discuss the purpose for attending Alcoholics Anonymous (AA) and his feelings about it may be more interested in attending than one who is told you must go because it's a program requirement.

Family members may request information about the outcome of the assessment process and the plans for treatment. Federal regulations protect the confidentiality of all substance abuse treatment and prohibit providers from sharing any information about a person's involvement in treatment without expressed written consent of the patient. See Chapters 5 and 10 for more information on confidentiality and family involvement in treatment.

Provide the Patient and Significant Others with Additional Information as Needed (39)

As treatment progresses, the patient and family members may have additional information and concerns regarding progress, expected outcomes, and continued care requirements. The questions don't stop as the treatment continues. In fact, more questions may arise as the full meaning of abstinence and recovery becomes apparent to the patient and their family. Counselors are encouraged to maintain open communication and a therapeutic relationship that allows patients to ask questions and share their hopes and fears.

Examine Treatment Options with the Patient and Significant Others (40)

As mentioned under Competency 29 in Chapter 1, patients have a right to know their treatment options and explore alternatives. Although options may be limited for active-duty military patients, opportunities to explore the benefits and limitations of available treatment will demonstrate a respect for the patient and their needs. Patients always have a choice, even if the choice to not go to the SARP treatment may result in discharge from the military.

CASE STUDY 3.1

Upon further screening, you learn that Ryan is having difficulty sleeping and, when he does, he has frequent nightmares that include some of the experiences he had while deployed.

How would you use this information, along with information gathered about his drinking, to determine initial treatment recommendations and guide the treatment planning process?

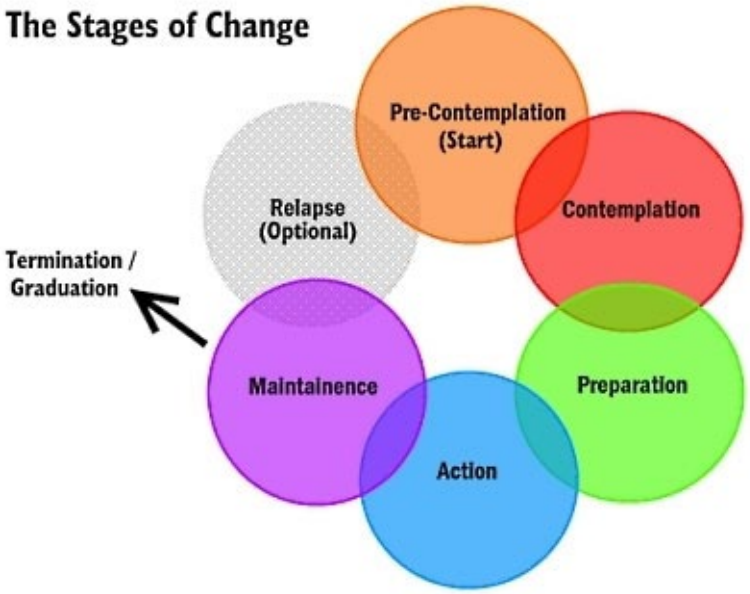
Consider the Readiness of the Patient to Participate in Treatment (41)

Stages of Change

The levels of change described by Prochaska and DiClemente (1984) are *precontemplation, contemplation, preparation, action, maintenance*, and *relapse*. Prochaska and DiClemente describe

the stages as cyclical: the stages can be presented in a wheel with those in pre-contemplation phase not yet having entered the wheel and those who have achieved long-term stability having left the wheel (**Figure 3.1**). This model is applicable to all sorts of change activities and was originally developed while studying smoking cessation. "For most substance-using individuals, progress through the stages of change is circular or spiral in nature, not linear. In this model, recurrence is a normal event because many patients cycle through the different stages several times before achieving stable change" (CSAT, 1999).

Figure 3.1: Stages of Change



SMART Recovery, 2022

Pre-contemplation is the first stage in the change cycle. In this stage, a patient is not considering change. There may be an active decision not to change, or the patient may not have given change much thought at all.

Contemplation, the second stage, occurs when a patient is actively considering change. Ambivalence is the hallmark of contemplation, as patients weigh the pros and cons of a considered change in lifestyle.

Preparation is the third stage in the change cycle. Once a patient has made a committed decision to make a change in the near future, the individual has entered the stage of preparation. The stage of preparation is a window of opportunity, open only for a limited period of time.

Action is the fourth stage in the cycle. Once patients have begun to change their behavior, they have reached the stage of action. In this phase, the patient must respond to the expected and unexpected challenges to maintain the new behavior. Such challenges may be internal or external to the individual. This stage often occurs when the patient is in counseling or therapy.

Maintenance, the fifth stage in the cycle of change, is reached when patients become comfortable with the usual challenges to their new behavior. A patient in this stage may still be in counseling and is meeting the challenge of avoiding relapse at times of major stress. Success requires a concerted effort to maintain change by recognizing the long-term benefits of change.

Relapse is the final stage in the change cycle and is considered a common, normal stage of change in which the undesired behavior is resumed. From relapse, patients may move back to an earlier stage of change.

SAMHSA's *Treatment Improvement Protocol* (*TIP*) series dedicates an entire volume to enhancing motivation for change. *TIP 35* offers guidelines and strategies for moving people through the stages of change (CSAT, 1999). **Table 3.1** summarizes the behaviors and beliefs consistent with the five stages of change. The counselor may use this table as a guide when identifying treatment assignments that will help the patient progress through the stages of change.

Table 3.1: Stages of Change in Treatment

Stage of Change	Patient's Behavior/Beliefs	Counselor's Task
Pre-contemplation	● Does not think there is a problem ● Not even considering change	● Raise awareness ● Raise doubt ● Increase patient's perception of risks
Contemplation	● Ambivalent ● Open to information and decisional balances information ● "Yes, but."	● Tip the balance ● Evoke reasons to change and risks of not changing ● Strengthen self-efficacy
Preparation	● Deciding to make a change ● Choosing strategy ● "What do I do?"	● Assess level of commitment ● Anticipate problems ● Remove barriers
Action (3–6 months long)	● Chooses a strategy and pursues it ● Practicing modified drinking or abstinence	● Increase self-efficacy ● Build skills for successful change ● Reaffirm decision ● Create environment where patient is free to admit lapse/relapse
Maintenance	● Building modified drinking or abstinent lifestyle	● Relapse prevention ● Skill enhancement
Relapse	● Reports lapse/relapse	● Recover as quickly as possible ● Help patient re-enter wheel

Adapted from Prochaska, Norcross, & DiClemente (1994)

It is important to remember that a patient may be in a different stage of change with different problems. For example, a patient may be in contemplation about their alcohol use and action about working on their marriage. Although patient problems are often interconnected to each other, like alcohol use and marriage problems, the patient may not be ready to actively work on both problems simultaneously. Therefore, it is important to prioritize goals and objectives based on the patient's stage of change and readiness. Writing treatment goals and objectives with the active participation of the patient will allow the patient and the counselor to be on the same page regarding what the patient will be working towards in treatment. Writing treatment plans that reflect the stages of change requires creativity and thinking "outside of the box." An example of a typical alcoholism treatment plan activity is to require patients to attend AA meetings immediately upon entering treatment. The *Stages of Change Theory* would question sending someone to a program designed to stop drinking when they have not even begun to consider that they have an alcohol problem.

CASE STUDY 3.2

Upon further screening, you learn that Ryan is concerned that his drinking has increased recently and feels guilty when he chooses drinking rather than spending time with his nephew, but he doesn't think he has a drinking problem. He stated that he can cut down on his drinking whenever he wants but doesn't need to because it isn't a problem.

What stage of change do you think Ryan is in and how will you use this stage of change information to guide the treatment planning process?

Prioritize the Patient's Needs (42)

The counselor and patient must collaboratively prioritize presenting problems in the treatment plan. This process involves making a connection between the patient's problems and needs, which demonstrates to the patient that problems will be treated in the order that best impacts the individual's rate of progress and success in meeting needs. Timing, sequencing, and sensitivity to the patient's needs and perceptions are all important to the success of the treatment plan.

Formulate Mutually Agreed-on and Measurable Goals (43)

The development of a mutually agreed-on plan is the crux of the treatment planning process. It involves formulating mutually agreed-on treatment outcome goals that are measurable and meaningful for successful treatment. It is also important that through the collaborating process with the counselor, the patient gains a sense of "ownership" of the treatment plan. A sense of ownership typically leads to motivation on the part of the patient to pursue the treatment plan goals they helped develop.

CASE STUDY 3.3

As Ryan begins to open up about some of his difficulties, he shares with you that there has been stress in his marriage since he returned from deployment 3 months earlier. There is tension between the two of them that was never there before his deployment.

With the information you have so far, how would you prioritize Ryan's needs in the order they would be addressed in treatment?

Once resolvable problems are identified, the patient and counselor will negotiate specific goals and objectives that are Specific, Measurable, Achievable, Realistic, and Time-related. When writing goal statements, the acronym SMART is a helpful tool in developing a set of clear objectives, or steps that one must take to reach a stated goal.

Specific. Focus must be on a specific area of progress, achievement, or change. What needs to happen for this patient to move to another level of care?

Measurable. Quantify or qualify goals to provide verifiable progress indicators. What dimensional criteria must be met to satisfy goal attainment? Are the goals and objectives measurable?

Achievable. How will the change be accomplished? Who is involved? Does the patient have the capacity to achieve the goal?

Realistic. What is possible? What is realistic? What will be the real results and benefits?

Time-related. Designate accurate time frames for accomplishing goals, objectives, and associated tasks.

Identify Strategies for Treatment Goals (44)

As mentioned above, the mutual development of goals is a crucial step to a successful treatment plan. Knowing the patient's level of motivation, cultural values, and unique treatment and life goals will help mold a mutually agreed-on treatment plan that is both individualized and outcome-oriented. In addition, consideration should be given to literacy levels, physical impairment, and cognitive abilities. For example, service members experiencing memory problems, following a traumatic brain injury, may have difficulty reading and remembering detailed information. Brainstorming creative interventions and confirming the patient's ability to complete the tasks will demonstrate respect for the patient's needs and improve treatment compliance.

CASE STUDY 3.4

As you continue to explore Ryan's needs and gather additional information, he shares with you that his wife has complained about his drinking and that, on occasion, he continues drinking at home after his wife goes to bed. He admits to trying to hide his drinking from her to avoid her complaints.

What short- and long-term goals would you negotiate with Ryan? What objectives do you think would be some appropriate steps for Ryan to make as components of each goal?

Coordinate Treatment Activities (45)

Treatment activities, community resources, and referrals are coordinated with the treatment planning process to ensure they are consistent with the patient's clinical evaluation, including diagnosis and level of care placement. The treatment program may not offer all the services needed by a patient. The counselor will function as a case manager to coordinate referral to other care providers when necessary. It is important that these activities and resources are congruent with the patient's ethnic culture, age, developmental level, gender, and other life circumstances.

Develop, Monitor, and Evaluate the Treatment Plan (46)

The treatment plan becomes the "road map" to the patient's treatment; when the course of treatment requires a "turn" in a new direction, the treatment plan can often point the way. For instance, the patient's level of motivation may change during the treatment process. Likewise, their stage of change may shift forward or backward in the change cycle. Whatever the case, any changes need to be addressed in the treatment plan, which continues to be a work-in-progress.

A patient's treatment may be viewed as a continuum, with all aspects of the treatment plan as ever-changing and fluid. Using the model of change as described in Miller and Rollnick (2012), the cycle allows any observed shift to be part of the process, rather than failure on the part of the patient. The treatment plan becomes the primary means of documenting this cycle.

A process is developed with the patient that is a mutually accepted plan of action and method for monitoring and evaluating their progress toward reaching goals. This also becomes an evaluation of the treatment plan itself. Criteria are established to evaluate progress such as the success of the patient's goal attainment. It is important that the patient is involved in the evaluation process and that the counselor is sensitive to gender or culture issues and is willing to negotiate with the patient in the process of changing or updating the treatment plan.

CASE STUDY 3.5

Sample Treatment Plan for Ryan

Date Entered: 2/8/23

Problem Statement: I know I got a DUI, but I don't know if I have a drinking problem.

Goal: Find out if I have a problem.

Objectives:

Attend class on alcohol use, misuse, and disorders.

Write a history of alcohol use to include use levels and consequences.

Ask my wife what it is about my drinking she doesn't like and share in group.

Target Date: 2/15/23

Date Achieved:

Inform the Patient of Rights to Confidentiality (47)

Throughout the entire treatment planning process, it is important that the patient be kept informed of their confidentiality rights and safeguards established to protect them. Patients also must be made aware of exceptions to confidentiality, such as the sharing of the treatment plan with other staff and/or clinical supervisor. Chapter 5 offers details on the federal and military-specific regulations related to confidentiality.

Review the above problem statement and treatment goals and objectives and determine if it meets the SMART criteria. Discuss with your preceptor.

Reassess the Treatment Plan (48)

Patients' treatment plans are to be assessed at regular intervals and modified as needed due to patient progress and/or changing circumstances. Generally, treatment plans are updated at least once a week or more often if needed. In this process, modifications may be made to the treatment plan to best meet the patient's changing needs based on progress in treatment. Goals may be revised, closed, or added, and target dates may be adjusted commensurate with the changing needs of the patient. The treatment plan thus becomes a living document.

Summary

Treatment planning is the process of working with the patient to mutually identify and rank problems that are individualized to patients' needs and to establish agreed-on goals along with objectives, methods, and resources to achieve them. A well-constructed treatment plan will allow the patient and treatment team to readily track progress and setbacks in treatment. As a road map, it will be returned again and again to assess progress, identify obstacles, and point the way to the next level of care or completion of treatment.

Learning Activities	
1.	Review a treatment plan developed by an experienced counselor with their patient.
2.	Read the presenting information of the case study, as well as the portion of this case included in this chapter. Using the Treatment Planning Grid near the end of this chapter, develop an initial treatment plan for the patient in the case study.
3.	Review and discuss the treatment plan with your preceptor.
4.	Using the Treatment Plan Template, work with a selected patient in the development of their treatment plan and review with your preceptor.
5.	How hard or easy has it been to truly individualize treatment plans? What are the challenges you have faced? Discuss with your preceptor. (Advanced)

Treatment Plan Template

Date Entered	Problem Statement	Goals	Objectives/ Methods	Target Date	Date Achieved

Self-Study Questions

1. What is treatment planning?

2. List five examples of significant problems or issues that a patient and counselor may identify.

3. True or False: Patient input into the treatment planning process is not necessary.

4. Explain why goals should be stated in concrete, behavioral terms.

5. The treatment plan must describe the _____ to be offered, who will _____ the services, _____ they will take place, and how _____ they are to occur.

6. Why is it important that the treatment planning process is a collaborative effort with the patient playing a major role in its formulations?

7. Give an example of a treatment goal.

8. Give an example of an objective as it applies to a goal.

9. Treatment planning should be _____ based on the patient's particular problems and _____.

Self-Study Answers

1. Treatment planning is a collaborative process through which the counselor and patient develop desired treatment outcomes and identify the strategies for achieving them. At a minimum, the treatment plan addressed the identified substance use disorder(s), as well as issues related to treatment progress, including relationships with family and significant others, employment, education, spirituality, health concerns, and legal needs.

2. Examples of significant problems or issues a patient and counselor may identify may include:
   - Lack of support in home environment
   - Lack of interests that support sobriety
   - Prior sexual abuse
   - Marital difficulties
   - Adult child of addicted parent(s)
   - Lack of alcohol-free peer group
   - Recent death of significant other
   - Lack of confidence in ability to make new friends

3. **False.** Patient input into the plan is essential for its success.

4. Goals must be stated in concrete, behavioral terms so that the patient's progress can be clearly measured.

5. The treatment plan must describe the ***services*** to be offered, who will ***provide*** the services, ***where*** they will take place, and how ***often*** they are to occur.

6. The patient becomes more invested in accomplishing the treatment goals as it gives them a sense of ownership and motivation to pursue the goals.

7. Examples of treatment goals are to:
   - Develop new interests to support an alcohol-free lifestyle.
   - Develop new work-related skills.
   - Resolve the grief resulting from the death of a significant other.

8. Examples of objectives are to:

    - Go to the gym 3 days each week
    - Attend four AA meetings each week
    - Enroll in a college course for next semester
    - Read a book about codependency
    - Identify five positive aspects about yourself and write about them in a journal

9. Treatment planning should be ***individualized*** based on the patient's particular problems and ***needs***.

Chapter 4 Referral

Purpose of This Chapter

This chapter reviews the Practice Dimension of Referral and its place in the substance abuse treatment process.

Learning Objectives

The learning objectives directly correlate with Competencies 49–55, as listed in the *TAP 21* (pages 69–74) and IC&RC Domain III: Evidence-Based Treatment, Counseling, and Referral.. Each competency is accompanied by a set of knowledge, skills, and attitudes that define the standard.

- Establish and maintain relationships with civic groups, agencies, other professionals, governmental entities, and the community at large to ensure appropriate referrals, identify service gaps, expand community resources, and help address unmet needs. (49)
- Continuously assess and evaluate referral resources to determine their appropriateness. (50)
- Differentiate between situations in which it is most appropriate for the patient to self-refer to a resource and situations requiring counselor referral. (51)
- Arrange referrals to other professionals, agencies, community programs, or appropriate resources to meet the patient's needs. (52)
- Explain in clear and specific language the necessity for and process of referral to increase the likelihood of patient understanding and follow-through. (53)
- Exchange relevant information with the agency or professional to whom the referral is being made in a manner consistent with confidentiality rules and regulations and generally accepted professional standards of care. (54)
- Evaluate the outcome of the referral. (55)

Introduction

Referral is defined by *TAP 21* as the "process of facilitating the patient's use of available support systems and community resources to meet needs identified in clinical evaluation or treatment planning" (CSAT, 2006).

In a treatment environment where individualized treatment is emphasized, not every facility is expected to meet all the needs of all patients. The continuum of care model emphasizes this point by providing a range of care levels for patient placement. "Once a patient is placed in an appropriate level of care, selection of the specific assessment-based modalities [completes the individualized treatment match]" (CSAT, 1995). This may include referring the patient outside of a specific treatment

program to obtain all required services. This is known as *unbundling* and involves a treatment plan that consists of a "menu" of services chosen to best meet an individual's unique needs. Effective patient care recognizes that not all a patient's needs may be met by one facility. This practice dimension emphasizes the fact that counselors must recognize their limitations and those of their program in meeting patient needs.

Establish and Maintain Relationships (49)

Depending on the size of your treatment program and the size and location of your community, there may be very few or multiple resources available to meet the needs of your patients. Effective and ethical referrals require that the counselor has a clear understanding about the program or clinic to which the referral is being made. For the counselor to be assured of the quality of the referral resource, they must take the following steps:

Consult with Others. Consult with contacts in the substance abuse treatment field. An effective and competent counselor is good at networking with other treatment providers. This includes providers within the Navy, in other branches of the armed services, and in the local community.

Network. Get to know the providers in your immediate community. Contact the Fleet and Family Support Center (FFSC), Family Advocacy Program (FAP), and other on-base providers. Identify what services they offer. Ask your contacts for recommendations for other potential referral programs that specialize in a variety of areas relevant to substance abuse treatment.

Gather More Information. Contact recommended resources over the telephone to gain further information about their philosophy and approach to treatment. What areas do they specialize in? For example, do they treat dually diagnosed patients? Do they support the 12-Step philosophy? Do they provide medication management?

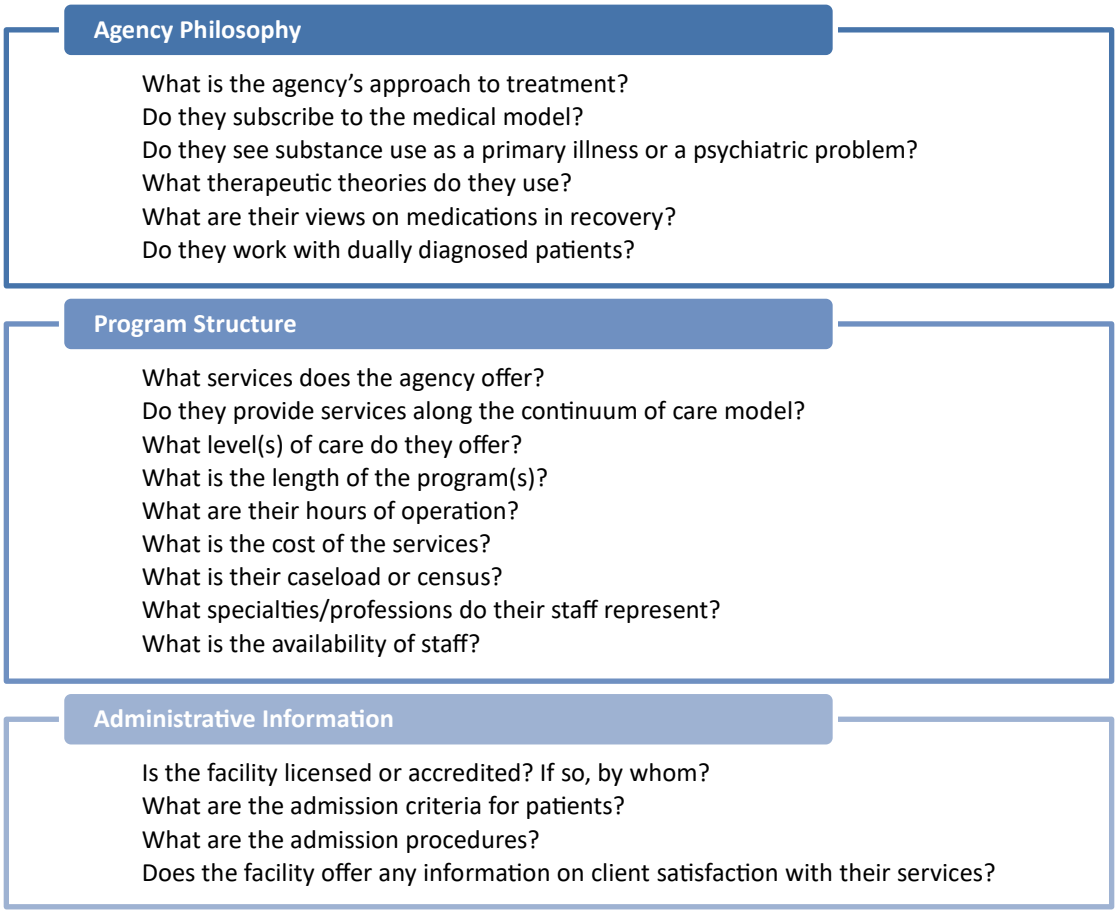
Meet Possible Referrals. Make site visits to tour various resources and gather additional information about their services.

Create a Directory. Develop a referral directory with as many appropriate resources as possible. Catalog the manual so that various types of services or specialties are appropriately referenced for accessibility.

Evaluate Referral Sources (50)

When referring to a resource in your community, it is important to remember that the sources you use are a reflection on you and on the Navy. When a doctor you trust sends you to a specialist, what kinds of expectations do you have about that pending referral? Your patient will have similar expectations of referrals you provide. As referral resources are contacted and toured, the following information may be documented in a referral directory (**Figure 4.1**):

Figure 4.1: Referral Directory



Evaluate the Need for Referral (51)

The need for referral may occur at any time during treatment; however, there are some specific times that lend themselves to evaluating whether the patient needs a referral. During screening, a patient may be determined not to be appropriate for the program. At intake, the patient may present information in more detail than during screening and, again, be referred to another resource. Another opportunity for a referral is during assessment when more detailed profiles are taken. Treatment planning is another natural opportunity for referral. During the treatment planning stage, the patient and the counselor may determine some specific needs of the patient that the facility cannot meet.

CASE STUDY 4.1

Your assessment of Ryan results in you determining that he is having some serious problems related to his possible PTSD and that there is continuing stress in his marriage. You also sense that his emotional problems seem to intensify whenever he starts to talk about his experience during deployment.

How do you determine what other resources (civilian or military) your facility uses for issues and problems that your SARP is not equipped to address? What other referral resources might you consider for Ryan?

Making the Referral (52, 53)

Once it has been determined that a referral is necessary, the counselor must discuss with the patient why the referral is needed. The counselor must demonstrate to the patient how a referral can best help them accomplish the goals in the treatment plan and why the agency or program to which they are being referred is the best resource. The counselor must take an active role in making the referral but, whenever appropriate, have the patient make the phone call to arrange an appointment. In the case of a referral to a self-help group such as AA, the patient should be given the name and phone number of a contact person along with a directory of meetings.

When making a referral, consider the following questions:

Does the patient agree with the referral? What is their comfort level with the program needing to be contacted? Is there an alternative that would result in increased patient interest?

- What is the patient's history of following through with recommendations and referrals?
- What is the patient's capacity to follow through on the referral? Example: Does the patient have a vehicle or access to public transportation? Do they need childcare?

Which group do you think was more likely to follow through on the referral to 12-Step meetings?

In Sisson and Mallams (1981), researchers wanted patients to begin attending AA and Al-Anon meetings. Patients attending an outpatient alcohol treatment program were randomly assigned to two groups. The patients assigned to the first group were encouraged to go to 12-Step meetings and given information about local meetings, including schedules and locations. The second group received assistance from the counselor that was designed to help overcome barriers to meeting attendance. With the patient in the room, the counselor made a phone call to an AA member. The member spoke with the patient and offered to provide transportation and accompany the patient to the first meeting. The member also obtained the patient's phone number and placed a reminder call to the patient the night before the scheduled meeting.

Of those patients assigned to the second group in which they received assistance from the counselor in facilitating the referral, 100 percent attended an AA or Al-Anon meeting within the first week and continued to attend. None of the patients assigned to the first group and only given a meeting schedule attended a meeting (Sisson & Mallams, 1981).

CASE STUDY 4.2

How would you explain the need for a mental health referral to Ryan? What are the potential obstacles you see? Where would you refer him? How can you assist him with this referral?

Confidentiality Requirements in the Referral Process (54)

If the referral is to a treatment agency outside of military medicine, a consent for release must be signed so that information may be shared with the agency. If the counselor is contacted by the agency after the patient begins treatment there, they must request that the patient sign a consent form at the agency so that information may be shared both ways, between the counselor and the referral resource.

CASE STUDY 4.3

You determine that Ryan will need to be referred for a mental health evaluation to rule out PTSD. The only psychologist on the team at the medical clinic on your base is on emergency leave for 30 days. Currently, all referrals for mental health screening are being made to a Tricare-approved civilian mental health provider.

What information would you share with the civilian provider? What documents would you release? What documents would the patient need to sign to facilitate the referral? What information would you want to receive from the mental health provider? How would you ensure communication between you and the referral source is consistent with confidentiality rules?

Evaluating the Outcome of the Referral (55)

It is important to follow up with patients regarding their experience with all referrals made on their behalf. Most importantly, you need to determine if the patient's treatment needs are being met by that referral source and, if not, make alternative arrangements to address those problem areas. Referrals may not result in additional care for a variety of reasons:

- The patient may be assessed as not having a problem served by that provider, such as when a mental health diagnosis is ruled out.

- The patient may not have liked the program or provider and does not want to follow up.
- The patient may experience obstacles to following through with the referral that were not previously identified.

The skilled counselor will question the patient about the referral process and identify any additional steps that need to be taken to meet the patient's needs.

When new information about a referral source is identified, the counselor can add information to the site's referral directory that will assist the team in making appropriate referrals in the future. This can include an update on parameters of the program and feedback received from patients regarding their experience with the provider or program.

Summary

Referral is the process of facilitating the patient's use of available resources to meet needs identified during assessment and treatment. An effective referral process considers the treatment needs and motivation of the patient, the services offered in the community, the openness of the provider to integrating care with the treatment program, and confidentiality regulations. Effective coordination of the referral process can teach patients to navigate the service delivery system and advocate for their recovery needs.

Learning Activities

1. Identify if your site has a referral directory available for the team. If not, write the names of 10 referral agencies within a 15-mile radius of your facility. Use your site's referral directory or the list you just created to answer the questions and complete the activities listed here:
   - Have you or anyone you know ever visited these agencies?
   - Using the questions provided in this chapter, answer as many as you can about each resource.
   - How did you learn this information?
   - Process with your preceptor.
2. Identify the "Release of Information" documents available at your site for use in referring patients to outside sources. With a senior counselor or your preceptor, review these documents and complete a form using a current case or the fictitious patient "Ryan." Review with your preceptor.
3. Looking back over the screenings done in the past 3-4 months and the referrals made to various treatment levels, were the referrals made appropriate for what was identified through the screening/assessment process for this patient? If you have had follow up with the patient, how was their experience with the referral? Did the patient make progress/improvement? Was the referral a good match for the patient's needs? Review with your preceptor. (Advanced)

Self-Study Questions

1. Describe the concept of *unbundling*.

2. **True or False:** You do not need to know much about a service provider to make an effective referral.

3. What information about a resource should go into a referral directory?

4. **True or False:** The best way to test a patient's seriousness about getting help is to leave it up to them to follow through with a referral.

5. **True or False:** The purpose of a referral is to compensate for a counselor's lack of skills.

6. Name four specific opportunities to evaluate whether the patient needs a referral to another resource.

Self-Study Answers

1. *Unbundling* refers to an approach to treatment that seeks to provide a combination of services to match a patient's needs. This may involve providing services to a patient that represent two or more levels of treatment along the continuum of care.

2. False. An effective counselor maintains a relationship with other service providers to match patients with unmet needs to the most appropriate resources in the community. It's very important that the counselor understands what services are provided, who provides them, and where and how they are provided.

3. Information about an agency's philosophy, program structure, and administration should go into a referral directory.

4. False. Putting the onus on the patient to follow through with a referral should not be a test of motivation. It is often necessary for the counselor to make first contact with the referral source to make it happen.

5. False. The referral process recognizes that there are limits to a counselor's scope of practice and to a program's ability to address all the biopsychosocial needs of a patient.

6. Four opportunities to evaluate whether a patient needs a referral source are:
   - Screening
   - Intake
   - Assessment
   - Treatment planning

Chapter 5 Service Coordination: Implementing the Treatment Plan

Purpose of This Chapter

This chapter reviews the Practice Dimension of Service Coordination by focusing on its first element: Implementing the Treatment Plan.

Learning Objectives

The learning objectives directly correlate with Competencies 56–61, as listed in the *TAP 21* (pages 79–85) and IC&RC Domain III: Evidence-Based Treatment, Counseling, and Referral. Each competency is accompanied by a set of knowledge, skills, and attitudes that define the standard.

- Initiate collaboration with the referral source. (56)
- Obtain, review, and interpret all relevant screening, assessment, and initial treatment planning information. (57)
- Confirm the patient's eligibility for admission and continued readiness for treatment and change. (58)
- Complete necessary administrative procedures for admission to treatment. (59)
- Establish accurate treatment and recovery expectations with the patient and involved significant others. (60)
- Coordinate all treatment activities with services provided to the patient by other resources. (61)

Introduction

TAP 21 defines service coordination as "the administrative, clinical, and evaluative activities that bring the patient, treatment services, community agencies, and other resources together to focus on issues and needs identified in the treatment plan" (CSAT, 2006, p. 79). The element of implementing the treatment plan focuses on the process of putting into place the recommendations made following the screening and assessment of the patient.

What motivational interviewing techniques might help you engage the patient who is angry that his command forced him into treatment?

Counselor awareness of the disposition of the patient at this time is crucial. Consider the following possibilities:

- Fear of the treatment process
- Confusion (if in detoxification stage or a comorbid disorder exists)

- Stage of change
- Short-term memory loss
- Difficulty concentrating

Demonstrating an awareness of these factors will assist the counselor in establishing a relationship based on respect for the patient as an individual with rights in the treatment process. The skills and attitudes that the counselor brings to the implementation of the treatment plan will help to establish a tone of service delivery to the patient.

Collaborating with the Referral Source (56)

The source of the referral to the treatment program will impact the amount of information that the counselor has available pertaining to the current issues at work in the patient's life. A patient referred from the emergency room following a car accident in which the patient had elevated blood alcohol content and was charged with driving while intoxicated may have more information readily available for the counselor than the patient who self-refers by stating "I need to get control of my drinking."

The task of the counselor is to collaborate with referral sources. The treatment process begins the first time a provider connects with a potential patient regarding their substance use. The referral agent may have a wealth of information, to include an impression of the motivation of the patient for seeking help or input regarding the social impact of their use.

CASE STUDY 5.1

Ryan was referred to the SARP following an arrest for a DUI. He was interviewed by the command Drug and Alcohol Program Advisor (DAPA) and referred to the SARP for further evaluation.

What information would the DAPA have that would be pertinent to your assessment and treatment recommendations for Ryan?

Although a patient may arrive with a referral form that provides details of the precipitating incident, it can be very useful for the counselor to contact the referral source and confirm their understanding of the data that has been transmitted. Not only does this offer an opportunity to gather further information from the referral source, but it also serves to validate the work of the referring agent. A community resource who knows that the information they pass on to a treatment provider is useful and valued will be likely to continue to provide thorough documentation with future referrals. Once treatment is initiated, ongoing communication with the referral source helps to maintain a continuity of care and may ease the transition back into the community once treatment has been completed.

Obtain, Review, and Interpret Information (57)

Patients seeking treatment for substance abuse will come with a variety of paperwork and documentation regarding their health, drinking patterns, prior treatment, and consequences due to

their substance use behavior. This may include items such as screening instruments, hospital discharge summaries, and military police blotter reports. Based on a review of the patient's reported history, the counselor should consider seeking out documentation that the patient may not have made available. For example, a patient may state that they have been in marital counseling prior to the referral for treatment. Following confidentiality regulations, the counselor can contact the marital counselor to obtain any information related to the patient's drinking and impact on their marriage.

CASE STUDY 5.2

Your SARP operates a Level 2 Intensive Outpatient Program (IOP), and you have determined that Ryan is an appropriate candidate for admission.

What would determine Ryan's eligibility to enter a Navy SARP Level 2 IOP? What are the necessary administrative procedures for Ryan's admission to treatment?

Confirm Eligibility and Readiness for Treatment (58)

The counselor needs to be familiar with the use of forms completed during screening that support the patient's admission to treatment. All documentation completed at the time of screening and assessment should be reviewed. Any unresolved issues or changes in circumstances should be noted.

CASE STUDY 5.3

Your treatment program has a policy of reconfirming all patients' status regarding their alcohol use upon arrival for admission to treatment. This includes completing a brief questionnaire reporting the patient's last drink and completing the CIWA-Ar (see screening tools in Chapter 1).

Would the date of Ryan's last drink influence his eligibility for IOP? What would you do if he were exhibiting withdrawal symptoms? What would you do if he has not had a drink in 30 days or more?

Readiness for Change

Part of the treatment process entails the ongoing assessment of the patient's readiness for change. Military personnel are mandated patients. Even those who self-referred and asked for help are ultimately required to participate in the level of care that is recommended by the treatment team. Motivational Interviewing (MI) can be a helpful technique for counselors to use when working with patients to assess their willingness to follow through on the plans that have been laid out. They may find that they "bit off more than they could chew" when they find themselves in an intensive

outpatient program requiring them to attend self-help groups and remain alcohol free for a year or more.

Historically, when most persons discussed substance use treatment, they used the term "receive treatment," as if treatment was something that was handed to you or that you took from a program. It implied a hierarchical relationship in which the counselor was in charge of the patient. "Today, treatment usually entails a partnership in which the patient and the clinician agree on treatment goals and work together to develop strategies to meet those goals" (CSAT, 1999). The task of the counselor is to engage the patient in this partnership.

Complete Administrative Procedures for Admission (59)

The counselor must be familiar with the administrative procedures and required forms for admitting a patient to the treatment program. This may include intake questionnaires, withdrawal assessments, privacy paperwork, informed consent, and insurance reimbursement forms. Working within the military system decreases the pressure related to treatment costs and managed care by insurance programs for active duty personnel. The Navy counselor, however, needs to understand that these are issues that impact accessibility to treatment for most persons in need of services.

Federal Confidentiality Regulations

Patients being treated for substance use are covered under federal confidentiality regulations (42 C.F.R. § 2). "These regulations impose restrictions upon the disclosure and use of alcohol and drug abuse patient records which are maintained in connection with the performance of any federally assisted alcohol and drug abuse program" (42 C.F.R. § 2.3). These regulations require that a consent to release information be signed by the patient before disclosures are made (42 C.F.R. § 2.22).

Confidentiality regulations must be clearly spelled out. This should include the purpose of these regulations, as well as their limitations. The counselor is both ethically and legally bound to follow the rules of confidentiality. These rules are designed to protect the patient's identity and the content of the counseling sessions, as well as to prevent the release of information to anyone, including family members, without the patient's written permission.

Exceptions to requiring a signed release to make disclosures include the following:
-Internal program communications
-Communications that do not disclose patient identifying information
-Medical emergencies
-Court-ordered disclosures
-Patient crimes committed on the premises of the program or to program personnel
-Qualified persons conducting audit, research, or program evaluation
-Child abuse and neglect

Confidentiality Requirements for the Navy

Although federal law governs confidentiality requirements, they can be superseded by Navy regulations. The federal code allows for an "interchange of information within the Armed Forces" and "between the Armed Forces and those components of the Veterans Administration furnishing health care to veterans" (42 C.F.R. § 2.12).

What kinds of obstacles might prevent a military patient from completing the treatment requirements? How might you elicit the identification of these obstacles early in treatment?

As Navy confidentiality regulations are explained in the initial counseling session, the patient must be assured that any information that is released is done so in their best interest. It is important how this explanation is made and that it is not made in a way that makes the patient distrustful or lose confidence in the counselor. The issue of confidentiality should be seen by the counselor as a therapeutic tool, not as a weapon. Navy SARPs use the "Privacy Act Statement" to document the regulations as they pertain to active duty personnel. The Privacy Act allows for specific exceptions in respect to maintaining confidential disclosures. Counselors need to be well versed in the current regulations regarding the Privacy Act and reportable information. Counselors should consult with program managers for current regulations.

It is incumbent upon the counselor to fully understand confidentiality regulations so that during the course of counseling, a high level of trust prevails, and the patient clearly understands the ramifications with regard to Navy confidentiality regulations. It is also important that the counselor let the patient know that there are other resources available, such as a chaplain, who may not be bound by confidentiality regulations. Military chaplains, when acting in their roles as clergy, are not bound by Navy confidentiality regulations for drug and alcohol counselors and, hence, will not disclose any information shared by the patient. The exception to this, however, is when a chaplain is acting in their role as a counselor.

CASE STUDY 5.4

Ryan's wife calls the SARP the afternoon of his first day in IOP. She wants to talk to someone about Ryan's drinking. The clerk who answered the main phone number forwarded the call to your voicemail.

What steps do you need to take before talking to Ryan's wife? What procedures does your program have to ensure that the presence of a patient in treatment is not disclosed inappropriately? What would you do if you had answered the phone and Ryan's wife had been on the line before you had time to prepare?

Establish Treatment and Recovery Expectations (60)

It is important at the start of the treatment process that the patient has an understanding of the treatment process and expectation for their recovery. These expectations include but are not limited to (CSAT, 2006, p. 84):

- The nature of services
- Program goals
- Program procedures
- Rules regarding patient conduct
- The schedule of treatment activities
- Costs of treatment
- Factors affecting duration of care
- Patient rights and responsibilities
- The effect of treatment and recovery on significant others

A thorough orientation to the treatment program should answer patient questions and help to reduce anxiety or apprehension. Additionally, the process of establishing expectations for treatment and recovery is another step in building trust with the patient. As the counselor has worked with empathic and reflective listening throughout the screening and intake processes, they continue a patient-centered approach throughout the orientation to the treatment program. By building comfort with the program and treatment system, the patient will be more at ease with the treatment setting and become more confident that the staff will be responsive to their needs.

Establishing expectations includes a review of program rules and the patient's rights and responsibilities. Each treatment program should have an established list of patient's rights and responsibilities, which should be made available in writing for each patient. Included in these expectations should be information regarding infractions that can lead to disciplinary action or discharge. Although completing this review may be time consuming, it provides a continued opportunity to establish a relationship with the patient that respects their role as a consumer of the service you provide.

For more information about the needs of families, see Chapter 10.

When possible and applicable, involvement of the family in the treatment process is always encouraged. Military operations and duty locations frequently limit the amount of involvement offered to family members. At a minimum, programs should make available written material in print or online that offers family members an overview of the program services, operating procedures, and rules governing confidentiality. Many self-help, community, and online resources are available for families impacted by substance use if services for families are not available at your site.

CASE STUDY 5.5

During your session with Ryan on his first day in treatment, he reported that he had been to see the psychologist he was referred to at the time of his assessment. He said that he has been referred to a group at the hospital for service members with PTSD. He asks how this will impact his treatment program.

What will you say to Ryan? What steps will you take if you have not received a report from the psychologist? How does his involvement in an outside group impact his recovery expectations? If his wife asks, can you release information about his PTSD to her?

A thorough explanation of the program expectations decreases the potential for misunderstandings and legal problems. It is in the counselor's best interest to be aware that at any time their behavior or professional judgment may be disputed by the patient and could involve legal action. If the counselor has been methodical in completing the orientation process, the patient should have signed off on each phase of the procedure and, therefore, may be considered fully aware of their rights and responsibilities. The oral program description should be supported with written documents, ensuring a paper trail that will support the counselor and the program.

Coordinate all Treatment Activities (61)

In Chapter 4, Referral, procedures for identifying and making referrals for patients who have treatment needs that cannot be met by the Navy were discussed. Competency 61 addresses the requirement to coordinate treatment activities that are provided by other resources. Careful coordination of treatment services allows the patient to obtain assistance for all issues that may impact their ability to resolve their substance use disorders. When coordinating services, the substance use counselor functions as a case manager.

Thorough coordination of treatment activities requires the case manager to:

- Deliver case presentations
- Collect and interpret treatment information from diverse sources
- Demonstrate accurate, clear, concise oral and written communication.
- Participate in interdisciplinary team meetings
- Serve as an advocate for the patient utilizing negotiation, conflict resolution, problem solving and mediation skills in the best interest of the patient.

When a patient is referred to services that will occur concurrently with substance use treatment, the case manager is responsible to ensure all required documentation is provided to other providers or agencies and to coordinate scheduling of services. The counselor may need to provide a case summary and arrange transportation, depending on the service. While complying with and

completing treatment is the patient's responsibility, comprehensive case management can go a long way in ensuring the patient gets all of their needs met.

Summary

Implementation of the treatment plan marks the process by which the activities identified in the assessment and treatment planning process are started. Counselors are responsible for providing patients with the information and materials that will allow them to take responsibility for their treatment and recovery process.

Learning Activities
1. Observe another counselor review the "Privacy Act Statement" with a patient, or role play the review with your preceptor. Discuss with your preceptor.
2. Gather your clinic's forms used to obtain and release medical information about patients. Review the forms with your preceptor and differentiate the circumstances in which each form would be used.
3. Review the documentation provided by the command DAPA for three different cases. List the information you would find most helpful when working with a patient and any additional information you would want. Discuss with your preceptor how you will apply these findings to your work with future patients.
4. Present a case presentation to your team or preceptor of one of your recent patient screenings where you made a referral to a level of care or service outside of the SARP clinic. Present your rationale for making the referrals that you made as well as how you coordinated the services for the patient. Discuss successes and challenges with service coordination. (Advanced)

Self-Study Questions

1. List three reasons why a counselor should contact the referral source when a new patient enters treatment.

2. **True or False:** A counselor may contact the Navy Family Advocacy Counselor who referred the active duty patient to treatment without having the patient sign consents to release or obtain information.

3. List four expectations of treatment that should be discussed with the patient.

4. A thorough explanation of the confidentiality regulations applicable to your program and patient is required because:

   a. The patient has a right to know.
   b. It will help prevent misunderstandings and legal problems.
   c. Both of the above.

Self-Study Answers

1. Three reasons to contact a referral source are:

    1. To confirm information that was documented on the referral form and gather additional information.
    2. To build a relationship with the referral source that will enhance ongoing referrals.
    3. To ease the transition of the patient back into the community.

2. **True.** Navy Family Advocacy Program and Fleet and Family Support Center counselors are military service providers and thus exempt from the requirements of the 42 C.F.R. § 2 regulations; however, the counselor may receive only information about the active duty member, not their spouse or children.

3. According to the *TAP 21,* the expectations for treatment and recovery that should be reviewed with the patient include:

    - The nature of services
    - Program goals
    - Program procedures
    - Rules regarding patient conduct
    - The schedule of treatment activities
    - Costs of treatment
    - Factors affecting duration of care
    - Patient rights and responsibilities
    - The effect of treatment and recovery on significant others

4. **C.** Patients have a right to know how information gathered about them will be used. Explaining the regulations and providing written copies of the program policies may help prevent the patient's misunderstanding of steps that are taken throughout his course of treatment.

Chapter 6 Service Coordination: Consulting

Purpose of This Chapter

This chapter reviews the Practice Dimension of Service Coordination by focusing on its second element: Consulting.

Learning Objectives

- Summarize the patient's personal and cultural background, treatment plan, recovery progress, and problems inhibiting progress to ensure quality of care, gain feedback, and plan changes in the course of treatment. (62)
- Describe the importance of understanding the terminology, procedures, and roles of other disciplines related to the treatment of substance use disorders. (63)
- Contribute as part of a multidisciplinary treatment team. (64)
- Apply confidentiality rules and regulations appropriately. (65)
- Demonstrate respect and nonjudgmental attitudes toward patients in all contacts with community professionals and agencies. (66)

The learning objectives directly correlate with Competencies 62–66, as listed in the *TAP 21* (pages 86–89) and IC&RC Domain III: Evidence-Based Treatment, Counseling, and Referral. Each competency is accompanied by a set of knowledge, skills, and attitudes that define the standard.

Introduction

As discussed in Chapter 5, the practice dimension of service coordination involves the activities that bring together the patient, treatment providers, and community resources. The element of consultation specifically focuses on the counselor's role in using the expertise and resources offered throughout the professional community to address the issues identified on the patient's treatment plan.

As a core function of alcohol and drug counseling, consultation was originally defined by the IC&RC as "relating with counselors and other professionals in regard to patient treatment (services) to assure comprehensive quality care for the patient" (Herdman, 1997, p. 81). The focus of the global criteria was on recognizing issues that went beyond the counselor's knowledge or skill level and the seeking of appropriate support following privacy regulations. The *TAP 21* expands the definition of consultation to include case conceptualization and management skills. In addition, competency in this element requires the counselor to take on the role of an advocate for quality patient care with an attitude of respect and professionalism.

For more information about referral guidelines, see Chapter 4.

Alcohol and drug counselors consult with other disciplines for two primary reasons. First, the counselor seeks consultation when an issue is beyond the scope of the counselor's role, or the services provided by the program. In the Navy SARP system, the issues that may be beyond the scope of the counselor or program include, but are not limited to, mental health treatment, family counseling, retirement planning, and legal services. A counselor would seek input from another counselor, preceptor, or other professional to discuss the needs of the patient and the availability of additional services to address those needs. Once it has been determined that another type of service will be included on the treatment plan, the consultation will turn into a referral and subsequent communication with providers will require following referral guidelines.

What are the six ASAM dimensions? What other disciplines might be involved in your patient's care?

Consultation is also required when a counselor determines that a patient's needs are beyond their skill level, even if the issue is within the scope of alcohol and drug counseling. In this instance, a counselor might contact their preceptor, clinical supervisor, or someone from another discipline to determine the best course of action, whether it might include ongoing treatment with close supervision and direction from a more experienced provider or referral to another program. An example of this might be a patient with a co-occurring disorder. Depending on the skill level of the counselor, available supervision, and the severity of the patient's problems, care may or may not be able to continue at the same level of treatment.

Summarize Information (62)

Consultation requires the counselor to synthesize and summarize material for presentation to the treatment team or other professionals. The counselor needs to be able to pull out the important information from the patient's history and treatment course that will enable other professionals to have a clear picture of the issues in question. This might be done in an oral presentation at an interdisciplinary team meeting or in writing as a case presentation. *TIP 52* offers a Sample Case Consultation Format that can be used by counselors for the purpose of documenting information for training purposes (CSAT, 2009, p. 124).

Key areas to discuss in a case presentation include:

- Identifying data
- Presenting problem
- Important history or environmental factors, including cultural factors
- Tentative diagnosis
- Plan of action
- Intervention strategies
- Concerns or problems, such as ethical concerns

TOOL 16 SAMPLE CASE CONSULTATION FORMAT

Name of Presenter: _____

Date: _____

Identifying data about the patient (age, marital status, number of marriages, number and ages of children, occupation, employment status):

_____
_____
_____

Presenting problem:

_____
_____

Short summary of session:

_____
_____

_____
_____

Important history or environmental factors (especially cultural or diversity issues):

_____
_____

_____

Tentative assessment or problem conceptualization (treatment plan):

_____

_____
_____

Plan of action and goals for treatment (treatment plan):

_____

_____

_____

Intervention strategies: _____ _____

_____

_____

Concerns or problems surrounding this case (e.g., ethical concerns, relationship issues):

_____

_____

Adapted from CSAT (2009)

CASE STUDY 6.1

You are asked to provide a case presentation, with Ryan as your case, to the rest of your SARP staff and preceptor.

What information would you include in the presentation? What would you expect to gain from others who will be discussing your case with you?

Understand Terminology, Procedures, and Roles of Other Disciplines (63)

Quality substance use disorder treatment requires the input of many disciplines. A reflection on the ASAM PPC-3R assessment dimensions is a place to start to consider the different professions that might be involved in a patient's care.

Case materials can include medical record reports from a detoxification unit, a mental health report with diagnoses identified, and documentation from the service record demonstrating nonjudicial punishment. The counselor will benefit from a working knowledge of common terminology used by members of your multidisciplinary team. The National Library of Medicine, National Institutes of Health offer an online medical dictionary at: www.nlm.nih.gov/medlineplus.

Each discipline or profession employs its own vocabulary and cultural norms that are apparent when communicating with each other. When consulting with other disciplines, it is important to remember that terminology second nature to you may not be to them. Just as medical terminology may seem like a foreign language to you, the acronyms, slang, and terminology that are part of the Navy counselor's everyday language may not be familiar to the community mental health provider you must consult with when the active-duty psychologist is on leave.

What does the following statement mean to you?

HMCS Jones received NJP following a health and comfort inspection during which Spice was found in his sea bag.

Which terms might only be familiar to a member of the military? Would you expect all other disciplines to know what Spice is?

How could you rewrite the statement so that nonmilitary, non-substance abuse treatment professionals might better understand it?

Multidisciplinary Treatment Team (64)

Professionals working together, supporting each other, and giving relevant input and feedback provide maximum benefits to the patient. When treatment staff members work together as a team, the effectiveness of the treatment process for each patient is improved. A consultation meeting with interdisciplinary team members provides a forum for clinical discussions that result in input from a variety of perspectives and disciplines. "The expertise and involvement of specialists from several disciplines are critical for positive patient outcomes (CSAT, 1999, p. 3). When a case is discussed among team members, a degree of synergism occurs. The diversity of the group provides creative ideas not considered by the counselor alone. The counselor benefits by articulating their perspective on the case and then receiving input from the other members of the team.

CASE STUDY 6.2

What other disciplines will be important to consult with for Ryan's care?

Role of the Preceptor

A primary source of consultation for the Navy counselor is the clinical preceptor. Your preceptor is a trained and experienced clinician who can be used as a valuable resource. Clinical supervision with a preceptor is a key ingredient in the counselor's training experience. Although this expertise is extremely valuable by virtue of what the preceptor has to offer, "nothing matters more to counselors than the process of open, professional sharing with a trusted, objective clinical expert" (Powell & Brodsky, 2004, p. xxxv).

"Every clinician, regardless of level of skill and experience, needs and has a right to clinical supervision."
CSAT 2009, p. 5

Counselors should meet individually with a preceptor as often as possible. Logistics and scheduling may prevent

individual supervision from occurring weekly, but regular and frequent interface with a qualified clinical supervisor is essential. Everyone benefits from clinical supervision, even preceptors.

CASE STUDY 6.3

Ryan has begun treatment at your SARP, and you find yourself struggling to connect with him. You have attempted to connect with him using the Motivational Interviewing (MI) approach but do not feel you have been having much success.

What resources are available to you to consult about your difficulties with Ryan?

Confidentiality and Consultation (65)

When developing a network of professional resources, counselors must be aware of regulations and policy issues relative to protecting the patient. For instance, if identifying patient information is to be shared with professionals outside of the Navy treatment system, consent for release of information must be signed by the patient. If, however, consultation is sought with an outside professional and no identifying information regarding the patient is revealed, no consent would be necessary. An example is the counselor who consults with a physician about the meaning of a patient's symptom but gives no other information about the patient. No consent is necessary because the physician in no way could identify the patient. The counselor who has a clear understanding of when consent for release of information is needed demonstrates competence in this dimension.

When might the sharing of identifying information be important when seeking consultation? Is it possible to break confidentiality when seeking consultation even if you do not use the patient's name?

Professional Demeanor (66)

In Competency 66, *TAP 21* states that addiction counselors need to "demonstrate respect and nonjudgmental attitudes toward patients in all contacts with community professionals and agencies" (CSAT, 2006, p. 89). To demonstrate competency in this area, the counselor needs to show that they can "establish and maintain non-judgmental, respectful relationships with patients and other service providers." Respectful treatment of patients has a significant impact on their satisfaction with and compliance with treatment recommendations.

In a national survey of more than 5,500 Americans, those who said they were treated with dignity during their last medical encounter were more likely to report higher levels of satisfaction with care, adhere to therapy, and get preventive services. (Johns Hopkins Medical Institutions, 2005)

The importance of respect for patients and colleagues has been firmly established in the helping professions as demonstrated by its mention in the Code of Ethics adhered to by many different professional organizations. The American Counseling Association (ACA), National Association of Alcoholism and Drug Abuse Counselors: The Association for Addiction Professionals (NAADAC), and the Navy all incorporate respect into their codes of ethics.

Navy Alcohol and Drug Counselor Code of Ethics: Paragraph e.3.	NAADAC Code of Ethics: Principle I-1: Client Welfare	ACA Code of Ethics: Section A.1.a.
I will treat patients and colleagues with respect, fairness, and courtesy, and will act with integrity in dealing with them and all others who seek my professional services.	Addiction professionals …shall act for the good of each client while exercising respect, sensitivity, and compassion. Providers shall treat each client with dignity, honor, and respect, and act in the best interest of each client.	The primary responsibility of counselors is to respect the dignity and promote the welfare of clients.

Respect for patients includes an acknowledgement of diversity and commitment to providing services without discriminating against patients or colleagues. Some organizations provide a detailed list of protected characteristics in their ethical codes.

All organizations make it incumbent on the counselor to educate themselves regarding diverse cultures and ethnic differences to provide the best care. The ACA goes one step further and asserts that respect for other disciplines, and the counselor's relationship with their colleagues has an impact on the quality of care and professionalism of the counseling.

NAADAC Code of Ethics: Principle I-6: Discrimination	ACA Code of Ethics: Section D
Addiction professionals shall not practice, condone, facilitate, or collaborate with any form of discrimination against any client on the basis of race, ethnicity, color, religious or spiritual beliefs, age, gender identification, national origin, sexual orientation or expression, marital status, political affiliation, physical or mental handicap, health condition, housing status, military status, or economic status.	Professional counselors recognize that the quality of their interactions with colleagues can influence the quality of services provided to patients. They work to become knowledgeable about colleagues within and outside the field of counseling. Counselors develop positive working relationships and systems of communication with colleagues to enhance services to patients.

Cultural Diversity

To be respectful of their patients and colleagues, it is important for counselors to acknowledge the cultural diversity among their patient and professional community. An effective counselor must examine their own stereotypes and assumptions about people, learn to value differences, explore perceptions of others, and learn how diversity can enhance the clinical environment. Counselors who are part of the majority culture tend to hold assumptions about human behavior and change that reinforce cultural bias and have an impact on the clinical relationship. Most treatment models and programs have been designed based on the needs of the majority culture. To develop their professional abilities further, counselors need to learn more about cultures or groups different from themselves. This may be accomplished through consultation with other professionals who are versed in multicultural issues.

> "We cannot assume that research and program design applicable to middle-class white Americans will be equally applicable to minority communities."
> (Mack, Harrington, & Frances, 2010, p. 170)

Counselors can benefit by identifying the assumptions, biases, and values that may interfere with their ability to work with patients and counselors of different cultural backgrounds. Counselors should make every effort to learn about people different from themselves by being inquisitive through personal experience, books, periodicals, the media, courses, and other training opportunities. Counselors also must not hesitate to seek the consultation of others, such as a preceptor, a fellow counselor, or another professional, all of whom are valuable resources in one's quest to become more culturally competent.

CASE STUDY 6.4

Have you made any assumptions regarding Ryan's race, culture, or ethnicity? Is there any information in the introduction of Ryan found in Part III: Chapter 1 that influenced your assumptions? What experiences of your own may have influenced your assumptions?

Summary

The importance of counselors developing competency in the skill of consultation has been recognized by the substance abuse treatment field since the adoption of the original Core Functions by the IC&RC. Its inclusion as an element in the practice dimension of service coordination in the *TAP 21* continues to mark consultation as a skill that is necessary for counselors to develop to deliver quality services. No one person can have expertise across all biopsychosocial dimensions that are impacted by substance use. By recognizing and developing the skills to work within a multicultural, multidimensional service delivery system, counselors will enhance their ability to reach their patients and ensure their treatment needs are met.

Learning Activities	
1.	Present a case to your multidisciplinary team. If you do not have a team, present a case to your preceptor. Ask the Licensed Independent Practitioner (LIP), your preceptor, and/or your department head for feedback regarding the quality of information you presented. What was helpful? Was anything missing? Did you spend too much or too little time focusing on any one area?
2.	Identify two disciplines that might be involved in the care of patients at your SARP. Make a list of at least three questions you would ask of a professional from those disciplines that would help you understand their specialty. Share these with your preceptor. As an additional challenge, can you find two professionals in your community and make an overture to get to know them?
3.	Identify at least three issues based on your level of training and experience that are beyond your expertise. Review these with your preceptor.
4.	Reflect on the past 3-4 months and identify at least one situation where you were concerned or aware that you were acting outside of your level of training or expertise. Review these situations with your preceptor. (Advanced)

Self-Study Questions

1. What are two reasons that would prompt a counselor to consult with another professional?

2. List at least four types of information that need to be included in a case presentation.

3. List three professionals you might consult on behalf of a patient.

4. When a case is discussed among team members, a _____ ___ _____ occurs.

5. **True or False:** Confidentiality regulations need to be considered when seeking consultation.

6. **True or False:** Research has shown that treating patients with dignity influences their adherence to treatment recommendations.

7. List three professional organizations that include respect for patients in their Code of Ethics.

8. List four ways counselors can learn more about cultural and ethnic diversity.

Self-Study Answers

1. Two reasons a counselor might consult with another professional are:
    a. When a patient's needs are behind their skill level.
    b. When a patient's needs are outside the scope of practice of an alcohol and drug counselor.

2. A case presentation should include all of the following:
    a. The presenting problem
    b. Important history or environmental factors
    c. Tentative diagnosis
    d. Plan of action
    e. Intervention strategies
    f. Concerns or problems that might affect care

3. A counselor might consult another counselor, preceptor, clinical supervisor, physician, or a psychologist.

4. When a case is discussed among team members, a **degree of synergism** occurs.

5. **True**. Counselors need to be aware if any information that is being discussed might in any way identify the patient to the consultant. When in doubt, a release of information should be obtained from the patient.

6. **True.** Patients who have been treated with dignity are more likely to report higher levels of satisfaction with care, adhere to therapy, and get preventive services.

7. Three professional organizations that include respect for patients in their Code of Ethics are:
    a. Navy Drug and Alcohol Counselors
    b. NAADAC
    c. The American Counseling Association

8. Counselors can learn more about cultural and ethnic diversity through:
    a. Personal experience
    b. Reading books and periodicals
    c. The media
    d. Training opportunities

Chapter 7 Service Coordination: Continuing Assessment and Treatment Planning

Purpose of This Chapter

This chapter reviews the Practice Dimension of Service Coordination by focusing on its third element: Continuing Assessment and Treatment Planning.

The learning objectives directly correlate with Competencies 67–74, as listed in the *TAP 21* (pages 90–95) and IC&RC Domain III: Evidence-Based Treatment, Counseling, and Referral. Each competency is accompanied by a set of knowledge, skills, and attitudes that define the standard.

Learning Objectives

- Maintain ongoing contact with the patient and involve significant others to ensure adherence to the treatment plan. (67)
- Understand and recognize stages of change and other signs of treatment progress. (68)
- Assess treatment and recovery progress, and, in consultation with the patient and significant others, make appropriate changes to the treatment plan to ensure progress toward treatment goals. (69)
- Describe and document the treatment process, progress, and outcomes. (70)
- Use accepted treatment outcome measures. (71)
- Conduct continuing care, relapse prevention, and discharge planning with the patient and involved significant others. (72)
- Document service coordination activities throughout the continuum of care. (73)
- Apply placement, continued stay, and discharge criteria for each modality on the continuum of care. (74)

Introduction

The *TAP 21* continues to address the importance of service coordination through the element of Continuing Assessment and Treatment Planning. Unlike some medical issues, substance use problems cannot be addressed by a visit to a counselor or a prescription for a short-term medication without any recommendations for further follow-up by a professional. Treatment of this multidimensional problem requires ongoing assessment and updating of the treatment plan based on the progress made in treatment. In addition, planning, consultation, and referral must continue as components of comprehensive care. These tasks fall under the auspices of "case management," which requires tasks and skills not traditionally considered when seeking out counseling services.

Case Management

Your understanding of the biopsychosocial impact of substance use should, by now, lead to your agreement that your role entails much more than providing group or individual counseling. The original IC&RC Core Functions defined case management as "activities intended to bring services, agencies, resources, or people together within a planned framework of action toward the achievement of established goals" (Herdman, 1997, p. 57). Case management activities are a component of the Service Coordination Domain. It is your responsibility to ensure that the patient's needs across the biopsychosocial dimensions are met, regardless of whether the service is offered by your organization.

As the case manager, you will use your knowledge to identify options for your patients but leave them the right to make their own choices. Once a patient chooses what to work on, the counselor helps her to access the services they desire. According to SAMHSA's *TIP 27*, "Case management is grounded in an understanding of patients' experiences and the world they inhabit – the nature of addiction and the problems it causes, and other problems with which patients struggle." (CSAT, 1998)

The Joint Commission on Accreditation of Hospitals (1979) and the National Association of Social Workers (1992) both describe the case management role in terms of functions. These functions are consolidated and delineated in **Figure 7.1**.

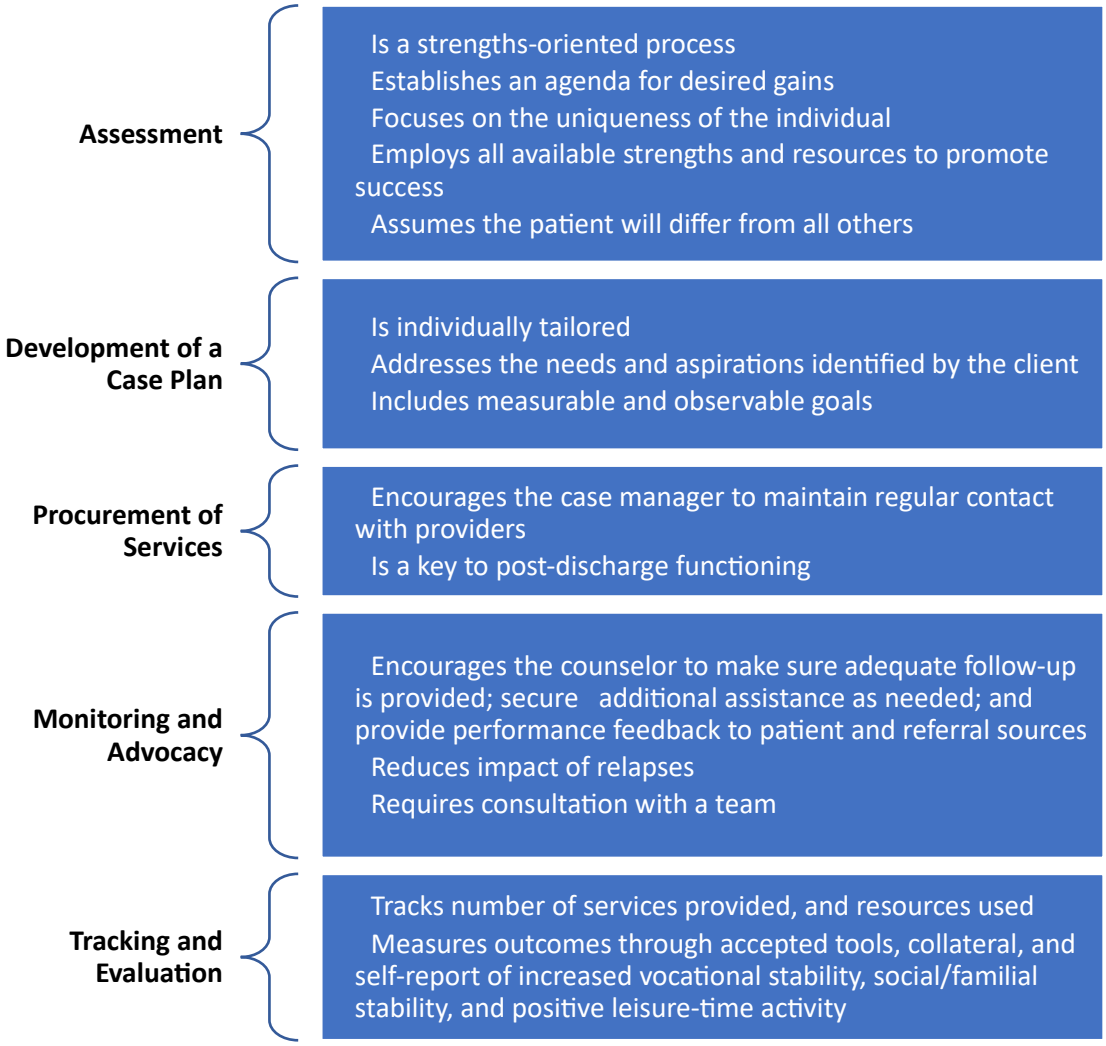
Maintain Ongoing Contact with the Patient and Involved Significant Others (67)

In a mandated program, it can seem a little obvious that you will maintain contact with your patient throughout the course of treatment. The SARP facility becomes the place where they report to duty unless they want to face charges of unauthorized absence. However, just because they are physically present does not mean they are engaged in the treatment process. It is important to check in with patients and assess their progress throughout the treatment process. Are homework assignments being completed, is the patient attending self-help meetings, are attempts being made to establish positive leisure activities?

Case Study 7.1

What would indicate that Ryan has engaged in the treatment process?

Figure 7.1: Case Management Role Functions



Family members. Based on the age of your patient and their assigned duty station, family members may or may not be involved in the treatment process. If your program does not offer a family program, it is still important to consider the impact of the patient's treatment involvement and progress in recovery on their family. Family members can be involved through individual sessions, referral to self-help groups, and therapeutic activities completed by the patient. Consider the sample situations in **Table 7.1**:

Table 7.1: Family Members in the Treatment Process

Family Situation	Goal	Objective
Single sailor is going home on leave to attend a family wedding where people will be drinking.	Maintain abstinence while on leave	• Obtain a list of AA groups in hometown • Call parents and tell them you will not be drinking while home on leave and ask for support • Discuss their response in group
Married sailor has not told their spouse about being in treatment.	Obtain support of spouse for treatment and recovery	• Sign a release for counselor to call spouse • Invite spouse into SARP to meet with counselor • Give spouse a list of Al-Anon meetings

Case Study 7.2

Refer to information you obtained in Chapters 1–3 on Ryan's family life. Answer the following:

Are there any problems on Ryan's list related to his family?
How would you involve Ryan's wife in treatment?
What options does your program offer?
Would you address family issues now or defer them to continuing care?
How will you ensure they are addressed in continuing care?

Stages of Change (68)

As part of the initial assessment completed when the patient enters care, a determination was made as to the stage of change they were in upon intake. As treatment progresses, the readiness and willingness of the patient to make changes will vary. In addition, their readiness to change in one area may differ from their readiness to change in others. The well-written treatment plan will reflect their readiness to change and be updated as they progress in recovery.

Case Study 7.3

When Ryan came into treatment, he said he did not think he had a drinking problem. You gave him several assignments to help him determine if he had a problem. After attending the class on Alcohol Use, Abuse, and Alcoholism, he comes to your office to tell you that he now realizes he has a drinking problem.

Assuming Ryan was in the Precontemplation stage at the time of screening, what stage of change do you think he might be in now? Do you have him complete the rest of the assignments designed to help him decide if he has a problem? What are the benefits? What are the risks? When do you update his treatment plan?

Helping a patient to change is the reason we have treatment programs. Those who are successful in changing on their own do not seek substance use treatment services. A patient might be in the Action stage of change regarding their need to stabilize their military career (they willingly came into treatment) but be in the Precontemplation stage regarding changing their drinking (i.e., they don't see their drinking as a cause of their work problems).

As mentioned in Chapter 4, SAMHSA's *TIP 35* focuses on motivating people to change. It is a valuable resource of ideas and strategies that can assist you in your work.

Keep in mind these key elements regarding change:

- Ambivalence about change is normal.
- Change is often nonlinear - there may be movement forward and then steps back.
- Readiness is not static - counselors can influence a patient's readiness.
- Attend to readiness in your work. Some refer to change readiness as a vital sign to be taken at each session. By attending to readiness levels, the counselor can direct sessions more effectively. For example, when patients are high in their confidence about making a change but low in their perceived importance of making that change, then attention and energy can be directed to exploring the issue of importance (Rosengren, 2017, pg. 13).

Consider This Case

A 56-year-old security guard is mandated to treatment by his employer because he had shown up for work with alcohol on his breath on several occasions. He tells the counselor he does not have an alcohol problem; he is only here to not lose his job. The counselor develops a treatment plan that includes reading material about alcohol use disorder, attending daily AA meetings, maintaining abstinence, and talking about his drinking problem in a group.

Counselor: "Here is your treatment plan and your reading material. *You need* to complete these and bring them back to me on the due dates."
Patient: "*I* don't need to do these. *You* need me to do them."

What happened in this brief interaction? What is the patient telling the counselor? What has the counselor missed?

MI provides a framework of principles that guides counselors. The principles can be expressed using the acronym RULE (Rollnick, Miller, & Butler, 2008):

R	Resist the righting reflex
U	Understand your patient's motivation
L	Listen to your patient
E	Empower your patient

Resist the righting reflex refers to the tendency of counselors to try and fix their patient's problems. While usually coming from a place of wanting to help a client make positive changes, it fails to recognize that patient may be ambivalent. Ambivalence is natural and associated with the costs of change – fear, changes in relationships, monetary impact, etc. When pushed to change, patients may push back, resulting in discord. Pushing for change may increase discord and reduce the patient's likelihood of change. Counselor behavior that increases resistance includes:

- Trying to convince patients that they have a problem
- Arguing for the benefits of change
- Telling patients how to change
- Warning them of the consequences of not changing

"Intensification of discord is then a signal to practitioners that a change in their behavior is needed."
Rosengren, 2017, p. 14.

Understand your patient's motivation. Counselors do not provide motivation. Their role is to find the motivation that lies within the patient and help patients to recognize it. Counselors do this by

directing patients toward the discrepancies that already exist between what they want and how their behavior impacts these goals. Counselors listen for and seek information about goals, beliefs, and aspirations and then explore how these relate to current circumstances. The goal is to create an environment in which the patient can tell us why and how change should happen.

Listen to your patient. If you reflect on your training at NDACS, you are likely to remember that listening is very different from hearing. Listening is a skill that can be learned. MI requires maintenance of a respectful attitude that tries to understand the other person's views.

Empower your patient. It is important to present a stance of hope to patients and communicate that hope to them. Many counseling theories point to the need for patients to have hope for success in solving their problems. Solution-focused counseling offers the technique of replacing "Why" questions with "How" questions and asking them in a solution-oriented manner.

Instead of asking: "Why do you drink?" try saying: "You must have some very good reasons for drinking. Can you talk about your good reasons?" Or rather than asking: "Why has your drinking gotten you in trouble now?" ask: "How have you managed to stay out of trouble with your drinking up until now?" (Berg & Reuss, 1998).

Signs of readiness for change. Patients will tell you when they are ready to change, but maybe not in so many words. The effective counselor looks and listens for these signs. Treatment plans are modified and updated in response to these indications.

Increased change talk. The patient increases their talk about their desire, ability, reasons and need to change. Their talk may reflect a high commitment, such as "I'm willing to give it a try" or low commitment, such as "I'll think about it." The MI consistent response to low commitment would be to be curious, but don't push for a full commitment.

Signs of Readiness for Change
Increased change talk
Taking steps toward change
Diminished sustain talk
Resolve
Envisioning
Questions about change

Taking steps. The patient may take a small step or two toward change. They may report "I went two days this week without drinking." The MI consistent response will affirm the success of the small steps.

Diminished sustain talk. The ratio between change talk and sustain talk indicates readiness to change. As change talk increases over the quantity of sustain talk there is movement toward change. Patients make direct statements about a desire to change, the ability to change, the reasons or benefits of change, and the need to change. They may also make statements of intention to change.

Resolve. The patient appears to have reached some resolution and may seem more peaceful, relaxed, calm, unburdened, or settled. This can also have a tone of loss, tearfulness, or resignation.

Envisioning. The patient talks about the consequences of change, both good and bad. They may imagine the good things that can happen, such as how much money they save. They may also consider the risks, such as losing friends if they stop drinking.

Questions about change. Patients may begin to ask what they could do about the problem, how people change once they decide to, and the like. These questions may indicate they are considering options. (Miller & Rollnick, 2013).

Does your SARP conduct any outcome measurement activities? What opportunities might you see for integrating one of these tools into your program?

Assess Progress and Modify Treatment Plan (69)

The treatment plan developed with each patient is the "road map" that is followed throughout the course of treatment. The map must be reviewed at least weekly to ensure that the destination is appropriate. When the course of treatment requires a "turn" in a new direction, the treatment plan can often point the way. A patient-driven treatment plan will include goals based on the identified concerns of the patient, not the mission of the treatment program. For instance, the patient's level of motivation may change during the treatment process. Likewise, their stage of change may shift forward or backward in the change cycle. Whatever the case, any changes need to be addressed in the treatment plan, which continues to be a work-in-progress. The goals can be updated, and activities modified as the patient progresses in their perception of areas in their life that need to change. Further disclosure of issues and concerns may also require additional resources and consultation to ensure the patient's needs are being met.

Case Study 7.4

Ryan is beginning to show signs of improvement in treatment. He followed through with the mental health evaluation and was put on a psychotropic medication that seems to be easing his PTSD symptoms. He is more open in the group, is beginning to show a change in thinking about his drinking, and reports that things at home are better with his wife.

What would you need to see from Ryan to show resolution (if any) to problems in his treatment plan? What new goals and objectives would you recommend for Ryan?

Document Process, Progress, and Outcomes (70)

Record keeping is discussed in Chapter 12. However, the importance of tying progress notes to the treatment plan must be emphasized here. A patient's success in reaching objectives toward a goal and the resolution of the goal itself should all be documented in the progress notes. Documentation of the rate of progress and any struggles in goal attainment should also be noted.

Progress is reported on the treatment plan itself by noting dates of accomplished objectives and goals, by closing goals reached, and by adding new goals. The treatment plan should be reviewed regularly by both the patient and the counselor. The treatment plan also serves as a gauge to inform other staff members and/or the counselor's preceptor how the patient is doing in treatment. Using input from the preceptor or other counselors can often be helpful in making appropriate alterations to the treatment plan.

Use Accepted Treatment Outcome Measures (71)

How do you know if your patient is getting better? How do you measure success? When do you want to know if your interventions are working? These are all questions that counselors need to ask themselves. Counselors have an ethical responsibility to know if their efforts are having a positive impact on patients' lives. Great efforts are being made in the field to provide tools that will measure the effectiveness of our treatment interventions. Some tools offer you opportunities to assess patient progress during the course of treatment and others look for improved functioning following the movement into the later phases in the continuum of care. Different tools can be used based on the information you are interested in gathering.

SAMHSA's *TIP 46, Substance Abuse: Administrative Issues in Outpatient Treatment,* provides information on outcome measurement tools that can be used in both outpatient and intensive outpatient settings. It provides an excellent overview of the purpose and value of measuring outcomes, as well as the use of several tools, including the Addiction Severity Index and the Treatment Services Review. Other measurement tools include:

Session Rating Scale (SRS) and Outcome Rating Scale (ORS). For many years now, researchers have been trying to determine which treatment models and therapeutic interventions are the most effective to use in treating a variety of behavioral health problems. "Over a thousand studies have demonstrated that the alliance between the clinician and the patient is 7 times more important than the technique of the therapist" (Duncan & Miller, 2006). In response to this data, Duncan and Miller developed paper-and-pencil measurement tools that can be used to assess the therapeutic alliance between the patient and the counselor during the course of treatment. The SRS and ORS are four-item, pencil-and-paper scales that can be completed by the patient to rate the effectiveness of the therapeutic relationship (SRS) and the quality of life functioning of the patient (ORS). Individual licenses are available to use the SRS and ORS at

https://scott-d-miller-ph-d.myshopify.com/products/performance-metrics-licenses-for-the-ors-and-srs

OQ–45. The OQ-45 is a 45-item self-report designed to measure patient progress through the course of treatment. The tool measures functioning in three domains: Symptom Distress, Interpersonal Functioning, and Social Role. The tool is available in a paper-and-pencil version for a fee. A software version can also be purchased that offers feedback and suggestions to the counselor. Information on obtaining the OQ-45 can be obtained at www.oqmeasures.com.

Substance User's Recovery Checklist and Worksheet. Many measurement tools rely on self-report from the patient, and some offer the opportunity for the patient to rate their concerns and desires for treatment and recovery. The Substance User's Recovery Checklist and Worksheet is one such tool (Berg & Reuss, 1998). The checklist offers five sections with 4 to 10 questions in each section. Each section asks the user to rate their functioning on a scale from "Never" to "Always." Patients can complete the checklist prior to starting treatment and at different points throughout their treatment course. The information gathered can be useful in setting goals and developing treatment plans. The checklist can be found online at https://onlinelibrary.wiley.com/doi/epdf/10.1002/9780470693742.app17

Conduct Continuing Care, Relapse Prevention, and Discharge Planning (72)

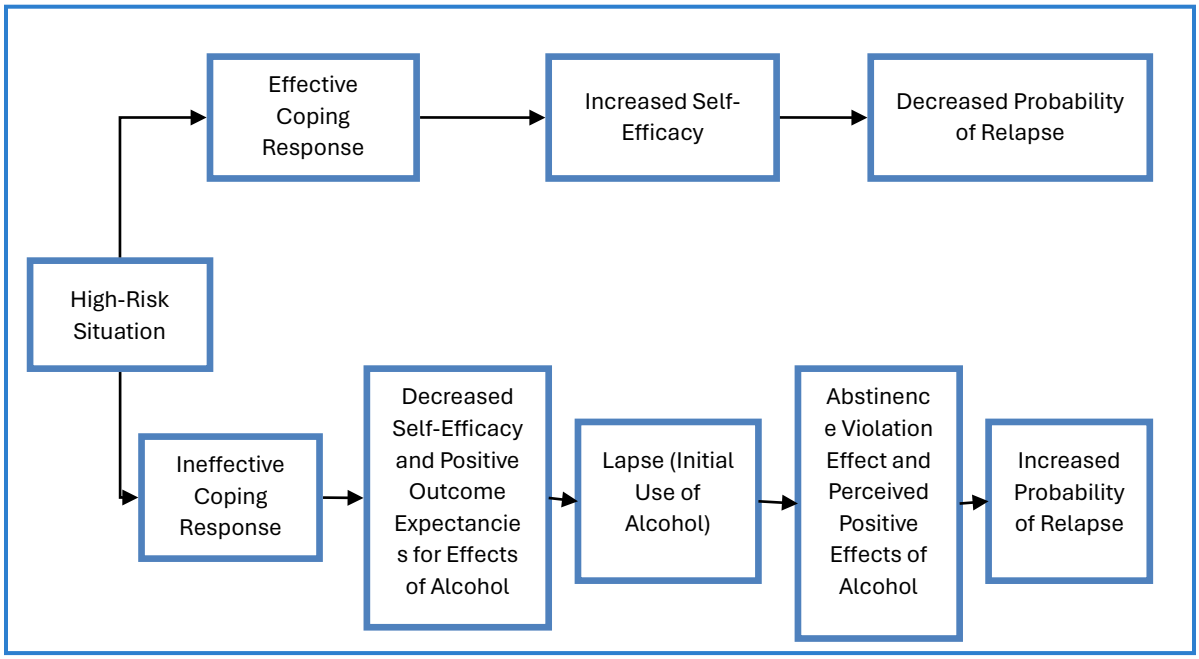
Discharge planning for a patient begins as soon as the patient enters treatment. The establishment of treatment goals becomes the benchmark for movement to a less intensive level of care. In the Navy SARPs, counselors are tasked with identifying which goals must be accomplished while the patient is in treatment and which goals will be continued or deferred into continuing care. The treatment team becomes a key resource to the counselor in determining the issues that will be continued into the next phase of treatment. For some patients, an issue may require initial mental health assessment and stabilization, but ongoing therapy will be deferred until the patient has obtained a period of abstinence. Other complications may require treatment concurrently with the substance use disorder.

All treatment for persons whose alcohol use goal is abstinence and sobriety will require relapse prevention as a component of their treatment. For many Navy patients, the challenges they face under the Relapse Potential and Recovery Environment dimensions keep them involved in the intensive treatment phase. A goal in their treatment is to develop the skills to attain their recovery goals in an environment that may not be supportive, such as military barracks. Several relapse prevention models and activities are explored next.

The Relapse Prevention (RP) Model developed by Marlatt and Gordon (1985) is a cognitive-behavioral treatment with a focus on the maintenance stage of addictive behavior change that has two main goals: to prevent the occurrence of initial lapses after a commitment to change has been made and to prevent any lapse that does occur from escalating into a full-blown relapse (Marlatt & Donovan, 2005). RP suggests that factors contributing to relapse fall into two categories: immediate determinants, such as high-risk situations and coping skills, and covert antecedents, such as lifestyle imbalances and urges and cravings.

Counselors work with patients to identify the emotional and environmental characteristics that are potentially associated with relapse. Next, the patient and counselor examine the lifestyle factors that put the patient at risk. They then work to develop cognitive-behavioral strategies to help reduce the risk. **Figure 7.2** demonstrates the consequences based on the effectiveness of the patient's coping response to a high-risk situation (Larimer, Palmer, & Marlatt, 1999).

Figure 7.2: Consequences Based on Effectiveness of Patient Coping Response



RP Model interventions would include activities such as a Decision Matrix **(Table 7.2)**. Patients would be asked to write down a list of the positive and negative consequences to making a decision to remain abstinent and to return to drinking. They would include both immediate and long-term consequences. Similar techniques are posited by MI and solution-focused counseling models. These assignments help to tip the balance toward positive change as the patient explores the consequences of their choices.

Table 7.2: Decision Matrix for Alcohol Abstinence or Alcohol Use

	Immediate Consequences		Delayed Consequences	
	Positive	**Negative**	**Positive**	**Negative**
Remain Abstinent	• Improved self-efficacy • Improved self-esteem • Family approval • Better health • More energy • Save money and time • Greater success at work	• Frustration and anxiety • Denied pleasures of drinking • Unable to go to bars • Anger at not being able to do what one wants without 'paying the price'	• Greater control over one's life • Better health and longevity • Learn about oneself and others without being intoxicated • More respect from others	• Not able to enjoy drinking while watching sports • Bored and depressed • Not able to remain friends with heavy-drinking buddies
Resume Alcohol Use	• Automatic pleasure • Reduced stress and anxiety • Not feel pain • Not worry about one's problems • Able to enjoy sports and drink with buddies	• Feel weak from drinking • Risk of accidents and embarrassment • Anger of family • Arrive late to or miss work • Hangovers • Waste money	• Maintain friendships with drinking buddies • Able to drink while watching sports • Not have to cope with family by staying out drinking	• Possible loss of family and job • Deterioration of health and early death • Loss of non-drinking friends • Ridicule by others • Low self-esteem

Adapted from Larimer, Palmer, & Marlatt (1999)

The Gorski-Cenaps Clinical Model delineates ten phases of relapse and 37 symptoms. This model offers opportunities for patients to identify the early symptoms of a relapse and intervene through the use of coping mechanisms; recovery resources, such as an AA sponsor; and a return to counseling. Counselors are encouraged to review materials on these phases included in your NDACS Student Guide. The AWARE Questionnaire (Advance WArning of RElapse) is a paper-and-pencil tool that asks patients to rate how much they have recently experienced the 37 relapse symptoms. It can be scored by a counselor and interventions designed to prevent further progression of their symptoms. The scoring guidelines include a table, titled "Probability of Heavy Drinking During the Next Two Months," which bases its predictions on the AWARE score (Miller & Harris, 2000). The AWARE Questionnaire can be found at the end of this chapter.

Discharge Planning in the Navy

The Defense Health Agency (DHA) endorses a continuum of care model for all branches of service, which includes a clinically appropriate level of treatment followed by ongoing support that may include outpatient counseling or monitoring of aftercare plans by the command, which in the Navy would be the DAPA. The timing of the transition to continuing care or aftercare should be individualized and based on completion of treatment goals. Counselors should work with patients to anticipate potential obstacles that may arise as they continue to stabilize in their recovery. Upcoming deployments, promotion boards, and orders to a new duty station are all potentially stressful circumstances that may increase a patient's risks for relapse. Quality case management would include a look at the future 6–12 months ahead and prepare plans to respond to any stressors. The continuum of care model allows for a patient to discontinue active participation in continuing care groups, while keeping open the option to return for individual sessions or additional group participation.

Document Service Coordination Activities Throughout the Continuum of Care (73)

A long-standing precept in medical and behavioral health holds that "if it isn't in the record, it did not happen." All treatment activities need to be documented in the medical record via progress notes, updates to treatment plans, and insertions of any consultation reports received from other providers. Should another counselor pick up the record, they need to be able to track the progress on the treatment plan, action level of all referrals, and any contact made with significant others, DAPAs, commanders, and other providers. Documentation of communication with other providers must demonstrate that all confidentiality and Health Insurance Portability and Accountability Act (HIPAA) regulations have been followed. This protects the patient from inappropriate disclosures and the provider from accusation of mismanagement of confidential information.

Apply Placement, Continued Stay, and Discharge Criteria for Each Modality on the Continuum of Care (74)

The ASAM PPC-3R was developed in response to questions in the behavioral health field regarding lengths of stay and what was termed "cookie-cutter" or "one size fits all" treatment. You would never expect that your physician would tell you that your pneumonia treatment would require a 3-day stay in the hospital, one round of antibiotics, and two follow-up visits, and then you'll be discharged from care regardless of whether you are symptom-free. Yet, that is how many substance use treatment programs were designed. Every patient came into treatment for the same length of stay, generally whatever was covered by insurance, and then moved on to "aftercare."

The continuum of care offers counselors the opportunity and challenge to treat patients in the "least restrictive environment." In a service delivery program that offers access to all levels of care, the patient would be assessed at least weekly on their ASAM dimension status (see grid in Chapter 2). Based on the patient's assessment, their level of care would migrate up or down the placement grid. Patients whose symptoms intensified could be moved to a more intensive level of care, and those

whose symptoms abated while their recovery skills increased could be moved to a less intensive level of care.

In Navy programming, *Dimension 7: Operational Commitments* allows a patient to be placed in an alternative level of patient care if the indicated treatment level is not available or not consistent with the military mission. In many program structures, Intensive Outpatient (IOP) treatment is offered in a location that requires patients to remain overnight at another duty location. This results in the patient moving from IOP to Continuing Care without a transition into Outpatient (OP) care. Weekly continuing care groups with monthly individual sessions are the OP follow-up to IOP for many SARP programs.

Counselors are challenged, therefore, to explore methods for individualizing care based on the patient's needs, even if they must remain present within a specific program structure. For example, consider whether a patient who has attended AA, obtained a sponsor, and begun working the Steps needs to participate in a class titled "Introduction to AA." Perhaps that patient would benefit more from individualized study on one of the 12 steps that could be completed while other patients attended the scheduled class.

Case Study 7.5

What components of your program would benefit Ryan the most? Are there any components you think he does not need? What goals would need to be accomplished to be downgraded to Continuing Care? What goals would remain on his plan to be addressed during continuing care?

Summary

Continuing Assessment and Treatment Planning is best summarized by reflecting on your role as a case manager in the treatment process. Managing a patient requires paying attention to the patient's motivation, stages of change, ASAM PPC dimension status, and progress on treatment goals. Multiple opportunities will be available to reassess, reconnect, and modify the treatment plan as you walk with your patient through the journey of recovery. Treatment is a process and recovery is a marathon, not a sprint. The greatest gift you can give to your patients is to empathically join with them as they embark on this journey.

Learning Activities

1. Download the electronic copy of SAMHSA's *TIP 35*. Figure 5–1 in Chapter 5 of *TIP 35* offers tips for moving patients from Contemplation to Preparation stage of change. Review these tips with your preceptor and discuss how you can integrate them into your counseling style.

2.	Using references from this chapter, materials at your site, and your colleagues, identify at least three relapse prevention activities that you can use with patients. Share with your preceptor.
3.	What relapse prevention activities have you found most useful to use with patients? What tools have you found less useful? Discuss with your preceptor. (Advanced)

Self-Study Questions

1. List the five functions of the case manager.

2. What does the acronym RULE stand for?

3. **True or False?** One solution-focused counseling technique is to substitute *How* questions for *Why* questions.

4. Which Relapse Prevention model includes a description of 37 symptoms of relapse?
   a. Gorski-Cenaps
   b. Living In Balance
   c. Marlatt & Gordon

5. **True or False?** Counselors have an ethical responsibility to learn about and pursue outcome measurement activities with their patients.

6. Treatment plans should be reviewed:
   a. At least weekly
   b. When there is a change in status in the ASAM PPC-3R dimensions.
   c. Whenever a patient demonstrates movement in the stages of change.
   d. All of the above.

Self-Study Answers

1. The five functions of a case manager are:
   a. Assessment
   b. Development of a case plan
   c. Procurement of services
   d. Monitoring and advocacy
   e. Tracking and evaluation

2. **R** – Resist the righting reflex
   U – Understand your patient's motivation
   L – Listen to your patient
   E – Empower your patient

3. **True.** Solution-focused counseling works to help patients examine their successes and identify solutions, rather than focusing on their problems and failures.

4. **B.** Gorski-Cenaps

5. **True**. Counselors have an ethical responsibility to learn about and pursue outcome measurement activities.

6. **D.** The treatment plan should be reviewed at least weekly and more often if there is a significant change in the patient's functioning and/or motivation.

The AWARE Questionnaire (Revised Form)

Please read the following statements and, for each one, circle a number, from 1 to 7, to indicate how much this has been true for you recently. Please circle one and only one number for every statement.

Statement	Never	Rarely	Some-times	Fairly Often	Of-ten	Almost Always	Always
1. I feel nervous or unsure of my ability to stay sober.	1	2	3	4	5	6	7
2. I have many problems in my life.	1	2	3	4	5	6	7
3. I tend to overreact or act impulsively.	1	2	3	4	5	6	7
4. I keep to myself and feel lonely.	1	2	3	4	5	6	7
5. I get too focused on one area of my life.	1	2	3	4	5	6	7
6. I feel blue, down, listless, or depressed.	1	2	3	4	5	6	7
7. I engage in wishful thinking.	1	2	3	4	5	6	7
8. The plans that I make succeed.	1	2	3	4	5	6	7
9. I have trouble concentrating and prefer to dream about how things could be.	1	2	3	4	5	6	7
10. Things don't work out well for me.	1	2	3	4	5	6	7
11. I feel confused.	1	2	3	4	5	6	7
12. I get irritated or annoyed with my friends.	1	2	3	4	5	6	7
13. I feel angry or frustrated.	1	2	3	4	5	6	7
14. I have good eating habits.	1	2	3	4	5	6	7
15. I feel trapped and stuck, like there is no way out.	1	2	3	4	5	6	7
16. I have trouble sleeping.	1	2	3	4	5	6	7

Statement	Never	Rarely	Some-times	Fairly Often	Of-ten	Almost Always	Always
17. I have long periods of serious depression.	1	2	3	4	5	6	7
18. I don't really care what happens.	1	2	3	4	5	6	7
19. I feel like things are so bad that I might as well drink.	1	2	3	4	5	6	7
20. I am able to think clearly.	1	2	3	4	5	6	7
21. I feel sorry for myself.	1	2	3	4	5	6	7Lar
22. I think about drinking.	1	2	3	4	5	6	7
23. I lie to other people.	1	2	3	4	5	6	7
24. I feel hopeful and confident.	1	2	3	4	5	6	7
25. I feel angry at the world in general.	1	2	3	4	5	6	7
26. I am doing things to stay sober.	1	2	3	4	5	6	7
27. I am afraid that I am losing my mind.	1	2	3	4	5	6	7
28. I am drinking out of control.	1	2	3	4	5	6	7
Adapted from Miller & Harris 2000							

SCORING: Total the numbers circled for all items but reverse the scoring for the following items: 8, 14, 20, 24, and 26.

INTERPRETATION: The higher the score, the more warning signs of relapse are being reported by the patient. The range of scores is from 28 (lowest) to 196 (highest). The following table shows the probability of heavy drinking (not just a slip) during the next 2 months based on a study by Miller & Harris, 2000.

Probability of Heavy Drinking During the Next Two Months		
AWARE Score	If *Already* Drinking in the Prior 2 Months	If *Abstinent* During the Prior 2 Months
28–55	37%	11%
56–69	62%	21%
70–83	72%	24%
84–97	82%	25%
98–111	86%	28%
112–125	77%	37%
126–168	90%	43%
169–196	95%	53%

Chapter 8 Counseling: Individual Counseling

Purpose of This Chapter

This chapter reviews the Practice Dimension of Counseling by focusing on its first element: Individual Counseling.

The learning objectives directly correlate with Competencies 75–87, as listed in *TAP 21* (pp. 101–111) and IC&RC Domain III: Evidence-Based Treatment, Counseling, and Referral. Each competency is accompanied by a set of knowledge, skills, and attitudes that define the standard.

Learning Objectives

- Establish a helping relationship with the patient characterized by warmth, respect, genuineness, concreteness, and empathy. (75)
- Facilitate the patient's engagement in the treatment and recovery process. (76)
- Work with the patient to establish realistic, achievable goals consistent with achieving and maintaining recovery. (77)
- Promote patient knowledge, skills, and attitudes that contribute to a positive change in substance use behaviors. (78)
- Encourage and reinforce patient actions determined to be beneficial in progressing toward treatment goals. (79)
- Work appropriately with the patient to recognize and discourage all behaviors inconsistent with progress toward treatment goals. (80)
- Recognize how, when, and why to involve the patient's significant others in enhancing or supporting the treatment plan. (81)
- Promote patient knowledge, skills, and attitudes consistent with the maintenance of health and prevention of HIV/AIDS, tuberculosis, sexually transmitted diseases, hepatitis C, and other infectious diseases. (82)
- Facilitate the development of basic and life skills associated with recovery. (83)
- Adapt counseling strategies to the individual characteristics of the patient, including disability, gender, sexual orientation, developmental level, culture, ethnicity, age, and health status. (84)
- Make constructive therapeutic responses when the patient's behavior is inconsistent with stated recovery goals. (85)
- Apply crisis prevention and management skills. (86)

- Facilitate the patient's identification, selection, and practice of strategies that help sustain the knowledge, skills, and attitudes needed for maintaining treatment progress and preventing relapse. (87)

Introduction

TAP 21 defines counseling as "a collaborative process that facilitates the patient's progress toward mutually determined treatment goals and objectives" (CSAT, 2006, p 101). The IC&RC defined counseling as "the utilization of special skills to assist individuals, families, or groups in achieving objectives through exploration of a problem and its ramifications; examination of attitudes and feelings; consideration of alternative solutions; and decision making" (Herdman, 1997, p 45). The counseling function is at the heart of treatment for the patient. The counselor's primary task is to motivate and empower the patient to identify problems and attitudes as they relate to issues agreed on in the treatment plan. Changes in behavior, attitude, and stage of change are all examples of changes that result from successful counseling. An effective counselor becomes a catalyst in the patient's effort to make progress by examining alternative solutions and eliciting the patient's active involvement in the change process.

The process of counseling involves helping the patient understand their impact on others, learn new ways of thinking about a situation, develop new skills to deal with a situation, and try out new behaviors. To do this successfully, a counselor must acquire a broad base of counseling techniques along with a well-grounded understanding of counseling theory. There are numerous theories of counseling. These theories have at least one thing in common: they can each be adapted and applied to help people resolve conflict in their lives. Many theories differ, however, in their views on the explanation of one's thought process, emotional responses, and behavior.

Theories of psychotherapy and counseling each have their own set of beliefs about how people think, feel, and behave. Many theories are accompanied by techniques based on these beliefs. Counselors tend to use the theories and techniques with which they feel most comfortable. Once a counselor has a good working understanding of several theories, they are most effective when an approach can be matched with a particular patient at an appropriate time.

Key Theories of Counseling and Psychotherapy

Below are brief descriptions of eight theories or models of counseling and psychotherapy. Ranging from the original psychoanalytic theory to more recent models of solution-focused and dialectic behavior therapy, these models have all contributed to the body of knowledge regarding human nature, motivation, distress, and change.

PSYCHOANALYTIC—Sigmund Freud

Psychoanalytic theory states that human behavior is motivated by unconscious factors or drives. Major emphasis is placed on the first 6 years of life. Long-term psychoanalysis is used to discover and resolve unconscious conflicts. The concepts of transference and countertransference originated with Freud and have resonance for all counselors, regardless of theoretical orientation.

GESTALT—Fritz Perls

The aim of Gestalt therapy is to integrate the functioning of the body and mind. The counselor acts as a catalyst to speed up the process by creating a safe, caring environment and providing a "here and now" challenge to speed up growth.

CLIENT-CENTERED THERAPY—Carl Rogers

In client-centered therapy, the counselor provides the environment in which the patient is free to discover and grow. The required conditions necessary for growth are empathy, genuineness, and unconditional positive-regard.

BEHAVIOR THERAPY—B.F. Skinner, Arnold Lazarus, Albert Bandura

This theory is based on the premise that behavior is a product of learning. The overall goal of behavior therapy is reducing or abolishing maladjusted behaviors and replacing them with more effective behaviors. Techniques include relaxation training, systematic desensitization, and assertiveness training.

REALITY THERAPY/CHOICE THEORY—William Glasser

Choice theory is based on the premise that we choose to behave the way we do at all times and that the only behavior we can control is our own. Therapy focuses on patients assuming responsibility for their behavior and learning more effective ways to meet their needs.

COGNITIVE BEHAVIOR THERAPY—Allbert Ellis, Aaron Beck, Arnold Lazarus

Cognitive Behavior Therapy is a title used to describe several different therapeutic approaches that focus on the role of thought in emotional and behavioral responses. One of the earliest forms, Rational Emotive Behavior Therapy (REBT), was developed by Albert Ellis and focused on the role of thinking and belief systems in behavior. Ellis saw behavior as a response to two processes: thinking and feeling. Aaron Beck founded cognitive therapy, which focuses on patients overcoming their difficulties by changing their thinking, behavior, and emotional responses. Arnold Lazarus developed multi-modal therapy, based on seven dimensions: behavior, affect, sensation, imagery, cognition, interpersonal relationships, and drugs/biology.

DIALECTIC BEHAVIOR THERAPY—Marsha Linehan

Dialectic Behavior Therapy (DBT) is a form of cognitive behavioral therapy that was designed for use with borderline patients. DBT focuses on helping patients modify their thinking and behavior. Dialectic refers to the interaction of two conflicting ideas. DBT counselors work with patients to accept themselves as they are while offering to teach them skills that would help them change their destructive behavior.

SOLUTION-FOCUSED THERAPY—Steve deShazer and Insoo Kim Berg

Solution-focused therapy emphasizes solutions rather than problems. Therapy focuses on the present and the future rather than the past. Patients are asked to envision how life will be different when the problem is no longer present and then work to repeat the behaviors that will be occurring at that time.

Another way of exploring different therapeutic theories and approaches is to combine them into categories based on their view of how personality develops or how persons change (Corey, 2016).

Psychodynamic Approaches

These include the theories of Freud and Adler. The focus of therapy is on insight, unconscious motivation, and the reconstruction of the personality. Adlerian therapy focuses on meaning, goals, purposeful behavior, conscious action, belonging, and social interest.

DEFENSE MECHANISMS Psychoanalytic therapists believe that when unconscious conflicts become too great, people will resort to the use of defense mechanisms to deal with these conflicts. In psychotherapy, the counselor uncovers the patient's use of defense mechanisms by exploring the unconscious, then helps the patient gain an understanding of how he or she is using these defenses. Brief descriptions of several defense mechanisms are listed below.
Repression Unconsciously forcing unacceptable thoughts and feelings from the conscious mind into the unconscious mind. The patient will insist he or she has "forgotten" but will still act from these thoughts because they are not resolved. *Example: A patient may hate her parent for having abused her during childhood. The hate creates so much anxiety that she pushes it out of the conscious mind. Since the hate is not resolved, she continues to be hostile toward her parent.*
Projection Assigning one's own emotions and characteristics to another person. *Example: A patient who is sexually attracted to his daughter accuses her of being seductive with him.*
Reaction Formation Expressing an attitude or behavior that is diametrically opposed to one's desire or impulse. *Example: A person is attracted to the use of pornography but leads a local campaign to shut down an X-rated bookstore.*
Displacement Occurs when the feelings a person has for one person creates anxiety, so those feelings are generated toward a safer, less threatening target. *Example: An emotionally abusive spouse criticizes his wife. She is too scared to confront her husband but then takes out her anxiety by criticizing her child for an insignificant mistake.*
Rationalization Finding a satisfactory reason for doing something unacceptable. *Example: When a patient returns to his favorite bar on a Friday night, he tells himself that his buddy got promoted and he couldn't miss the party.*
Intellectualization A person understands a difficult situation with his or her mind but does not allow himself or herself to experience feelings about it. *Example: A combat veteran experiences guilt over the death of a buddy who he could not save during a fire fight. He goes over the details of everything that was done during the battle but does not express any emotion regarding the loss or the fact he was unable to save his buddy.*

Experiential and Relationship-Oriented Therapies

These therapies include the existential approach, person-centered approach, and Gestalt therapy.

EXISTENTIAL APPROACH	PERSON-CENTERED APPROACH	GESTALT THERAPY
This approach stresses a concern for what it means to be fully human. Rather than a therapy technique, existentialism is a philosophy of counseling that stresses that there are many different methods for understanding a person's world.	This approach is rooted in humanistic philosophy. The attitudes of the therapist and the quality of the client-patient relationship are the prime determinants to the treatment outcome. Person-centered counselors do not take an active role but reflect the qualities of genuineness, empathy, and unconditional positive regard for the patient. Counselors using this approach learn to reflect feelings.	Counselors following this approach focus on the here and now. The goal of therapy is the integration of experiences into the whole personality. The counselor takes an active role and engages the patient in any of several ways: by pointing out parallels between a patient's interpersonal relationships and the patient/counselor interaction, by analysis of dreams, by discussing something the patient said, or by focusing on the patient's body language.

Action Therapies

These include reality therapy, rational emotive behavior therapy, and cognitive therapy. Frequently, all three approaches may be blended into a cognitive-behavioral approach. The cognitive-behavioral approach has been further broken down into sub-approaches including dialectical behavior therapy and acceptance and commitment therapy.

Reality Therapy

The goal of reality therapy is to help patients discover what they want and determine whether their current behavior is bringing them closer to their goals. It is based on the premise that problems are caused by unsatisfying relationships. The focus is not on the past but on whether current behaviors are getting the patient closer to the positive relationships in the present. The relationship between the counselor and the patient is extremely important. In a warm and caring relationship, the counselor helps the patient evaluate his present behavior. The counselor then assists the patient in planning and making a commitment for change. The commitment may be made in writing and then modified if the patient cannot follow through on the plan.

Rational Emotive Behavior Therapy

Rational Emotive Behavior Therapy (REBT) is based on the premise that most problems are caused by irrational thoughts. Ellis believed that children are taught to think and feel certain things about

themselves, others, and the world. This results in the individual making value judgments. A collection of these judgments then becomes the person's belief system from which he or she experiences life. Some of these judgments may be irrational and result in distorted belief systems. Examples of these distortions are:

"Everyone must love me for me to be lovable."

"I must succeed at everything I do, or I am a failure."

"I must be capable in everything I do, or I am a failure."

"If I become angry, no one will like me."

"If I am 'together,' I will never feel afraid."

Ellis posed the ABC model: a patient responds to an **A**ntecedent with a distorted **B**elief that leads to a negative emotional **C**onsequence. The goal of REBT is to teach the patient to analyze his or her belief system and correct the irrational distortions. This goal is accomplished by engaging in active dialogue with the patient and working to understand his irrational beliefs. See the example below:

Patient: "I've ruined my chances with my son by drinking so much. He calls me (**A**ntecedent), but I know he'll never forgive me (distorted **B**elief). I could never make it up to him (**C**onsequence—hopelessness)."
Counselor: "His telephone calls seem to say that he really does care about you." (Examine and explore alternative judgments of the event.)
The counselor creates new judgments that are rational (logical), based on data from the patient's life using verbal and behavioral affirmations.

Cognitive Therapy:

This model is based on the theory that the way we perceive a situation influences the way we will feel. Two persons can experience the same situation, but their emotional response may vary based on their perception of the event. Counselors work to help patients examine their thoughts and work to change any distortions they have in their thinking.

Mindfulness-Based Cognitive Therapy

Mindfulness-Based Cognitive Therapy (MBCT) is a therapeutic approach that combines elements of cognitive therapy with mindfulness practices. It was originally developed to prevent relapse in people who have experienced recurrent episodes of depression but has since been applied to various mental health concerns. Here are the basics of MBCT:

1. Mindfulness: Mindfulness involves paying attention to the present moment non-judgmentally and with an open and accepting attitude. It means being fully aware of your thoughts,

feelings, bodily sensations, and the surrounding environment without getting caught up in them or trying to change them.

2. Cognitive Therapy: Cognitive therapy focuses on understanding and changing negative thought patterns and beliefs that contribute to emotional distress. It helps individuals become aware of their automatic thoughts and learn how to challenge and reframe them in a more constructive way.
3. Integration of Mindfulness and Cognitive Therapy: In MBCT, mindfulness techniques are integrated into the cognitive therapy framework. It helps individuals become more aware of the patterns of their thoughts and feelings, allowing them to step back from automatic negative reactions and reduce their emotional reactivity.
4. Techniques: MBCT employs a variety of mindfulness practices, including mindfulness meditation, body scan, and yoga. These practices help individuals develop a greater sense of self-awareness, reduce rumination, and enhance their ability to manage stress and difficult emotions.
5. Relapse Prevention: One of the primary aims of MBCT is to help prevent relapse in individuals who have recovered from depression but can also be applied to substance use disorders. By developing mindfulness skills, individuals can recognize early signs of relapse or other mental health issues and respond with greater resilience.
6. Group Format: MBCT is often delivered in a group format, where participants can share their experiences and provide support to each other. The group setting can create a sense of community and shared understanding.
7. Commitment to Practice: Regular practice of mindfulness exercises outside of therapy sessions is essential for the success of MBCT. Participants are encouraged to integrate mindfulness into their daily lives to cultivate lasting changes in their thought patterns and emotional responses.

Cognitive Behavioral Therapy

Cognitive Behavioral Therapy (CBT) is a therapeutic approach based on the concepts associated with cognitive, rational emotive, and behavioral therapy. It is usually more focused on the present, more time-limited, and more problem-solving oriented than other forms of therapy. Patients learn specific skills that they can use for the rest of their lives. These skills involve identifying distorted thinking, modifying beliefs, relating to others in different ways, and changing behaviors. CBT counselors are direct and active in their teaching and correcting of irrational thoughts. The techniques that are used vary depending on the kind of problems the patient is dealing with, but may include keeping a diary of thoughts, feelings, and behaviors; questioning and testing thoughts, assumptions, and beliefs to see which are unhelpful or unrealistic; systematic desensitization; and practicing new behaviors.

Dialectical Behavior Therapy

Dialectical Behavior Therapy (DBT) is a therapeutic approach developed by psychologist Marsha M. Linehan in the late 1980s. It was originally designed to treat individuals with borderline personality disorder (BPD) but has since been adapted for various other mental health conditions. DBT combines

elements of cognitive-behavioral therapy (CBT) with Eastern mindfulness practices, emphasizing acceptance and change.

The original format for DBT included a combination of individual counseling, skills training groups, phone coaching the patient, and the counselor participating in a consultation group with other DBT counselors. While this original format is still done, DBT has been adapted in many substance use programs to utilize the individual counseling and group training skills components.

DBT is an evidence-based treatment that has been found effective for various mental health issues, including borderline personality disorder, self-harm, substance use disorders, depression, anxiety, and eating disorders. It offers a comprehensive and compassionate approach to helping individuals build a life worth living by promoting emotional regulation, coping skills, and enhanced interpersonal relationships.

Basics of Dialectical Behavior Therapy	
Dialectics	The term "dialectical" refers to the balance between two opposing ideas. In DBT, this means finding a balance between acceptance and change. Clients are encouraged to accept themselves and their current circumstances while simultaneously working towards making positive changes in their lives.
Four Modules	DBT is typically structured around four modules, each designed to address different aspects of an individual's emotional and behavioral difficulties: a. *Mindfulness:* This module focuses on cultivating present-moment awareness without judgment. Mindfulness practices help individuals observe their thoughts, emotions, and bodily sensations without reacting impulsively. b. *Distress Tolerance:* The distress tolerance module teaches coping skills to deal with crisis situations and intense emotions without engaging in harmful behaviors. c. *Emotion Regulation:* This module helps individuals identify and understand their emotions, learn to manage emotional intensity, and develop healthier ways to regulate their emotions. d. *Interpersonal Effectiveness:* Interpersonal skills are taught to improve communication, assertiveness, and the ability to navigate relationships effectively.
Individual Therapy	Clients meet one-on-one with their DBT therapist for weekly individual therapy sessions. During these sessions, clients work on problem-solving, goal-setting, and learning skills from the four modules.
Skills Training Group	In addition to individual therapy, clients participate in weekly group sessions where they learn and practice the skills from the four modules. These group sessions also provide an opportunity for clients to receive support and validation from others facing similar challenges.

Validation	A core component of DBT is validation, which involves acknowledging and understanding a person's thoughts, feelings, and experiences without judgment. This validation helps build trust and rapport between the therapist and the client.

Acceptance and Commitment Therapy

Acceptance and Commitment Therapy (ACT) is a form of psychotherapy that falls under the broader category of cognitive-behavioral therapies. It was developed by Steven C. Hayes in the 1980s and has gained popularity as an effective approach for addressing a wide range of psychological issues. ACT is based on the idea that psychological suffering is a natural part of being human and aims to help individuals develop psychological flexibility and live a more meaningful life.

Key concepts and techniques:

1. Psychological Flexibility: The core goal of ACT is to foster psychological flexibility. This involves being open to experiencing difficult emotions and thoughts without attempting to avoid or control them. Instead of getting caught up in trying to eliminate negative experiences, individuals learn to accept and embrace them as part of their human experience.
2. Six Core Processes: ACT incorporates six core processes to help individuals develop psychological flexibility:
    a. Acceptance: Acknowledging and embracing one's thoughts, feelings, and sensation without judgment or attempts to change them.
    b. Cognitive Defusion: Learning to distance oneself from unhelpful thoughts and beliefs, recognizing that thoughts are not facts, and gaining freedom from their influence.
    c. Present Moment Awareness: Being fully present and engaged in the here and now, promoting mindfulness and consciousness.
    d. Self-as-Context: Recognizing that the "self" is more than just thoughts and emotions and connecting with a sense of observing self or consciousness.
    e. Values: Clarifying and connecting with what truly matters to the individual, their core values, and what they want their life to stand for.
    f. Committed Action: Taking purposeful and meaningful steps aligned with one's values, even in the presence of difficult emotions or obstacles.
3. Defusion Techniques: ACT employs various exercises and metaphors to help individuals detach from unhelpful thoughts. These techniques reduce the impact of thoughts and beliefs on behaviors and emotional experiences.
4. Mindfulness: ACT incorporates mindfulness practices to increase present-moment awareness, promote acceptance, and foster a non-judgmental stance towards one's experiences.
5. Values Clarification: Helping individuals identify and clarify their deeply-held values. When clients connect with their values, it becomes easier to make choices that align with what is truly important to them.

6. Committed Action: Encouraging individuals to take purposeful steps toward their chosen values, even when faced with challenges or discomfort.
7. The Hexaflex Model: The Hexaflex model is a diagram that represents the six core processes of ACT. It illustrates how these processes interact and support one another to create psychological flexibility.

ACT is widely used to treat various mental health conditions, including anxiety, depression, chronic pain, and stress-related disorders. By learning to accept their internal experiences and act in ways that align with their values, individuals can create more meaningful and fulfilling lives.

How would you describe your counseling style? What theoretical orientation fits best for you at this time in your development?

Systems Approach to Therapy

These approaches include feminist therapy and family therapy. They are based on the belief that an individual's surroundings influence his or her development and behavior. Without changing the system, attempts to change the individual may fail. Counselors who follow this approach pay attention to how the patient is affected by his or her culture, family, gender-role socialization, and other systems.

Postmodern Approaches

These include solution-focused brief therapy, narrative therapy, and social constructionism. They challenge more traditional approaches by not assuming there is one "truth," but that people's reality is shaped by their interactions. Postmodern therapists work collaboratively with patients and do not take on the role of "expert."

Integrative Combined Therapies

The term "Integrative Combined Therapies" (ICT) can be misleading as counselors provide services in the 21st century. A search of the Internet using these words can lead to the work of John Norcross and Mark Goldfried, to the co-occurring disorder treatment approaches of Dartmouth Medical School and Hazelden, and to doctoral dissertations on cognitive-behavioral therapy (CBT). As a school of therapy or theoretical orientation, ICT is an approach that has been developing over the last several decades and receiving great attention in the last 10 years. ICT refers to a multi-modal approach that combines theories and techniques from different schools of thought into one integrated approach. It combines elements from different theories into an overall frame of reference. ICT differs from eclecticism, which tends to pick and choose from multiple approaches based on individual patients. Integration suggests that the elements are part of one combined approach to theory and practice, as opposed to eclecticism, which picks from several approaches based on a particular case (Palmer & Woolfe, 2000).

Norcross and Goldfried (2005) describe four pathways toward integrating different schools of therapeutic thought. Each path differs in the degree of theoretical and technical integration of therapy models:

1. **Technical eclecticism.** Technical eclectic counselors use techniques from different therapeutic systems without necessarily subscribing to the theories behind the techniques. They may not have a clear conceptual framework behind their choice of techniques. Choices are frequently based on what works for others.

2. **Theoretical integration.** Counselors using this path combine two or more approaches to therapy with the hope that the result will be better than using each approach by itself. The goal is to create a conceptual framework that synthesizes the best elements of two or more therapies.

3. **Common factors.** Counselors following this theme look for the "core ingredients" that different theories have in common. They believe that therapy successes are due to these shared factors. The factors most frequently considered are the development of a therapeutic alliance, opportunity for catharsis, acquisition and practice of new behaviors, and patients' positive expectancies.

4. **Assimilative integration.** Counselors on this path have a firm grounding in one system of psychotherapy and are willing to incorporate practices and views from other systems.

In the addiction treatment field, the title "Integrating Combined Therapies" has been used as the name for co-occurring disorder treatment programs. Dartmouth Medical School, under contract with the National Institute on Drug Abuse (NIDA) has developed the Integrated Cognitive Behavioral Therapy (ICBT) model for the treatment of co-occurring posttraumatic stress disorder and substance abuse. Hazelden Publishing uses the term "Integrating Combined Therapies" as a title to its co-occurring disorder curriculum. It describes the model as an integration of motivational enhancement therapy (MET), CBT, and 12-Step Facilitation (TSF) therapy. Hazelden's curriculum description states that "MET engages change, CBT works to assist change, and TSF sustains change and elaborates on it" (Hazelden, 2010).

Summary of Theoretical Orientations and Therapeutic Models

This section of the chapter has served as an introduction to multiple theoretical orientations and therapeutic models used in the counseling and psychotherapy professions. As you grow in your knowledge and skill level as a counselor, you may find that you connect with a specific theoretical orientation and start to define yourself as a particular kind of counselor. More than likely, however, you will find yourself integrating a variety of theories and techniques into your frame of reference. "Practitioners need to pay attention to what their clients are thinking, feeling, and doing, and a complete therapy system must address all three of these factors. Some (...) therapies (...) highlight the role that cognitive factors play in counseling. Others place emphasis on the experiential aspects of counseling and the role of feelings. Still others emphasize putting plans into action and learning by doing. Combining all of these provides the basis for a powerful and comprehensive therapy" (Corey, 2016, p.9).

Establish a Helping Relationship (75)

As was discussed in Chapter 7, the therapeutic alliance between the patient and the counselor has been found to be the most positive predictor of successful outcomes in therapy. It does not appear to matter so much which theoretical frame of reference you adhere to or techniques you use with a patient, as how well the patient feels they are accepted and how positively they view the relationship. This does not mean you should not work to understand theories and develop therapeutic skills, but the most skillful counselor may not be successful if attention is not first paid to the relationship with the patient.

"The kind of person a therapist is remains the most critical factor affecting the patient and promoting change. If practitioners possess wide knowledge, both theoretical and practical, yet lack human qualities of compassion, caring, good faith, honesty, presence, realness, and sensitivity, they are more like technicians. I believe that those who function exclusively as technicians do not make a significant difference in the lives of their patients" (Corey, 2020, p. 4).

Counseling demands a high degree of authenticity on the part of the counselor. A counselor who is genuine and honest in the therapeutic process will promote a growth-enhancing, person-to-person relationship. This is an individual who is willing to take an honest look at his or her own life, is self-affirming regarding the personal risks for change, and models authenticity with appropriate self-disclosures. This display of psychological health can only promote inspiration and motivation for the patient. Effective counseling also demands an understanding of one's limits. It becomes an ethical issue for a counselor to know when they are dealing with a patient problem that requires the expertise of another professional or consultation with the appropriate resource, such as a preceptor. This includes the acknowledgment of limits both to their therapeutic knowledge as well as to their cultural awareness.

In his book on counseling theories, Gerald Corey (2020) lists personal qualities and characteristics of counselors who can make a significant difference in the lives of others. These counselors:

- Have an identity
- Respect and appreciate themselves
- Are open to change
- Make choices that are life-oriented
- Are authentic, sincere, and honest
- Have a sense of humor
- Make mistakes and are willing to admit them
- Generally live in the present
- Appreciate the influence of culture
- Have a sincere interest in the welfare of others
- Possess effective interpersonal skills
- Become deeply involved in their work and derive meaning from it
- Are passionate
- Are able to maintain healthy boundaries

Carl Rogers' person-centered therapy is a useful framework to use when working to establish a therapeutic relationship. Rogers believed that each person has a natural healing ability. When given a safe environment, they can explore life without fear of criticism and make changes. The counselor creates this safe environment by expressing genuineness, acceptance, and empathy. It is useful to look back at how Rogers originally defined these terms in 1961 (Rogers, 1995, pp. 33–34).

GENUINE	ACCEPTANCE	EMPATHY
"Being genuine involves the willingness to be and to express, in my words and my behavior, the various feelings and attitudes which exist in me."	"By acceptance I mean a warm regard for him as a person of unconditional self-worth – of value no matter what his condition, his behavior, or his feelings."	"It is only as I understand the feelings which seem so horrible to you, or so weak or so sentimental, or so bizarre – it is only as I see them as you see them, and accept them and you, that you feel really free to explore all the hidden nooks and frightening crannies of your inner and often buried experience."

In addition to genuineness and empathy, *TAP 21* also identifies the characteristics of warmth, respect, and concreteness as being important in the helping relationship.

WARMTH	RESPECT	CONCRETENESS
Evident in nonverbal responses, including smiling, touching, and leaning toward a patient.	Demonstrates to a patient your belief that he or she has a right to make his or her own decisions and choose a path in life.	The ability to keep the patient and yourself on topic and to avoid getting lost in generalizations or nonrelevant discussions by bringing the patient back from distractions to the issues and feelings at hand.

Counselors must gain the ability to develop rapport and create a therapeutic relationship. Effective counselors have the ability to use the inherent power they hold in appropriate and therapeutic ways. They learn to model healthy uses of this power and never abuse it by holding it over a patient. Counselors who are comfortable with themselves and are ethically well-grounded will find it easy to create a warm, inviting, and safe therapeutic relationship with a patient.

How do you reflect these characteristics in your counseling style? What might prevent you from being genuine? Are you carrying around baggage that prevents you from being genuine? Are there patients for whom you cannot show unconditional positive regard? What are your options in regard to your answers? Have you shared them with your preceptor?

Active Listening Skills

Along with projecting an atmosphere of warmth, genuineness, and acceptance, substance use counselors can use the skills of active listening to help establish a positive relationship with their patients. Below are listed four active listening skills. Refer back to your NDACS curriculum for additional review of active listening.

ATTENDING

Demonstrating to the patient via verbal and nonverbal skills that you are paying attention. Examples include leaning forward, nodding your head, saying "ah-huh."

PARAPHRASING

Briefly restating what the patient has said, using fewer words to communicate an understanding of the content, connecting with the patient and/or encouraging further elaboration.

REFLECTING FEELINGS

Using feeling words, verbalize your understanding of the patient's emotions. This serves to validate emotions and can be used to explore deeper feelings.

SUMMARIZING

Bring together main points that have been discussed in the session either at random intervals or to end the session. This skill can serve as a transition point toward deeper exploration, to other topics, or as a conclusion to the session.

Transference and Countertransference

Transference refers to the process in which a patient redirects their feelings for another person or unresolved issues onto the counselor. For example, a female patient may have unresolved issues with her father and having a male counselor may project some of those struggles onto the counselor. If late for group, she might anticipate being punished in the way her father punished her when she broke curfew. It is important for a counselor to be aware how personal characteristics, such as gender, may play into the therapeutic relationship.

Have countertransference issues arisen for you in your counseling work? Are there particular issues that you have identified that you need to be aware of? Have you shared them with your preceptor?

Countertransference occurs when the counselor projects their unresolved issues onto the patient. Signs of countertransference include:

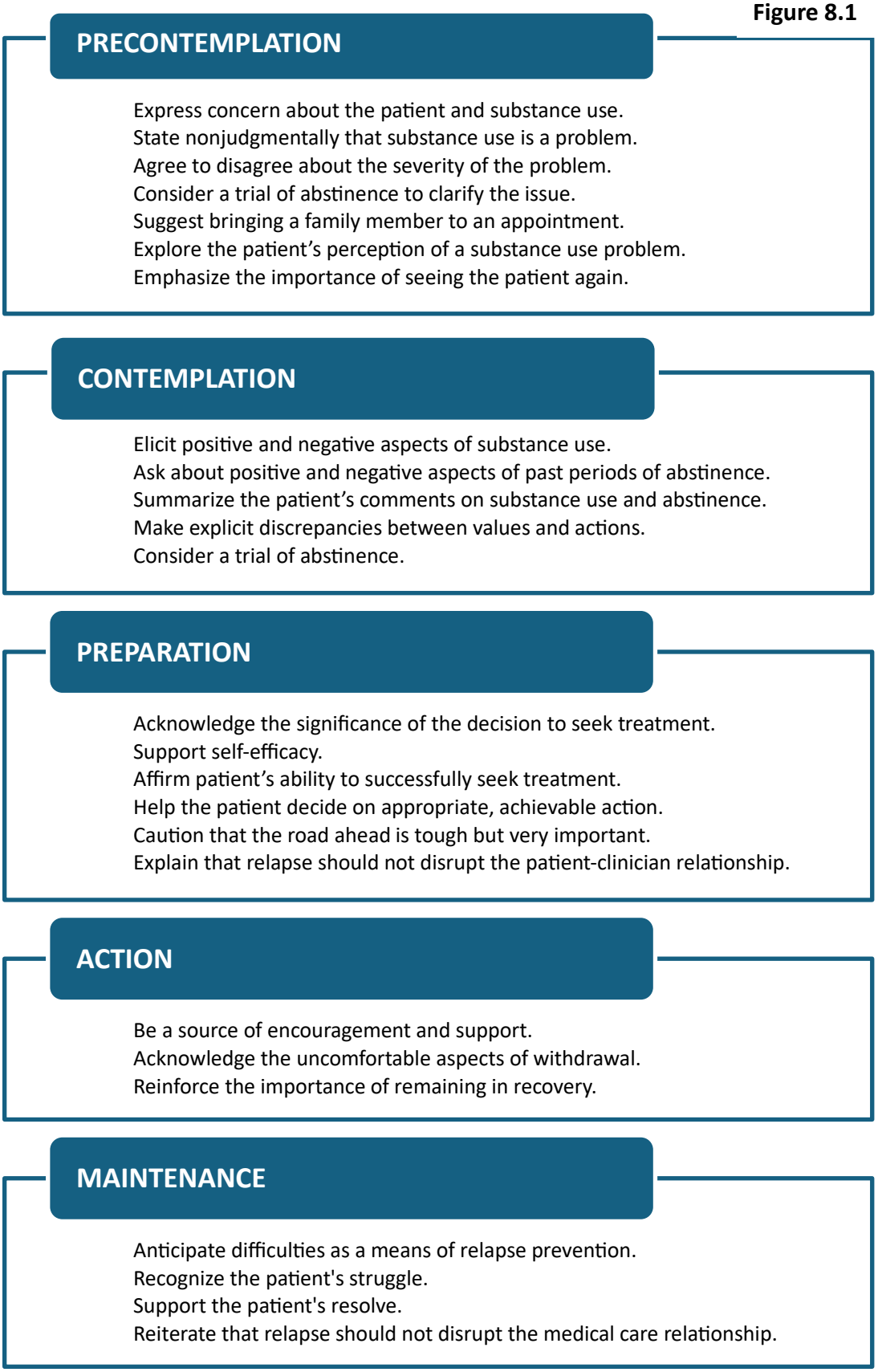
- A feeling of loathing, anxiety, or dread at the prospect of seeing a specific patient
- Unexplained anger or rage at a particular patient
- Distaste for a particular patient
- Mistakes in scheduling patients, missed appointments
- Forgetting the patient's name, history
- Drowsiness during a session or sessions ending abruptly
- Excessive socializing

Transference and countertransference issues are excellent topics for discussion with your preceptor. Preceptors will not provide counseling to you but can provide strategies for dealing with countertransference and referral to an outside counselor when appropriate.

Facilitate the Patient's Engagement in Treatment and Recovery (76)

A key to engaging patients in treatment is to meet the patient where they are. For example, if a male patient is angry about being in treatment and thinks his command is out to get him, telling him he is an alcoholic and needs to remain abstinent for the rest of his life will likely not motivate his treatment engagement. *TIP 35* offers interview strategies for engaging patients based on their stage of change. **Figure 8.1** offers therapeutic approaches to take with a patient based on their stage of change.

Figure 8.1


PRECONTEMPLATION
Express concern about the patient and substance use.
State nonjudgmentally that substance use is a problem.
Agree to disagree about the severity of the problem.
Consider a trial of abstinence to clarify the issue.
Suggest bringing a family member to an appointment.
Explore the patient's perception of a substance use problem.
Emphasize the importance of seeing the patient again.
CONTEMPLATION
Elicit positive and negative aspects of substance use.
Ask about positive and negative aspects of past periods of abstinence.
Summarize the patient's comments on substance use and abstinence.
Make explicit discrepancies between values and actions.
Consider a trial of abstinence.
PREPARATION
Acknowledge the significance of the decision to seek treatment.
Support self-efficacy.
Affirm patient's ability to successfully seek treatment.
Help the patient decide on appropriate, achievable action.
Caution that the road ahead is tough but very important.
Explain that relapse should not disrupt the patient-clinician relationship.
ACTION
Be a source of encouragement and support.
Acknowledge the uncomfortable aspects of withdrawal.
Reinforce the importance of remaining in recovery.
MAINTENANCE
Anticipate difficulties as a means of relapse prevention.
Recognize the patient's struggle.
Support the patient's resolve.
Reiterate that relapse should not disrupt the medical care relationship.

CASE STUDY 8.1

During Ryan's involvement in your SARP's intensive outpatient program, he shows signs of withdrawal from other patients, does not seem as motivated as he was when he entered the IOP, and is beginning to show signs of depression. After a period of progress, especially after he began treatment for PTSD, he now seems to have taken a negative turn.

What approaches, techniques, or other actions would you take to re-engage Ryan into the treatment and recovery process?

Work to Establish Realistic Goals Consistent with Recovery (77)

Goal setting was first discussed in Chapter 3 as a key element of the treatment planning process. Through the counseling relationship, patients will continue to work on their goals for treatment and recovery. Throughout the course of treatment, goals and objectives can be updated and modified based on the stage of change and motivation of the patient. Key questions to ask are:

- Are the goals individualized, measurable, and realistic?
- Are the treatment goals the patient's or the counselor's?
- Do the goals reflect the patient's current stage of change?

Involving the patients in setting goals for treatment gives them the responsibility for their success in treatment and makes them the driver of their recovery program. Research has shown that patients who establish concrete goals tend to report having a greater sense of control of their recovery and greater expectation of success. "Negotiating well-formed goals should be thought of as a process that occurs when patients feel that solving their problems will depend on themselves, and when patients have high hopes that their problems will be solved" (Miller, Hubble, & Duncan, 1996, p. 323).

CASE STUDY 8.2

Ryan admitted he has a drinking problem. You have determined he is now in the Contemplation stage. He is not sure what he needs to do about his drinking. Listed below are a goal and three objectives that have been written based on Ryan's statements. Evaluate them using the three questions above.

Stage of Change: Contemplation

Goal: Stop drinking.

Objectives:

Attend AA meetings.
Share the reasons you believe you have a drinking problem in group.
Learn ways to express your feelings.

A Solution-Focused Approach to Goal Setting

Solution-focused counselors consider the circumstances that led the patient to make an appointment for assistance when setting goals. Berg and Reuss (1998) designated relationships as customer-type and visitor-type. The customer-type patient-counselor relationship applies to the patient who comes into treatment knowing they have a problem and wanting to fix it. The visitor enters treatment because some outside source expects them to be there. The goal of the visitor may be to get the referral source to leave them alone, rather than to change the substance use behavior. Consider these questions when working with mandated patients to set and modify goals during treatment:

- Whose idea was it for you to come here today?
- What makes _____ think that you need to come here?
- Do you agree with _____'s idea that coming to see me is a good idea?
- What would have to happen for _____ to say this has been helpful to you?
- What will _____ do differently when they believe you are making these changes?
- How will that be helpful to you?
- Are there times now when you are making even small changes?
- Tell me, how do you do that?
- What would it take for you to keep making these small changes?
- Suppose you kept it going for 3/6/9 months, what would be different in your life then?
- What would _____ say about how your life would be different then?
- What would _____ do differently to let you know that they notice these changes?

The goal in the mandated scenario may be to get the "someone"—in Navy treatment, usually the command—off the patient's back. That becomes the goal of treatment. The counselor then focuses on what it will take for the command to get off the patient's back. The response may be something related to decreased drinking, not getting in trouble, or getting to work on time. Treatment activities then focus on what changes the patient needs to make in his or her life to accomplish that goal. Additional solution-focused techniques include:

Pre-session change. Asking questions that highlight pre-session change recognizes that change is occurring constantly, and patients often start the change process before attending the first treatment session. If a patient approaches the first session with the idea that "I have already cut down my drinking," the counselor can use this as a basis for constructing other changes.

Exception questions. These questions look for times when the problem was not occurring or was not so bad. Asking exception-finding questions enhances existing and past successes. This allows a patient to discuss what life was like without the problem. This information can help identify strengths and abilities that have helped them be successful. In the case of substance-using patients, they can discuss what they felt like without the substance, how they coped without it, and what other people's reactions to them were like.

The "miracle" question. Ask the patient to tell you what life would be like without the problem. Say the following: "Suppose when you go to sleep tonight a miracle happens and the problems that brought you here today are solved. But since you are asleep you can't know this miracle has happened until you wake up tomorrow. What will be different tomorrow that will let you know this miracle has happened and the problem is solved?" (Berg & Reuss, 1998, p. 30) Berg and Reuss (1998) report that when they ask the miracle question, they pay attention to three things:

1. They use the word "suppose" to encourage the patient to believe in a reality, at least for a moment, where the problem does not exist.
2. They state "the problem that brought you here" to allow a solution that is not tied to a specific problem.
3. They pause for a long time after asking the question because it is a hard question for people to answer. If a patient says, "I don't know," they pause longer to give him or her more time to think about it.

Scaling questions. When evaluating problems, solution-focused counselors ask patients: "On a scale of 1 to 10, where 1 is the worst the problem has been for you and 10 is you are no longer concerned about the problem, where are you today?" This can be followed with: "What would be different in your life when you move up one step?" The same format can be used to assess motivation: "On a scale of 1 to 10, how much would you say you are willing to work to solve the problem?" Scaling questions allow the patient and counselor to evaluate progress to date and assess the perceptions of both the patient and the counselor.

Coping questions. Some patients present themselves in treatment with a very heavy burden. Their lives feel hopeless to them. The issue may be a feeling of hopelessness that stems from a long history of battering as the spouse of a problem drinker, or it may come from being told over and over that he would never amount to anything. Whatever the source of the hopelessness, the patient is very difficult to work with because of the belief that nothing will ever get better. An example of such a situation might be working with a Wounded Warrior who will have to manage chronic pain. In a case such as this, the counselor needs to find something from which to build. Reviewing the situation with the patient and then stating, "It's amazing that you are able to get by each day; how do you do it?" allows the patient the opportunity to continue to tell the counselor how bad things are. Eventually, continuing to ask, "How do you do it?" will bring the patient to a point of offering something. It may be as small as "I just do it." The counselor needs to recognize when the patient "puts it on the table" and must build on the patient's ability to accomplish this each day under such difficult conditions.

Promote Patient Knowledge, Skills, and Attitudes that Support a Change in Substance Use (78)

Competency 78 in *TAP 21* states that counselors will "promote knowledge, skills and attitudes that contribute to a positive change in substance use behaviors" (CSAT, 2006, p. 103). How will you know if a patient is gaining the knowledge, skills, and attitudes needed for a change?

One tool available for use is the treatment plan. Too often, the treatment plan is a generic document that may list individualized problem statements, but the activities include standard treatment services such as talk in group, go to AA, or attend a class. Attendance at these program events demonstrates compliance; but in and of themselves, they do not ensure that a patient is building the skills needed to achieve their recovery goals. A well-structured treatment plan will help the counselor get to know the patient better over time. Progress on the treatment plan can help the patient and counselor identify what is and is not helpful in meeting their goals.

Consider the following treatment plan assignments. Before assigning these tasks, ask yourself these questions.

Go to three AA meetings in the first week.

What is the purpose of going? Has he chosen abstinence as a recovery goal? Does he have transportation, is childcare an issue, has he been connected to anyone in AA to serve as a point of contact? If the patient does not go to three AA meetings, how will you respond?

Write a drinking history and share five negative consequences to his drinking in group.

What are his literacy skills? Would it be helpful to provide a format for writing the history? Is he ready to share this in group?

Talk about the things that make you angry in group.

Does she think she has anger issues? Is she the only female in the group? What is talking in the group going to accomplish? Has she kept an anger log?

Asking these kinds of questions of yourself and the patient before developing the treatment plan and when assessing progress will help you both identify whether the patient is learning what they need to learn to meet their goals.

Encourage and Reinforce Patient Actions Beneficial to Treatment Goals (79)

When searching for tools to reinforce the patient's positive steps in treatment, it is useful to utilize Motivational Interviewing (MI) skills and techniques. Miller and Rollnick (2023) state that change is facilitated by having the patient explore the options and advantages of change. It is designed to strengthen an individual's motivation and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion. MI identified four tasks in working towards motivating patients: engaging, focusing, evoking, and planning.

1. *Engaging* is the relational foundation of building rapport with a patient.
2. *Focusing* identifies agenda and change goals that the patient desires to address.
3. *Evoking* uses MI core skills and strategies for moving toward a specific change goal (OARS outlined below).
4. *Planning* is the bridge to behavior change and identifies specific action steps for the patient to take once change talk is more prevalent than sustain talk.

These tasks overlap, and there is typically not a defined beginning and end to each.

As a counselor works with a patient using MI, the counselor is looking for "change talk" or "sustain talk." When discussing progress toward treatment goals, change talk can be used to reinforce and encourage positive steps. Sustain talk refers to the patient making a statement indicating that – in their ambivalence about changing – they are leaning toward the status quo (i.e., not changing). When a patient is using more change talk than sustain talk, they are ready to move into the planning task. Change talk falls into four categories:

Recognizing the Disadvantages of the Status Quo

"I didn't realize my boss thought I was drinking too much" or "maybe I have more of a problem than I thought."

Recognizing Advantages of Change

"My spouse is happier now that I'm coming home from work on time."

Expressing Optimism about Change—Statements that Reflect Self-Efficacy

"I lost weight and passed my physical fitness test last year, and that was hard."

Expressing Intention to Change

"I've got to do something; I don't want to lose my spouse and career."

Using MI techniques will serve to reinforce positive steps the patient is taking and open the door for identifying obstacles to success. As the patient talks about change, listen for the areas of their life that have been impacted by drinking and obstacles they may face. Ambivalence may reflect a belief that they cannot be successful, feelings of grief about the things they have had to give up, or lack of knowledge of what it takes. The treatment plan can be updated with activities that address these areas as they are revealed.

The counselor can elicit change talk by asking open-ended questions and using the OARS method introduced in Chapter 1.

Open-ended questions that pull for change talk: *"What have you learned about your drinking that surprises you?"*

Affirm and reinforce change talk: *"You're already seeing improvements at home."*

Reflect back on change talk the patient has used: *"You've been successful before and could be again."*

Summarize the change talk: *"It sounds like it's time to make some changes."*

Work with Patient to Recognize and Discourage Behaviors Inconsistent with Treatment Goals (80)

Each patient entering treatment brings a variety of experiences and skills that influence their ability to meet their treatment goals. As you will recall, the ASAM-PPC calls for the ongoing assessment of the patient's functioning regarding their readiness to change, relapse potential, and recovery environment. Treatment interventions can be selected based on the progress needed in each of these areas.

The treatment program offers many opportunities to help patients identify behaviors that are not in keeping with their stated treatment goals. Most programs have educational components that address issues of lifestyle change, recovery, and relapse prevention. The treatment group provides an opportunity through which patients can practice new behaviors and receive feedback.

Some patients will benefit from the use of medication to support drink refusal and to deal with cravings. Disulfiram, or Antabuse, is a medication that causes unpleasant side effects when even a small amount of alcohol is consumed. Naltrexone is an opiate antagonist that works by decreasing the craving for alcohol. It is also used to block the effects of opioid medications and opioid street drugs. SARP counselors should consult with their multidisciplinary treatment team regarding the use of medication therapies in the treatment of substance use in your program.

Many substance use counselors gather materials and tools they find helpful to use with patients to assist in the ongoing assessment and skill building that is required for recovery. Your coworkers and preceptors are available resources as you build your own toolkit of materials.

CASE STUDY 8.3

As Ryan begins to re-engage in treatment, he shares with you that tension has continued in his marriage, and he is beginning to lose hope that things will improve. He also seems to be losing sight of the goals of his treatment plan and is expressing much discouragement over his ability to reach some of the target dates in his plan. You also learn that his attempts at spending time with his 7-year-old nephew have been thwarted by his sister-in-law, whom he suspects is being negatively influenced by his wife.

What can you do to work appropriately with Ryan to recognize and discourage behaviors and thoughts inconsistent with progress toward the goals in his treatment plan?

Recognize How, When, and Why to Involve Patient's Significant Other (81)

As discussed in Chapter 7, the involvement of significant others in Navy treatment varies significantly based on the duty station of the patient, age, marital status, program size, and other factors. Throughout the course of treatment, counselors should weigh the viability of family involvement and discuss this with the patient and the treatment team. For those whose family is far away, creative

interventions may include having the patient role-play telling their father they don't drink any more in group or writing and mailing a letter to their mother. The definition of family may be explored, and consideration given to bringing a roommate in for a session to discuss not keeping alcohol in the barracks room. Careful consideration must be made to ensure that family issues are not ignored because the treatment population is primarily young, single men. At all times, any contact with significant others, family members, or close associates must be made following all confidentiality regulations.

CASE STUDY 8.4

What would lead you to consider arranging a joint session for Ryan's wife? How, when, and why would you involve Ryan's wife in his treatment?

Promote Knowledge, Skills, and Attitudes Consistent with Health and Prevention of Infectious Diseases (82)

Substance use counselors need to develop the skills to discuss issues of physical and sexual health with their patients. Alcohol and drug use can increase the likelihood of risk-taking behavior, including unsafe sexual practices, intravenous drug use, and increased activity with multiple partners. This may result in exposure to sexually transmitted diseases, HIV/AIDS, tuberculosis, hepatitis, and other infectious diseases. The Center for Substance Abuse Treatment (CSAT) recognizes the substance use counselor as serving a key role in intervention and prevention of the spread of infectious diseases (CSAT, 1993). The substance use counselor may be called on to fulfill some or all of these functions, depending on the treatment setting and role delineation in your program. **Figure 8.2** details the infectious disease prevention functions.

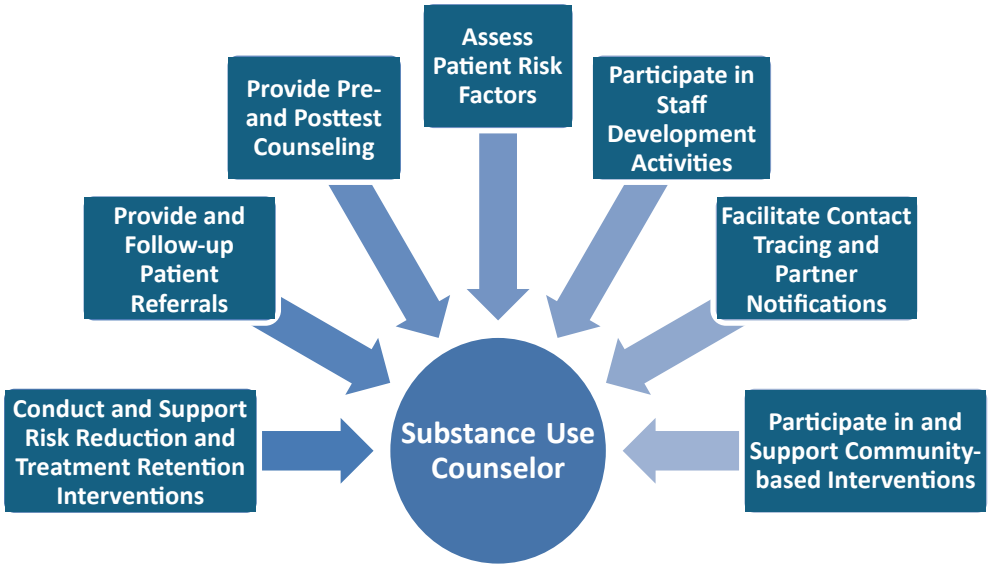


Figure 8.2

Facilitate the Development of Skills Associated with Recovery (83)

The skills and attitudes that a person needs to develop to achieve their treatment goals will vary based on a variety of factors. Their choices for recovery and the obstacles they may face will be influenced by their individual characteristics. Suggesting to an 18-year-old that they may never safely consume alcohol again may elicit a very different response than what you would hear from a 37-year-old. Military service members are members of a subculture with a long history of promoting drinking and not leaving their buddies behind when they get in trouble. A young sailor may have great difficulty envisioning a Friday night in which they do not go to the bar with their buddies. On the other extreme, a 37-year-old sailor preparing to retire in a year may have vocational, marital, and parenting issues that would be unfamiliar to the 18-year-old.

Treatment activities can be designed to address the specific skills needed by each patient. The more opportunities a patient has to practice new skills, the greater likelihood they will use them once they leave treatment. These skills can include assertiveness training, drink refusal, relaxation techniques, stress and anger management, and financial management.

As discussed earlier, solution-focused counseling suggests that counselors help patients to identify when they have been successful in the past in meeting their goals and building on those successes. Having the patient complete an inventory of successful substance use management will help the patient identify what has and has not worked to date. Questions such as:

- When are you able to limit your drinking even though it would be easy to overdo it?
- How do you accomplish this?
- When are you able to refuse alcohol even though it is available?
- How do you accomplish this?
- How do these activities help you to cut down or not drink?

How do you determine what a patient will need to know to change their substance use? What kinds of questions do you ask?

Helping the patient to envision success and what their life will be like when they are living as they would like to will help to identify the skills that need to be developed. In addition, the relapse prevention models introduced in Chapter 7 also offer tools for building skills.

Adapt Counseling Strategies to Individual Characteristics of the Patient (84)

A person's access to treatment, motivation, readiness for change, and responsiveness to treatment interventions are all influenced by their individual characteristics. These characteristics set parameters from which the patient functions, as well as from which the counselor views the patient. Counselors must become adept at adapting treatment strategies as necessary for each patient. Patients may be impacted by capabilities, such as age, literacy level, health status, or by attitudes, such as cultural norms for alcohol use, views of women who drink, and beliefs regarding sexual

orientation. Some stereotypes and other ideas to consider are suggested below. *What more can you think of?*

Gender	•Is drinking a way to express machismo? Is it okay for men to cry? •Are women who drink loose? •Does being a drug addict make her an unfit mother? •Is she the only female in an all male group?
Age	•Is the patient below the legal drinking age? •Is the patient elderly? •Is the patient significantly younger or older than other group members?
Developmental Level	•Did substance use impact emotional development? •Are they still an adolescent? •Will they grow outof this behavior?
Disabilities	•Does the patient have developmental disabilities? •Is the patient a Wounded Warrior? •Do they take medication due to chronic pain? •Are there grief and loss issues related to a disability?
Sexual Orientation	•What is the patient's sexual orientation? •Is it public knowledge? Who in their life knows? •Do they want to tell the group? What are the benefits and risks to telling the group?
Ethnicity	•What are the recovery rates for their ethnic group? •Who are their role models for sobriety? •What labels does their ethnic group carry related to substance use?
Culture	•What are norms related to drinking for their culture? •How did they learn about drinking?
Health Status	•Do they have any chronic health problems? •Did they drink when pregnant? •Do they have any STDs? •Do they have a co-occurring mental health problem?

These questions explore the characteristics of the individual and how they affect treatment needs.

The continuum of care model allows for treatment to be individualized for each patient. Reading and writing assignments may not be the most appropriate for patients with literacy problems. It may not be appropriate for a female patient to discuss her sexual assault in an all-male group. The sailor who lost a limb in combat or a work accident may not be ready to attend the grief class on his 6th day in treatment. Proper care and consideration must be given to the needs of each patient, their unique story, and readiness to change as treatment strategies are identified and assigned.

Make Constructive Therapeutic Responses (85)

Counselors are called on to respond therapeutically to the data their patients present to them:

- Patients may arrive on time for sessions or be late.
- Homework may be done or not done.
- Feelings may be shared with the group or avoided.
- Responsibility may be taken for recovery or blame focused on others.

While continuing to reflect the qualities of genuineness, empathy, and acceptance, counselors also need to guide patients to look at the behaviors they exhibit that support or get in the way of their treatment goals. Counselors use the tools they have to point out discrepancies between the stated goals and the patient's behaviors.

Miller and Rollnick (2013) offer a framework for addressing patient adherence to treatment, outlined in Table **8.1**.

Table 8.1: Framework for Addressing Adherence to Treatment

MOTIVATIONAL CATEGORY	
Problem Acceptance	**Treatment Acceptance**
SOURCES OF NONADHERENCE	
• Misperceptions, misunderstanding, and/or uncertainties about the significance of the presenting problem • Fears about unintended consequences of change • Doubts about whether change is possible or within reach	• Uncertainty or ambivalence about change • Concerns about the suitability of the treatment modality offered • Misperceptions about treatment needs • Previous negative treatment experiences • Negative therapist or treatment outcome expectancies • Negative general relationship expectancies • Culture-specific differences • Stigma • Mandated treatment/coercion • High barriers to care (financial problems, family hardships) • Low self-efficacy in handling treatment demands
SELECTED STRATEGIES	
• Open questions • Empathic reflection • Providing feedback • Deploying discrepancy • Normalizing unclarities • Normalizing anxiety about change • Eliciting 'change talk' • Exploring values • Reviewing past successes	• Persistent empathy and nondefensiveness • Normalizing gradual development of trust • Exploring understandings of how treatment works • Providing information about how treatment works • Eliciting perceptions of treatment needs • Providing information on treatment needs • Decisional balancing • Reviewing post-treatment experiences • Exploring and addressing previous and future barriers to change in treatment • Negotiating proximal goals • Communicating a nonperfectionistic message • Recognizing nonadherence as a sign of damaged rapport • Addressing breeches in rapport • Involving a supportive other for motivational support • Identifying positive experiences of receiving help • Supporting self-efficacy or coping capacities • Displaying optimism about treatment effectiveness
Adapted from Miller & Rollnick (2013), p.315	

Apply Crisis Prevention and Management Skills (86)

There are several different definitions in the literature for the word *crisis* and for *crisis intervention*. Crisis intervention is defined by the IC&RC as "those services which respond to an alcohol and/or other drug abuser's needs during acute emotional and/or physical distress" (Herdman, 1997, p. 61). Another definition states "a crisis is a perception or experiencing of an event or situation as an intolerable difficulty that exceeds the person's current resources and coping mechanisms" (James, 2008, p. 3). A third definition is known as the "trilogy definition" (Kanel, 2011, p. 2). It refers to the three parts of a crisis:

1. A precipitating event
2. A perception of the event that causes subjective distress.
3. The failure of a person's usual coping methods, which causes the person to function at a lower level than before the event.

James (2008) describes *crisis* as a part of a substance user's life. He expands his definition of a crisis by dividing it into "transcrisis state" and "transcrisis points." A transcrisis state refers to the state of an addicted person's life. The biopsychosocial nature of addiction results in patients being in a constant state of crisis across their life. Transcrisis points are those times when a stressor erupts into a crisis. These crisis points can occur throughout withdrawal, treatment, and continuing care or early recovery. Crisis points can also be experienced by the support persons in the patient's life and may not always be identified as being connected to the addiction. The crisis state becomes a way of functioning, with the crisis points being opportunities for change.

In Chinese, the word *crisis* is represented by the characters for *danger* and *opportunity*. A crisis can be dangerous because it can overwhelm a person to the point that they may harm themselves or others. It is also an opportunity because the pain the crisis causes may motivate the person to seek help or change. Frequently, a crisis is what facilitates a patient to seek treatment. Their spouse threatens to leave; their command tells them their career is in jeopardy, a doctor reports on medical problems caused by alcohol. A crisis point in early recovery can result in a return to drinking (danger) or the seeking of additional help resulting in growth, insight, and a deeper commitment to recovery (opportunity).

Kanel (2011) describes two types of crises:

1. Developmental: These are crises triggered by normal, transitional phases of life, such as marriage, birth of a baby, adolescence, midlife, empty nest, and retirement.

2. Situational: These are caused by extraordinary events that the patient cannot predict and has no control over, such as crime, death, disaster, divorce, and illness. Situational crises differ from developmental crises due to their sudden onset, unexpectedness, emergency quality and potential impact on the community.

Crisis Prevention

A counselor may assist a patient in preventing a developmental crisis by being aware of the skills, resources, and support system available in the person's life. When conducting the biopsychosocial assessment, the alert counselor can consider the patient's stage in life and explore the potential for a developmental crisis. Situational crises are more difficult to prevent; however, the ability to recognize the risk factors that a precipitating incident may turn into a crisis can be considered as part of a thorough assessment.

Crisis Response

The factors that will influence the ability of a person to return to a higher level of functioning following a traumatic event or crisis include:

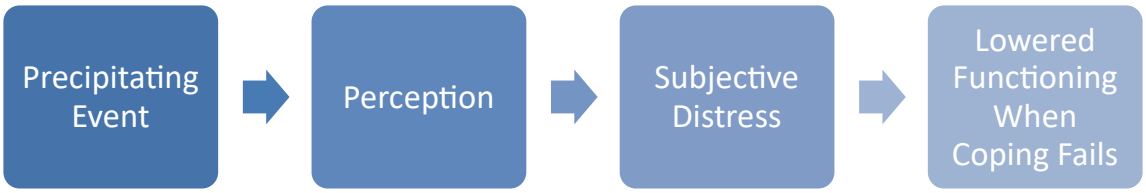
- The duration of the crisis—the sooner assistance is received, the better the prognosis.
- The nature of the trauma—generally the less severe the trauma, the better the prognosis. The counselor must remember, however, that it is the patient's perception that makes something a crisis.
- Material resources—money, food, clothing, transportation, shelter.
- Personal resources—ego strength, personality, intelligence, education.
- Social resources—family, friends, employment, religious community, social supports.

The crisis counselor responds to the event by working with the patient to access and/or build the necessary resources to improve functioning.

A person's response to a crisis may be varied and influenced by their level of functioning prior to the precipitating event:

- Cognitive responses—they may blame themselves or others; appear disoriented or confused; exhibit poor concentration or have difficulty making decisions.
- Physical responses—increased nervous system arousal: rapid heartbeat, chest pains, difficulty breathing, dizziness, and sweating.
- Emotional responses—depression, anxiety, panic, helplessness, hopelessness, anger, fear, guilt, feeling of a need to flee.
- Behavioral responses—withdrawal, conflicts with others, loss of interest in usual activities, difficulty eating or sleeping, substance use, relapse.

Kanel (2011) offers a formula regarding the formation of a crisis (p. 2).



The goals in crisis intervention are:

- To stabilize the individual so no further deterioration in functioning occurs.
- To relieve the individual of as much pressure as possible.
- To convert the emergency to a solvable problem and resolve it.
- To return the person to their pre-crisis level of functioning.

Again, Kanel offers a useful formula (2011, p 3):

Several models for crisis intervention are available in the literature. Roberts and Ottens (2005) offer a "Seven-Stage Crisis Intervention Model." Kanel (2011) presents a three-stage model known as the "ABC Model of Crisis Intervention." Both models have similarities. **Figure 8.3** presents the ABC model in more detail.

Figure 8.3

ABC Model of Crisis Intervention	
A. Use Basic Attending Skills to Develop and Maintain Rapport	
Attending behaviors Open-ended questions Paraphrasing Reflection of feelings	Clarifying Close-ended questions Summarizations
B. Identify the Nature of the Crisis and Therapeutic Interaction	
Identify the precipitating event. Identify cognitions. Identify subjective distress. Identify impairments in functioning: behaviorally, socially, academically, occupationally. Ethical checks: suicide, homicide, organic issues, psychosis, substance abuse, child abuse, elder abuse Therapeutic interaction statements: educational, empowerment, validation, reframes.	

C. Coping Strategies
Explore what the patient wants to do now to cope.
Explore what the patient has tried in the past to cope.
Explore other things the patient can do to cope.
Offer alternative strategies: support groups, 12-step groups, marital therapy, lawyer, doctor, bibliotherapy, assertion training, stress management, shelters.
Secure a commitment and follow-up.

Adapted from Kanel (2011), p. 55

The original global criteria that IC&RC developed for crisis intervention are also appropriate guidelines for competency in crisis intervention.

1. Recognize the elements of the patient's crisis.
   - What aspects about the individual make this a crisis?
   - What are the patient's cognitive, behavioral, and affective responses to the event?
   - What was the event that led to the crisis?
2. Implement an immediate course of action appropriate to the crisis.
   - Intervene immediately.
   - Ensure safety.
   - Follow facility's prescribed safety policies.
   - Individualize the crisis response plan.
3. Enhance overall treatment by using crisis events.
   - Modify the treatment plan to include crisis and safety plans
   - Provide opportunities for insight and development of new coping skills

Risk Assessment

Each Navy SARP and Health Clinic has a protocol for crisis intervention and suicide prevention. Counselors need to familiarize themselves with their local protocol. Clinical supervision and the local protocol should be followed anytime a counselor is concerned about a patient's risk for suicide. **The preceptor is not the immediate point of contact when a patient presents with suicidal ideation**. Following the intervention on the crisis at hand, the case should be discussed at the next scheduled supervision session with your preceptor.

What is the suicide intervention protocol at your SARP? Review the procedures with your preceptor. If you do not know, seek input from a clinical supervisor, senior counselor, or the Licensed Independent Practitioner (LIP) working in your program.

When working with patients in crisis, it is important to assess their risk levels for suicide. It is a myth to say that you might cause someone to commit suicide by asking about it. A list of suggested questions is provided below (Steiner, 2011).

1. Ask if the person has thought of killing themself.
   - How often?
   - How badly does the person want to die (on a scale of 1 to3)?
   - Does the person see suicide as a good solution or a bad solution?

- Does the person perceive suicide as weak or strong? (A person is at high risk if they think about suicide often, has a score of 3, sees suicide as a good solution, and perceives suicide as strong.)

2. Ask family members if they are concerned that the person will commit suicide.
   - A person is at high risk if their family members say they don't believe it would happen and believe that the person is just acting.
3. Check the person's plan for suicide.
   - Is it detailed? General?
   - Does the person have materials to carry it out?
   - Does the person intend to do it soon?
   - Has the person given away possessions or said goodbye or both?
4. Check the person's mental status.
   - Is the person confused? Intoxicated? Using street drugs? Hallucinating? In control of their faculties? Impulsive? Clinically depressed? Emerging from clinical depression?
5. Check the history of suicide in a person's life.
   - Has the person made other attempts?
   - Does the person have friends or family who died by suicide?
6. Find out what the individual's support system is like by asking these questions:
   - What friends or relatives have you talked to about your intent?
   - Who do you talk with when you are down?
   - How does your family respond to your concerns?
7. Find out how much control the person has by asking these questions:
   - Can anyone or anything stop you?
   - What has been stopping you?
   - What made you come for help (or tell me today)?
8. Ask the person for a commitment to talk with you, to see you in 2 days, to give up all rights to suicide for a set period of time. Have the person tell you how they will do that.

TIP 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment (CSAT, 2009) offers additional guidelines and training on the role of substance use disorder counselors in intervening with patients at risk for suicide. Counselors are encouraged to download the electronic copy of *TIP 50* and review the guidelines with your preceptor.

https://store.samhsa.gov/product/tip-50-addressing-suicidal-thoughts-and-behaviors-substance-abuse-treatment/sma15-4381

Counselor Behaviors to Avoid

When counselors encounter a patient who is in a state of crisis, it is natural that altruistic characteristics and a desire to intervene and "fix" things may rise to the surface. It is incumbent upon the counselor to turn to the skills you have been developing and remember you are the patient's "counselor," not their friend. Specific behaviors to avoid include:

Taking responsibility for the decision. Once the intensity of emotions has decreased, most people are capable of making choices. The counselor assists in decision making but does not make the decision.

Giving false assurance. It is not appropriate to paint a brighter picture than what really exists. The patient may feel the counselor does not understand, which can lead to a lack of rapport and trust. False assurances set up false expectations that may not be realized, leaving the patient potentially more devastated.

Becoming anxious. It is sometimes difficult to remain calm when dealing with an anxious, panicky individual. This is especially difficult if the patient poses a threat of injury to self or others. Knowing one's limits and asking for help from other colleagues is a way to ensure appropriate help for the patient and a clear head for the counselor.

Focusing on the problems not solutions to resolve the crisis. A solution-focused approach can be effective in a crisis situation. Be aware that excessive focus on the crisis may fuel the patient's vulnerability and produce no solutions.

Projecting your own interpretation of the trauma. As stated earlier, one's individual resources, skills, and perceptions are what define a trauma. What may not be a trauma for you, may well be one for your patient.

PTSD, Co-occurring Disorders, and Crisis Intervention

The presence of a co-occurring disorder or exposure to a traumatic incident complicates the process for crisis intervention. Many resources are available for additional training regarding trauma intervention. The National Center for PTSD offers training for counselors and mental health personnel. Counselors are encouraged to review their website at https://www.ptsd.va.gov/.

Standards of care for traumatic intervention have, until recently, included critical incident debriefing. The National Center for PTSD offers details regarding critical incident debriefing as studies have shown debriefing may not be helpful and may, in some instances, be harmful. The body of knowledge regarding trauma intervention and treatment is expanding greatly and outside the scope of this manual. Readers are referred to the below website for more information:
https://www.ptsd.va.gov/professional/treat/type/debrief_after_disasters.asp

The role of the substance use counselor in treating patients with co-occurring disorders continues to expand as the presence of patients with mental health issues enter treatment programs. Counselors need to work closely with mental health staff to assess and provide appropriate treatment interventions for persons who have been identified as having a co-occurring disorder or have been exposed to traumatic incidents. The multidisciplinary team, clinical supervisor, and preceptor are vital in the skill development of counselors working with co-occurring disorder patients.

Confidentiality, HIPAA, and Crisis Intervention

Federal regulations on confidentiality allow for the release of patient identifying information for the purpose of treating a condition that is an immediate threat to the health of a patient and requires immediate medical intervention. In addition, confidentiality laws regulate the disclosure of information when a patient has threatened to harm another person. Although many states instill in a counselor a duty to warn when a counselor believes a person is at risk of danger from a patient, the federal regulations limit the application of these regulations. Counselors need to consult with command legal staff should these circumstances arise.

HIPAA allows patients to gain access to their records. Application of this regulation in Navy medicine is set by the medical facility under which the SARP operates. Counselors need to refer to their site's policies and seek supervision regarding patient access to records.

Case Study 8.5

Ryan seems to be at risk for relapse. He has expressed to you his discouragement in an individual counseling session, broke down in tears, and appeared to be on the brink of returning to drinking.

What therapeutic responses would you make as part of a crisis intervention for Ryan?

Facilitate the Patient's Selection of Strategies that Support Recovery (87)

Adopting new behaviors that support a change in a patient's substance use requires practice. Whether the patient is choosing to modify their drinking or choosing abstinence, modifications need to be made in many aspects of their lives, including daily routines, relationships, problem solving, and recreational choices. Once again, a reflection on the biopsychosocial nature of substance use will help the counselor and patient identify the areas in their life that will require focus and learning new skills to function free of substances. For some patients, treatment is as much about "habilitation" as rehabilitation. Some patients cannot identify a social event in which they have not consumed alcohol since childhood. Others have never had a drug-free relationship or drug-free sex. Some patients will not know how to manage the money they may be able to save once they stop spending it on alcohol.

Learning skills that support moderate drinking or abstinence will require practice for most patients. Behavioral counseling techniques are useful tools to help learn and reinforce these new skills.

Relaxation Methods

Relaxation training is used as a method of teaching people to cope with normal stress caused by daily living. The most common type of relaxation training is progressive relaxation. Aimed at achieving both mental and muscle relaxation, the patient is given a set of verbal instructions that involve alternating between tightening and relaxing different muscle groups, one at a time. This is typically done starting at the head or the toes, then moving up or down the body progressively.

Systematic Desensitization

Based on the principle of classical conditioning, this is a self-monitoring process where the patient is asked to observe and record events that trigger anxiety. The patient then ranks the events as an anxiety hierarchy. The patient is eventually asked to imagine the least anxiety-arousing scene on the hierarchy. The counselor then moves progressively up the hierarchy until the patient experiences anxiety. When anxiety is experienced, then the counselor often coaches the patient through grounding activities until the anxiety is decreased. This continues until the patient can move all the way up the hierarchy without experiencing anxiety.

Modeling

The terms modeling, observational learning, imitation, social learning, and vicarious learning have all been used interchangeably. This simply involves the modeling of behavior after someone else. This could include the counselor, but also may include friends, family members, or even celebrities. Modeling involves acquiring new responses or skills through observing the behavior of others. This could also occur in group counseling where the patient has multiple models.

Assertiveness Training

This refers to a type of training that helps patients learn to interact successfully through assertive communication. Patients are taught that they have the right to state their viewpoints and that they can do so without ignoring the feelings of others.

Self-Management Programs

This technique involves integrating cognitive and behavioral methods to help patients manage their own problems. An example is the development of a relapse prevention plan. Such a plan teaches self-exploration as a precursor to the development of a well-planned program of self-monitoring. This would include the identification of relapse triggers and alternative behaviors.

Thorough relapse prevention also includes a discussion regarding the difference between a lapse and a relapse. Marlatt and Gordon's Relapse Prevention Model, first presented in Chapter 7, defines the reaction of a drinker to a lapse in drinking as the "abstinence violation effect." Based on the drinker's emotional response to an initial drinking episode, they may interrupt the episode and develop more effective ways to deal with high-risk situations in the future. Their research showed that those who responded to a lapse with an attitude of "I need to learn from my mistakes" were more likely to return to abstinence than those who blamed the lapse on their own personal failure (Larimer, Palmer, & Marlatt, 1999).

Donovan and Marlatt (2008) define relapse prevention as "a wide range of cognitive and behavioral strategies designed to prevent relapse in the area of addictive behaviors." The goals of relapse prevention are to:

- Prevent an initial lapse back to drinking
- Prevent an initial lapse from becoming a serious return to drinking

Cognitive-behavioral strategies that teach patients to prepare for the possibility of relapse and methods to cope with high-risk situations include:

- Identifying and coping with high-risk situations
- Enhancing self-efficacy
- Eliminating myths and placebo effects
- Lapse management
- Cognitive restructuring

Solution-focused counseling offers an additional perspective on relapse prevention. Consistent with their focus on solutions, counselors using this approach focus on successes. With the attitude that there could not have been a relapse if there had never been successful abstinence, the solution-focused counselor asks:

- What happened just before the relapse ended? How did you know it was time to stop again?
- When did you notice your plan to drink was not working?
- How did you stay sober for all that time before this last drinking period?
- How are you staying sober now?
- What is different about this relapse and staying sober, compared to previous ones? How did you get back on the right track? (Berg & Reuss, 1998)

CASE STUDY 8.6

Ryan was drinking on the way home from work, has been diagnosed with PTSD, has marital issues, and is experiencing feelings of grief regarding the loss of frequent contact with his nephew.

What relapse prevention techniques do you think would be helpful for Ryan?

Summary

This chapter offered extensive information in support of Competencies 75–87 outlined in *TAP 21*. They are vital to the delivery of high-quality, evidenced-based treatment to those seeking substance use counseling assistance. As a professional counselor, your skill level in these areas will continually grow as you read the literature, consult with other professionals, and deliver counseling services. Just as you begin to feel competent in these areas, new techniques, research, and patients will challenge you to grow further. Use your multidisciplinary team and clinical preceptor to assist you in this journey.

Learning Activities

1. Observe an experienced counselor conduct an individual counseling session. Considering the following questions as you observe:
   a. What did you note in the counselor's verbal and nonverbal behavior that demonstrated genuineness, acceptance, and empathy?
   b. How do you demonstrate these qualities in your sessions?
2. Videotape one of your individual sessions. Review the tape and make notes on paper of the number of times you find yourself using the OARS motivational interviewing techniques. If your site lacks videotaping capabilities, observe another counselor, and keep track of the same techniques. Review with your preceptor.
3. Review the treatment plans you (or another counselor) have developed with three different patients. Identify any areas where you might have individualized the goals or objectives to better meet the patient's needs. Discuss with your preceptor.

Self-Study Questions

1. Match the following theories with key persons associated with that theory.

_____ 1. Cognitive Therapy
_____ 2. Reality Therapy
_____ 3. Psychoanalytic
_____ 4. Integrative Combined Therapies
_____ 5. Solution-Focused
_____ 6. Dialectic Behavior Therapy
_____ 7. Person-Centered
_____ 8. Rational Emotive Behavior
_____ 9. Gestalt
_____ 10. Behavioral Therapy

A. Aaron Beck
B. Marsha Linehan
C. Carl Rogers
D. Fritz Perls
E. B. F. Skinner
F. William Glasser
G. Albert Ellis
H. Sigmund Freud
I. Norcross and Goldfried
J. Steve DeShazer and Insoo Kim Berg

2. List four active listening skills:

   a. _____

   b. _____

   c. _____

   d. _____

3. **True or False:** Countertransference is the process by which a counselor transfers their unresolved issues onto the patient?

4. Asking the question "what would have to happen for your command to believe that coming here was useful" is an approach used by:

   a. Cognitive-behavioral counselors
   b. Solution-focused counselors
   c. Behavioral counselors
   d. Feminist counselors

5. Asking a patient to keep an anger log listing what happens before they feel angry and their response to the anger is an example of a

   a. Psychoanalytic technique
   b. Solution-focused technique
   c. Cognitive-behavioral technique
   d. Gestalt technique

6. **True or False**: Projection is a defense mechanism in which a person assigns their own feelings or characteristics to someone else.

7. 'OARS' is a motivational interviewing technique. What does the acronym stand for?

   O _____

   A _____

   R _____

   S _____

8. List three of the roles a counselor plays in the prevention of infection diseases according to CSAT:

   1._____

   2._____

   3._____

9. **True or False**: Counselors should consider the educational and literacy level of a patient when choosing treatment intervention strategies.

10. When a counselor is concerned that a patient who is in their office is at risk for suicide, they should:

    a. Call their preceptor
    b. Call 911
    c. Not leave the patient alone
    d. Consult with the onsite clinical supervisor, LIP, or medical officer
    e. Both c. and d.
    f. All of the above

11. The three steps included in the ABC Model of Crisis Intervention are:

    a. _____

    b. _____

    c. _____

12. **True or False**: A lapse in drinking will always turn into a full-blown relapse.

Self-Study Answers

1.

1. Cognitive Therapy	A. Aaron Beck
2. Reality Therapy	F. William Glasser
3. Psychoanalysis	H. Sigmund Freud
4. Integrative Combined Therapy	I. Norcross and Goldfried
5. Solution-Focused	J. DeShazer and Berg
6. Dialectic Behavior	B. Marsha Linehan
7. Person-Centered	C. Carl Rogers
8. Rational Behavior Therapy	G. Albert Ellis
9. Gestalt	D. Fritz Perls
10. Behavioral Therapy	E. B.F. Skinner

2. Active listening skills include attending, paraphrasing, reflecting feelings, and summarizing.

3. **True**. Projection is when a person assigns his own feelings or characteristics to someone else.

4. Asking the question "what would have to happen for your command to believe that coming here was useful" is an approach used by b) Solution-focused counselors.

5. Asking a patient to keep an anger log is an example of a c) Cognitive-behavioral technique.

6. **True**. Counselors should consider the educational and literacy level of a patient when choosing treatment intervention strategies.

7. 'OARS' stands for: **O**pen-ended, **A**ffirm, **R**eflect, **S**ummarize

8. A counselor's roles may include assess patient risk factors, provide pretest and posttest counseling, provide and follow up with patient referrals, conduct and support risk reduction and treatment retention interventions, facilitate contact tracing and partner notifications, participate in staff development activities, and participate in and support community-based interventions.

9. **True**. Counselors should consider the literacy level of their patients when developing a treatment plan.

10. When a counselor is concerned that a patient is at risk, they should c) not leave the patient alone, *and* d) consult with the onsite clinical supervisor, LIP, or medical officer.

11. The three steps in the ABC Model of Crisis are: 1) use basic attending skills, 2) identify the nature of the crisis, and 3) coping strategies.

12. **False.** Relapse intervention techniques can be used to interrupt a drinking episode and prevent the patient from returning to a pattern of drinking.

Chapter 9 Counseling: Group Counseling

Purpose of This Chapter

This chapter reviews the Practice Dimension of Counseling by focusing on its second element: Group Counseling.

Learning Objectives

The learning objectives directly correlate with Competencies 88–93, as listed in *TAP 21* (pp. 112–116) and IC&RC Domain III: Evidence-Based Treatment, Counseling, and Referral. Each competency is accompanied by a set of knowledge, skills, and attitudes that define the standard.

- Describe, select, and appropriately use strategies from accepted and culturally appropriate models for group counseling with patients with substance use disorders. (88)
- Carry out the actions necessary to form a group, including but not limited to determining group type, purpose, size, and leadership; recruiting and selecting members; establishing group goals and clarifying behavioral ground rules for participating; identifying outcomes; and determining criteria and methods for terminating or graduation from the group. (89)
- Facilitate the entry of new members and the transition of existing members. (90)
- Facilitate group growth within the established ground rules and movement toward group and individual goals by using methods consistent with group type. (91)
- Using the concepts of process and content, shift the focus of the group when such a shift will help the group move toward its goals. (92)
- Describe and summarize the patient's behavior within the group to document the patient's progress and identify needs and issues that may require a modification in the treatment plan. (93)

Introduction

As has been stated several times in this workbook, substance use is a problem that has biopsychosocial consequences for the user. It is the social aspects of substance use disorders that lead us to the use of Group Counseling as a treatment modality. Human beings are by nature social beings. Throughout our lives, we are part of, influenced by, and impact social groups. We are members of families, neighborhoods, communities, classrooms, scouting troops, and church groups, as well as a company, a platoon, a squad, and various other groups. Groups can serve to provide support, guidance, and strength to its members. *TIP 41* states that "people who abuse substances often are more likely to remain abstinent and committed to recovery when treatment is provided in groups, apparently because of rewarding and therapeutic forces such as affiliation,

confrontation, support, gratification, and identification" (CSAT, 2005). This chapter will focus on the counseling competencies that will support a counselor in providing therapeutic and effective groups.

Understand, Select, and Use Appropriate Group Counseling Model (88)

Group counseling comes in a variety of forms, each having its own purpose, characteristics, leadership requirements, techniques, and theoretical base. One of the common advantages of most groups is that participants are given the opportunity to learn effective social skills. This can be done in a safe environment where patients can explore their styles of communication, experiment with new styles, and receive feedback from others, often in a very nonthreatening way.

The treatment literature (*TIP 41*) describes many advantages to using groups in substance use treatment, including:

- Providing positive peer support and pressure to abstain from substances of abuse
- Reducing the sense of isolation that most people who have substance use disorders experience
- Enabling people who use substances to witness the recovery of others
- Helping members learn to cope with their substance use and other problems by allowing them to see how others deal with similar problems
- Providing useful information to patients who are new to recovery
- Providing feedback concerning the values and abilities of other group members
- Offering family-like experiences
- Encouraging, coaching, supporting, and reinforcing as members undertake difficult or anxiety-provoking tasks
- Offering members the opportunity to learn or relearn the social skills they need to cope with everyday life instead of resorting to substance use
- Effectively confronting individual members about substance use and other harmful behaviors
- Allowing a single treatment professional to help a number of patients at the same time
- Adding needed structure and discipline to the lives of people with substance use disorders who often enter treatment with their lives in chaos
- Instilling hope and a sense that "if he can make it, so can I"
- Often supporting and providing encouragement to one another outside the group setting (CSAT, 2005)

Most treatment programs offer a variety of group formats. Part of the role of the counselor is to identify the most appropriate group setting to use for specific treatment goals.

TIP 41 identifies six distinct types of group therapy that may be applied to substance use disorder treatment:

1. **Psychoeducational groups** teach about substance use and misuse.
2. **Skills development groups** hone the skills necessary to break free of addictions.
3. **Cognitive-behavioral groups** rearrange patterns of thinking and action that lead to addiction.
4. **Support groups** comprise a forum of peers experiencing similar issues where members can debunk each other's excuses and support constructive change.
5. **Interpersonal process group psychotherapy** enables patients to recreate their pasts in the here-and-now within the group and rethink the relational and other life problems that they have previously avoided by using substances.
6. **Specialized groups**
    - Relapse prevention
    - Communal and culturally specific treatment groups
    - Expressive groups (e.g., art therapy, dance, psychodrama)

The delineation between the different types of groups and the criteria for membership can easily become blurred in a clinical setting. A psychoeducational group composed of persons in the Precontemplation stage of change regarding their drinking is quite different from a group made up of people in the Action stage. The information they need is very different. Both types of patients, however, may be in the same group.

The size of your treatment population, staffing level, and program structure may require groups to use more than one model of group in the same setting. "For example, a therapy group in an intensive early recovery treatment setting might combine elements of psychoeducation (to show how drugs have ravaged the individual's life), skills development (to help the patient maintain abstinence), and support (to teach individuals how to relate to other group members in an honest and open fashion)" (CSAT, 2005).

Table 9.1 outlines characteristics of five group models.

Table 9.1: Characteristics of Five Group Models

Characteristic	Psychoeducational	Skills Development	Cognitive-Behavioral	Support	Interpersonal Process
Group/Leader Focused	Leader-focused	Leader-focused	Mixed/Balanced	Group Focus	Group Focus
Specificity of the Group Agenda	Specific	Specific	Either	Nonspecific	Nonspecific
Heterogeneous or Homogeneous	Either	Either	Either	Either	Heterogeneous
Open-Ended/ Determinate	Either	Either (topic-dependent)	Either	Open-ended	Open-ended
Level of Facilitator Activity	High	High	High	Low–moderate	Low–moderate
Duration of Treatment	Limited by program requirements	Variable	Variable and open-ended	Open-ended	Open-ended
Length of Session	15–90 minutes	45–90 minutes	60–90 minutes	45–90 minutes	60–120 minutes
Space and Arrangement	Horseshoe or circle	Horseshoe or circle	Circle	Circle	Circle
Leader Training	Basic	Basic with some specialized training	Specialized training	Specialized training with process-oriented skills	Specialized training in interpersonal process groups

Adapted from *TIP 41*, Figure 2-2

The counselor can benefit from a study of the different formats so that the appropriate techniques and focus are being used based on the individualized needs of each group member. *TIP 41* provides a thorough review of the five group models summarized above. Information regarding the following characteristics is explored.

- Purpose
- Principal characteristics
- Leadership skills and styles
- Techniques

Activity

Download *TIP 41* by accessing: https://store.samhsa.gov/product/TIP-41-Substance-Abuse-Treatment-Group-Therapy/SMA15-3991. Read Chapter 2 and complete the following activity:

Using your site's program, list the groups offered during Outpatient (OP) and Intensive Outpatient (IOP) treatment and answer the following questions. If you do not offer OP or IOP, use the program you most frequently refer to as your source.

What are the models of each group?
Do the characteristics and leadership style used by the team fit the intended model for the group?
Are the techniques used in the groups consistent with the intended model?

Although many of the groups offered in the treatment program are multi-modal and transition between the five different group models, it is important to understand the intended purpose for each group in the treatment program and to set goals for each group session. On a particular day, the plan may be for a group to be focused on skill development, yet a group member mentions an issue that results in the group processing a here-and-now situation and moves into an interpersonal process group. Although the here-and-now experience may have been a priority, counselors will need to ensure the skill development opportunities are offered in another group or through other means.

The reverse may happen as well when a novice counselor who is not yet comfortable with process uses psychoeducational techniques to share information about a topic and misses the opportunity for a patient to experience a therapeutic catharsis of feelings. Proper use of pre- and post-group briefing sessions between co-facilitators, clinical supervisors, and/or your preceptor can help you develop the skills to maintain the appropriate balance based on the goals of the group and individualized needs of the members.

Cultural Diversity and Group Therapy

The substance use counselor in the 21st century needs to be prepared to provide treatment services to patients from diverse cultural and ethnic backgrounds. Not only will the counselor need to develop the attitudes, knowledge, and skills required for cultural competency, but they must understand how cultural diversity plays out in the group setting. Corey (2011) proposes that becoming a "diversity-competent group counselor" requires more than the knowledge and skills to work with people from different cultures. He calls on counseling students to answer the following questions:

- Are you aware of how your own culture influences the way you think, feel, and act?
- What could you do to broaden your understanding of both your own culture and other cultures?
- Are you able to identify your basic assumptions, especially as they apply to diversity in culture, ethnicity, race, gender, class, religion, language, and gender identity?

- How are your assumptions likely to affect the manner in which you function as a group counselor?
- Can you be flexible in applying the techniques you use in your groups, depending on the specific makeup of the membership?
- How prepared are you to understand and work with individuals from different cultural backgrounds in a group?
- What life experiences have you had that will help you to understand and make contact with group members who have a different worldview from yours?
- Can you identify any areas of cultural bias or any of your assumptions that could inhibit your ability to work effectively with people who are different from you? If so, what steps might you take to challenge your biases and assumptions? (Corey, 2011)

DeLucia-Waack states that "the multicultural context of group work requires attention to two tasks: (1) the application and modification of theories and techniques of group work to different cultures in ways that are congruent with cultural beliefs and behaviors, and (2) the development of the theory and practice of group work that makes full use of the diversity among members as a way to facilitate change and growth" (as cited in Corey, 2011, p. 11). Part of the role of the counselor is to help build group cohesion and a therapeutic alliance among the members. The counselor can help the group discuss cultural and ethnic diversity among the group members and help build trust.

Corey (2011) offers guidelines for providing counseling services to multicultural populations:

- Learn more about how your own cultural background influences your thinking and behaving. Become familiar with some of the ways that you may be culturally encapsulated. What specific steps can you take to broaden your base of understanding both of your own culture and of other cultures?
- Identify your basic assumptions – especially as they apply to diversity in culture, ethnicity, race, gender, class, religion, and gender identity. Think about how your assumptions are likely to affect your practice as a group counselor.
- Recognize that all encounters are multicultural.
- Move beyond the perspective of looking within the individual for the sources of their problems and strive to adopt a self-in-relation perspective. Take into account the environmental and systemic factors that often contribute to an individual's struggles.
- Respect individual differences and recognize that diversity enhances a group.
- Learn to pay attention to the common ground that exists among people of diverse backgrounds. What are some of the ways that we all share universal concerns?
- Realize that it is not necessary to learn everything about the cultural background of your patients before you begin working with them. Allow them to teach you how you can best serve them.

- Spend time preparing patients for a successful group experience, especially if some of their values differ from the values that form the foundation of group work. Teach patients how to adapt their group experience to meet the challenges they face in their everyday lives.
- Recognize the importance of being flexible in applying the methods you use with patients. Do not be wedded to a specific technique if it is not appropriate for a given group member.
- Remember that practicing from a multicultural perspective can make your job easier and can be rewarding for both you and your patients.

Those who may **not** be appropriate for group placement include:

Patients with significant personality disorders.
Patients who refuse to participate.
People who cannot honor group agreements.
Patients who, for some reason are unsuitable for group therapy. This may include people who are prone to dropping out, getting and remaining stuck, or acting in ways contrary to the interests of the group.
People in the throes of a life crisis. These patients may require more concentrated attention than groups can provide.
People who cannot control impulses. They may be more suitable for homogeneous groups designed for people with co-occurring disorders.
People whose defenses would clash with the dynamics of a group. People who cannot tolerate strong emotions or get along with others are examples.

Carry Out the Actions Necessary to Form a Group (89)

The decision to place a patient in a therapy group for the purposes of substance use treatment should be made when designing the individualized treatment plan. Although group treatment is an effective and efficient method for treating patients, proper assignment to a group needs to be considered. *TIP 41* (CSAT, 2009) identifies three criteria to be considered before placing a patient in a group:

1. The patient's characteristics, needs, preferences, and stage of recovery
2. The program's resources
3. The nature of the group or groups available

Although most of the patients seen in the Navy SARPs will have the capacity to participate in a group situation, counselors need to be aware that not all people in need of substance use treatment services are appropriate for group. Consideration to the dynamics of the group, co-occurring diagnoses, stage of recovery, and drugs of abuse are just a few of the areas to be examined when placing a patient.

The ASAM continuum of treatment model is designed so that a treatment system offers, or finds through other resources, a variety of treatment levels and services to meet the needs of each patient. Based on the size of the treatment population, various groups may be offered to provide opportunities for people with different needs to benefit from group format. One format used at some locations is to conduct pre-treatment groups. These psychoeducational groups may help to equalize the knowledge base of patients so when they enter treatment groups that are more often process oriented, their stage of change and recovery may be more homogeneous.

Stage of Recovery

The most commonly used classification system delineates the states of recovery as early, middle, and late stage. *TIP 41* defines these stages as outlined below.

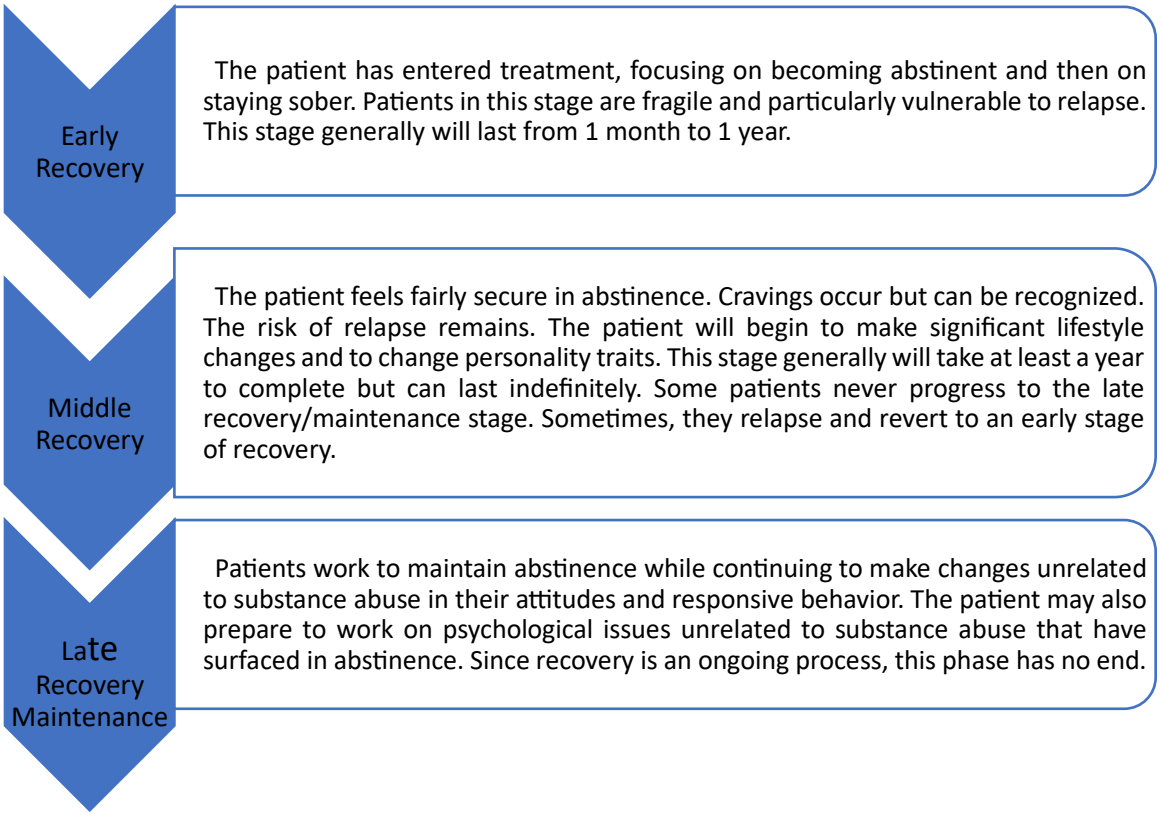


Table 9.2 outlines the appropriate group models based on a patient's stage of recovery.

Table 9.2: Patient Placement by Stage of Recovery

Group	Early	Middle	Late & Maintenance
Psychoeducation	Necessary and most important	Sometimes necessary	N/A
Skills-Building	Usually necessary	Usually necessary	N/A
Cognitive-Behavioral	Sometimes necessary	Usually necessary	Usually necessary
Support	Necessary and most important	Usually necessary	Sometimes necessary
Interpersonal	Sometimes necessary	Necessary and most important	Necessary and most important
Relapse Prevention	N/A	Necessary and most important	N/A
Expressive	Sometimes necessary	Sometimes necessary	NA
Cultural	Depends on the culture and the context of treatment		

Adapted from *TIP 41*, Chapter 3

Stages of Change and Group Assignment

Using the work of Prochaska and DiClemente, the consensus panel for *TIP 41* developed the following table (**Table 9.3**) to designate the types of groups that are appropriate based on a patient's stage of change. When the size and structure of the program prevent a pure application of these recommendations, the counselor can be attuned to the flow of the group to ensure that patients do not get lost as issues they are not ready to explore, such as drink refusal skills, are discussed.

Table 9.3: Patient Placement Based on Readiness for Change

Group	Precontemplation	Contemplation	Preparation	Action	Maintenance	Recurrence
Psychoeducation	●	●	●	●		
Skills-Building		●	●	●	●	●
Cognitive-Behavioral	●	●	●	●	●	●
Support		●	●	●	●	●
Interpersonal	●	●	●	●	●	●

Relapse Prevention				●	●	●
Expressive		●	●	●	●	●
Cultural	●	●	●	●	●	●

Adapted from *TIP 41*, Chapter 3

Review your SARPs' treatment schedule and consider how your program matches up to the tables included in *TIP 41* for patient placement based on group model, stage of recovery, and stage of change. *What options do you have if you do not think group is an appropriate placement for a patient?* Discuss with your preceptor.

Gender-Specific Groups

Research has generally shown that gender-specific groups are a benefit to a variety of gender identities including men, women, non-binary, transgender, or genderqueer individuals. These groups provide a safe and comfortable space for patients to discuss and explore issues that are particularly relevant to their gender identity. The focus of gender-specific counseling groups is to address unique challenges, experiences, and societal pressures that can impact individuals based on their gender. The size of a particular gender identity population in a Navy SARP may preclude the ability of the program to offer gender-specific groups. The individual needs of each patient should be considered when assigning them to particular groups or to discuss specific topics in a mixed-gender group. Some issues may be more appropriately addressed in individual sessions rather than group counseling.

Confidentiality

The confidentiality regulations that apply to you as a counselor also apply to group members. A group rule should include that members do not discuss anything outside the group that could reveal the identity of other members. The saying that "what is said in group stays in group" is vital to setting group boundaries and building trust. Members may continue the discussion of their own issues and the themes of the group, but not that of others. Confidentiality among group members is of particular importance in small, military communities. A person who is in group with someone today may well be working alongside them or shopping in the Base Exchange tomorrow. Counselors need to address feelings of discomfort when people find they know someone in the treatment group.

Group Agreements or Rules

Generally, groups will function better if there is an agreed-upon set of rules. In a fixed-entry group, these rules may be established with the members at the start of the group. The counselor can provide guidance regarding issues such as confidentiality, length of group, use of recording equipment, and the observation by team members. In an inpatient or ongoing outpatient program, generally the program has a standard set of rules that are adopted by the program and may be added to depending on the individual needs of the group members. It is important for new members to be oriented to the group rules.

> Does your site have established group rules? Can you anticipate a time when you might want to add to those rules? Discuss with your preceptor.

Facilitate Entry and Exiting of Members (90)

Treatment groups are organized based on the entry and exit of group members. Groups can have one start date on which all members start at the same session, or revolving entry dates. Groups can be fixed and time limited or the members may leave the group based on their individual needs. Chapter 4 in *TIP 41* (CSAT, 2009) offers details on the ways in which groups are organized and how the entry and exit dates and the length of a group impact the structure, goals, and skills required of a group leader.

Preparing Patients for Group

Part of the role of the group counselor is to prepare the patients to enter the group. Although the active-duty patient may have much experience living with, working with, and being part of a group, they may not have been involved in the kind of experience they will have in a substance use treatment group. As you orient them to treatment and the group process, consider the following:

- Explain how group interactions compare to those in self-help groups, such as AA.
- Explain group rules and expectations.
- Let new members know they may be tempted to leave the group at times.
- Give new members an opportunity to express anxiety about group work and help allay their fears with information.
- Recognize and address patients' therapeutic hopes.
- Be sensitive to people who are different from the majority of the other participants in some way.
- Acknowledge cultural or ethnic backgrounds and emphasize that differences can be strengths that can contribute to the group.
- The counselor is responsible for raising the level of group members' sensitivity and empathy.

Group Development

Groups go through phases of development as they develop cohesion and trust and begin the tasks of the group. The group development is influenced by the structure, model, and goals of the group.

The entrance and exit of members into a psychoeducational group will have a different impact on members than the movement within a process therapy group. When members start at the same time, the group will grow together as the members get to know each other. The orientation phase may take anywhere from a few moments to a few days, depending on the individuals in the group. Groups who receive new members on a revolving basis will face these start-up issues to a lesser degree every time a new member enters the group. The new member has to join the group process, and the established group has to accept the new member as one of them. The group counselor is responsible for attending to the issues that may arise at each phase of the group.

Orientation to the group begins in individual sessions with the counselor and continues when the patient joins the group. Even involuntary patients can benefit from the group process when they understand the workings of the group. "The key to successful participation lies in thorough member orientation and preparation and in the leader's belief that the group process has something to offer to these prospective members" (Corey, 2011, p. 75.)

Beginning Phase
• Introductions—provide an opportunity for members to introduce themselves and share a little about themselves. When new members join the group, a brief amount of time should again be devoted to introductions. • Be aware of the impact of new members. Attend to issues of trust and cohesiveness. • Review group rules, modify as needed for a particular group. • Provide a safe and cohesive environment, encourage people to participate. • Establish norms—using "I" statements, appropriate touch, closing rituals, etc. • Initiating the work of the group—why are we here?
Middle Phase
• Counselor balances content (information and feelings expressed) with process (how members interact). • Process needs to be attended to, even in educational groups. • Patients receive feedback that helps them make productive changes. Leaders help members by modeling healthy interactions, paying attention to process, and addressing issues that arise. • Encourage connections among members and use the members to do the work of the group by making observations and providing feedback. When problems occur, ask the group members how to proceed.
End Phase
• Termination puts closure on the experience. It can be the end of the group as a whole or for an individual patient. • Explore the impact that group has had on each member. Note growth, changes, stumbling blocks, and successes. Note roles of different members in the process. • Acknowledge the feelings that are triggered by the ending of the group experience – scared, confident, nervous, relieved, anxious, overconfident. • Complete any unfinished business. • Explore ways to continue learning after leaving the group – How can the relationships skills built in group be applied outside of group? How will the tools they have learned help them face future challenges? • Recognize that some patients may pull back and isolate as they get closer to the end of group. This behavior needs to be addressed and connected to ways patients deal with endings in their lives. • Counselors need to be genuine and share their feelings about termination.

Ambivalence in Group

Patient ambivalence to treatment or the group may be manifested by absenteeism, tardiness, disruptive behavior, and/or not completing assignments. Psychodynamic-oriented counselors may see ambivalence as a defense against exploring painful feelings or issues from the past. Counselors using motivational and solution-focused techniques will view ambivalence as a signal that they need to change their approach and explore what is motivating the patient to behave in these ways. The counselor's job at this point is to identify the reason or source of the ambivalence and address it using skills to motivate the patient to move through their ambivalence (Miller & Rollnick, 2023).

Transference and Countertransference in Groups

Just as they occur in individual counseling, transference and countertransference issues will likely arise in counseling groups. Transference issues may be complex in that the patient may project unresolved feelings onto the counselor and/or onto other patients. The group process provides an opportunity for exploration and discussion of how these unresolved issues impact the patients' relationships and contribute to dysfunctional behaviors. The group provides an opportunity for catharsis and resolution of unresolved feelings.

Countertransference issues also have many opportunities to arise in the group setting. Vannicelli (2001) describes three forms of countertransference common to substance use treatment groups:

1. **Feelings of having been there.** This may occur for counselors who have family or personal histories with substance use. These feelings can put the counselor at risk of trying to resolve their own issues in the group process and should be discussed in supervision.
2. **Feelings of helplessness** when the counselor is more invested in treatment than the patient. These feelings can be discussed in supervision, and the counselor can attend to issues of resistance or ambivalence in the group.
3. **Feelings of incompetence** due to unfamiliarity with culture and jargon. Counselors will benefit from being familiar with recovery vocabulary and the culture of 12-Step programs. Counselors can learn how particular vocabulary fits for a patient by asking questions such as "can you tell me a little more about what 'letting go' means to you?"

Corey (2022) identified several other ways countertransference can arise in group:

- Counselors see themselves in some members and over-identify with them to the point of being unable to work effectively with those members.
- Counselors may project traits they despise in themselves onto a patient and declare the patient resistant or ambivalent to treatment.
- Counselors may take advantage of their role as leader to win special affection from certain members.
- Direct observation and clinical supervision of a group by the preceptor is a vital tool to help counselors address transference and countertransference issues.

Ask of yourself and discuss with your preceptor:

How do I respond to the different forms of transference exhibited by group members?
What kind of transference tends to elicit my countertransference?
Do I take the defensiveness of members in a personal way?
Do I blame myself for not being skillful enough?
Do I become combative with patients I view as problematic?
Does the way in which I respond to problematic behaviors tend to increase or decrease defensiveness on the part of members?

Ending Group/Ending Treatment

Termination in an ASAM Continuum of Care model of treatment can have multiple pathways and issues. The patient, counselor, and group members will all be impacted as the patient moves up or down the continuum of care.

For the patient, leaving group may reflect:	For the other group members, termination of a member may represent:	For the counselor, temination may represent:
•Progress in changing behaviors, bulding new relationships, and solidifying recovery •Greater struggles in maintaining abstinence and the need for a more intensive level of care.	•Hope that they too can succeed. •Anxiety wondering who in this group will understand me now? •Fear that if he can relapse, then so can I.	•Success in guiding a patient to a new life. •Anxiety over the loss of a key group member. •Dissoluton of the group for lack of enough members. •Failure because the patient relapsed. •Increased paperwork to document discharge.

Again, we turn back to the treatment plan as a guide to the decision to terminate a patient from group and/or treatment. The decision to have a patient exit a treatment group needs to reflect the individualized needs of the patient, not the needs of the group or the counselor.

Facilitate Group Growth and Progress Toward Goals (91)

Irvin Yalom has long been considered the “guru” of group therapy. The sixth edition of his primer on group therapy was printed in 2020. Yalom describes 11 therapeutic factors that operate in every therapy group. He describes the factors as interdependent. (Yalom & Leszcz, 2020). The therapeutic factors are:

- **Installation of hope:** The person must feel that there is hope to solve their problem.
- **Universality:** The person must feel that they have a problem common to others.
- **Imparting information:** An informed person is better able to cope and think through new problems.
- **Altruism:** Caring about others decreases an unhealthy absorption.
- **Corrective recapitulation of one's family:** Members behave the way they did while growing up in their families. Through group process, they learn healthier ways to behave.
- **Development of socializing techniques:** The person learns to interact with people in a positive manner.
- **Imitative behavior:** The leaders and senior group members act as role models of healthy behavior for newer members.
- **Interpersonal learning:** The person learns new skills. When new skills are evident, the person takes note of the progress.
- **Group cohesiveness:** When members feel a sense of togetherness, they are more willing to participate, to help other members, and to defend group rules.
- **Catharsis:** After a person has a release of intense emotions, they may be freer to use information and new experience to grow.
- **Existential factors (self-responsibility):** The person owns responsibility for their thoughts, feelings, and behaviors.

Activity

Observe a live group or videotape of a group. While watching, observe the interaction among group members. Place a tally mark in a box below every time you observe one of the therapeutic factors at work. Discuss with your preceptor.

Videotape yourself facilitating a group. Watch the video and tally the therapeutic factors at work. Discuss with your preceptor.

Stages of Treatment

In different stages of treatment, some of Yalom's therapeutic factors are more important than others. These stages are outlined in **Table 9.4**.

Table 9.4: Stages of Treatment

Beginning Stage Treatment
Universality—Group members are not alone in their struggles. **Hope—**Seeing others make progress instills hope that I can do it, too. **Imparting information—**Members need to learn about addiction and recovery. **Group cohesiveness—**Members will not experience the full benefits of the group if they do not feel they belong. **Other tasks of early treatment**: Engage patients in treatment by encouraging sharing of commonalities among the members. Help patients acknowledge and understand how substance use has impacted their lives. Provide structure and support. Creating structure and boundaries in group can provide the balance to the chaos they may have been experiencing when actively using. In process groups, help patients to identify and label feelings. Many substance misusers don't know what they feel and/or lack the language to label emotions. Teach skills to manage cravings and prevent relapse.
Middle Stage Treatment
The middle stage of recovery, as defined by the *TAP 41*, refers to the period after a patient has been abstinent for 4–6 months. Involvement in continuing care services is individualized based on patient need.
Interpersonal learning—Neurological studies have shown that the brain continues to recover from the impact of chemicals for several months after abstinence starts. Improved cognitive functioning may help patients more effectively explore life changes. **Altruism, catharsis**, existential factors, and recapitulation of family groups may begin to be evident if a process group has been able to maintain cohesiveness over time. **Universality**, imparting information, cohesion, and hope continue to be important. **Other tasks of middle stage treatment**: Helping patients to begin to identify and start making lifestyle changes that will support long-term recovery. They may begin to remember the good times and forget the negative consequences of their use. Cognitive behavioral techniques can assist patients in learning to modulate their feelings and express feelings in appropriate ways. When painful issues are explored in group, counselors need to work with patients to regulate the emotions and come up with a plan for the day after the patient leaves group. Exploration of painful feelings may increase relapse risk and patients can learn healthy alternatives to deal with disappointments, anger, and hurt.
Late Stage Treatment
The tasks of late stage treatment focus on the longer-term issues of managing emotions, facing conflict, and exploring painful realities without turning to substances to ease the pain. The goal is to transition from a state of abstinence to sobriety, where the patient's life no longer revolves around the substance. The role of the group leader is to help the patient explore the maladaptive patterns, character traits, and coping styles that may interfere with the development of a life of sobriety.

Group Leadership

An important component of the group process is the skill and ability of the counselor who functions as the group leader. The following inventory poses a number of statements related to the role and function on a group leader:

Attitude Questionnaire on Group Leadership	
Complete the above questionnaire then read the next section on group leadership. Discuss your responses with your preceptor and how your attitudes compare with Corey's description of an effective group leader.	
1 = strongly agree 2 = slightly agree 3 = slightly disagree 4 = strongly disagree	
	1. It is the leader's job to actively work at shaping group norms.
	2. Leaders should teach group members how to observe their own group as it unfolds.
	3. The best way for a leader to function is by becoming a participating member of the group.
	4. It is generally wise for leaders to reveal their private life and personal problems in groups they are leading.
	5. A group leader's primary task is to function as a technical expert.
	6. It is extremely important for good leaders to have a definite theoretical framework that determines how they function in a group.
	7. A group leader's function is to draw people out and make sure that silent members participate.
	8. Group leaders influence group members more through modeling than through the techniques they employ.
	9. It is generally best for the leader to give some responsibility to the members but also to retain some.
	10. A major task of a leader is to keep the group focused on the here and now.
	11. It is unwise to allow members to discuss the past or events that occurred outside the group.
	12. It is best to give most of the responsibility for determining the direction of the group to the members.
	13. It is best for leaders to limit their self-disclosures to matters that have to do with what is going on in the group.
	14. If group leaders are basically open and disclose themselves, transference by members will not occur.
	15. A leader who experiences countertransference is not competent to lead groups.
	16. Group leaders can be expected to develop a personalized theory of leadership based on ideas drawn from many sources.
	17. To be effective, group leaders must recognize their reasons for wanting to be leaders.

	18. Part of the task of group leaders is to determine specific behavioral goals for the participants.
	19. A leader's theoretical model has little impact on the way people actually interact in a group.
	20. If group leaders have mastered certain skills and techniques, it is not essential for them to operate from a theoretical framework.
	21. Leaders who possess personal power generally dominate the group and intimidate the members through this power.
	22. There is no place for a sense of humor in conducting groups because group work is serious business.
	23. Group leaders should not expect the participants to do anything that they, as leaders, are not willing to do.
	24. Group leaders have the responsibility for keeping written documentation summarizing group sessions.
	25. For co-leaders to work effectively with each other, it is essential that they share the same style of leadership.
	26. In selecting a co-leader, it is a good idea to consider similarity of values, philosophy of life, and life experiences.
	27. If co-leaders do not respect and trust each other, there is the potential for negative outcomes in the group.
	28. It is best that those who co-lead a group be roughly equal in skills, experiences, and status.
	29. Co-leaders should never openly disagree with each other during a session, for this may lead to a division within the group.
	30. The group is bound to be affected by the type of modeling that the co-leaders provide.

Adapted from Corey, Corey, & Corey (2010), p. 62–63

Although much of the power of the group belongs with the group members, the group leader has a major impact on the ability of the group to develop the cohesion that will lead to change. Below is listed the personal characteristics of group leadership described by Corey (2011).

Personal characteristics of an effective group leader:

- **Presence:** being emotionally present means being moved by the joy and pain of others
- **Personal power:** self-confidence and awareness of one's influence on others
- **Courage:** willing to take risks in group, admit mistakes, being willing to share their power with group members
- **Willingness to confront oneself:** a willingness to take an honest look at oneself includes awareness of one's needs and motivations, personal conflicts and problems, defenses and weak spots, areas of unfinished business, and of the potential influence of all of these on the group process
- **Sincerity and authenticity:** sincere interest in the well-being and growth of others may include telling members what may be difficult for them to hear (authenticity is a form of

sincerity) and a willingness to appropriately disclose oneself and share feelings and reactions to what is going on in the group

- **Sense of identity:** knowing what you value and living by these standards; being aware of your own strengths, limitations, needs, fears, motivations, and goals; being aware of your cultural heritage, your ethnicity, and your sexual and gender identity
- **Belief in the group process and enthusiasm:** need to show that you enjoy your work and like being with your groups
- **Inventiveness and creativity:** avoid getting trapped in ritualized techniques and programmed presentations

Understand Process and Content and Be Able to Shift Focus of Group (92)

A task of the group counselor is to be aware of and explore both the content and process of group discussions. The "content" of the group is the actual information that is being shared. A person may be telling the group about their drinking history or the breakup of their marriage. The "process" is how this information is being communicated by the speaker and how it is being received by the members. The energy that the content brings to the group offers opportunities to explore feelings, relationships, and unresolved issues. The group leader needs to be aware of the process occurring within the group, while listening to the content of the exchange. The group leader "must be able to multitask, continuously scanning the room, observing the verbal and nonverbal communications of multiple members, and tracking process and content issues for each member" (Corey, 2008, p. 39). The leader needs to know when to respond to the information— "the content"—and when to focus on the responses— "the process."

As a group is forming, the counselor generally allows the group to share a lot of content. It is through the sharing of information that the members begin to get a sense of who each other are and what experiences they have in common. The counselor can take silent note of the reactions of different members as life stories are shared. These impressions can then be discussed in a post-group debrief with a co-leader or preceptor. As the group members get to know each other and cohesion is built, the counselor can move the group toward the calling of process and examination of how the responses of members reflect their own issues. Corey (2008) identifies several ways the group leader can facilitate the group process:

- Assist members to openly express fears and expectations.
- Actively work to create a climate of safety and acceptance.
- Provide encouragement and support as members explore personal materials or try out new behavior.
- Involve as many members as possible in the group.
- Work toward lessening the dependency on the leader by encouraging members to speak directly to each other.
- Encourage open expression of conflict and controversy.
- Help members overcome barriers to direct communication.

The group leader is cautioned to avoid questions that ask the whys of a story or interaction and instead to ask questions such as: “Where is the group with this topic?” “What is happening to your body as you tell this story?” “How much energy is in the group right now?” “What is not being said?” Questions like these help to facilitate the group process.

Group Leadership Skills

Counselors conducting groups will continue to use the skills they use in individual counseling, as well as techniques that encourage interaction among members. Corey (2011) identifies the following group leadership skills:

- **Active listening.** Listen to the content and observe the nonverbal expression.
- **Restating.** Restating or paraphrasing is to put what someone said into different words to clarify the meaning for both the speaker and the group. When done effectively it zeroes in on the core message and encourages deeper self-exploration.
- **Clarifying.** Focus on underlying issues and sort out confusing and conflicting feelings.
- **Summarizing**. This skill can be used when the group gets tied up in a particular issue and may help them determine where to go next.
- **Facilitating.** Encourage communication between members, support the expression of feelings, and help the group to share the responsibility for the group discussion.
- **Empathizing.** As a counselor expresses an understanding of what it means to walk in someone’s shoes, they model caring and concern to the entire group.
- **Interpreting.** Counselors present interpretations as hunches and can make them toward an individual or the group. Caution is given to not make them too soon in the group’s development and to consider cultural implications of a member’s behavior before making an interpretation.
- **Questioning.** As mentioned earlier, questions need to be well timed and worded in a way that encourages deeper exploration. Questions that probe or search for explanations for a behavior tend to shut down further discussion.
- **Linking.** This skill serves to connect members to each other and facilitate member-to-member communication. The leader tracks when a feeling or concern posed by one member is shared by others and makes the linkage between the two people. Questions that promote linking include: “Does anyone feel connected to what X feels?” and “Who can relate to what X is saying?”
- **Confronting.** When confronting disruptive behavior or a discrepancy between verbal and nonverbal responses, the counselor should be careful to challenge the behavior and not label the person and to share their feelings about the behavior.

- **Supporting.** Showing support by listening intently or leaning forward can be helpful, but counselors need to not jump in too soon with verbal support and potentially shut down a person before they have fully experienced their feelings.
- **Blocking.** Counselors are responsible for blocking behaviors that disrupt the group process, such as members bombarding others with questions, gossiping, storytelling, and breaking confidences.
- **Assessing.** Counselors continue the process of assessment of the patient's progress but also include assessing behaviors and choosing appropriate interventions. The counselor needs to know when it is appropriate to encourage deeper expression of a pent-up emotion and when deferring an issue to another setting (individual session) or time may be more appropriate.

Review the listed group leadership skills. Choose three that you would like to become more skillful in using. Develop a plan with your preceptor for increasing your group skills and include it on your IDP.

- **Modeling.** Counselors teach desired behaviors by modeling them in themselves. These may include the giving and receiving of feedback, empathy, respect for diversity, and appropriate self-disclosure. Co-facilitators can model appropriate communication between members.
- **Suggestions.** Suggestions are used to facilitate a person's ability to make their own decisions. The counselor models exploration of alternatives, rather than giving answers, which can help deter members from telling each other what to do.
- **Initiating.** Counselors initiate activities such as getting members to focus on goals, assisting them to work through places where they are stuck, helping them identify and resolve conflict, providing links between members, and helping members assume responsibility for their communication. Initiating can give a jump start to the interchange among group members.
- **Evaluating.** The counselor can ask themselves and the group members: "What is working in the group?" "What's not working?" "What changes are occurring because of the group?"
- **Terminating.** Counselors need to model structure by ending a group on time. As the group time is winding down, if new issues are raised, counselors can ask things such as "Can this wait until the next group?" "Are there any burning issues?" Should a crisis be disclosed, such as a patient sharing suicidal thoughts 10 minutes before group is scheduled to end, the counselor can choose to extend group for a short time or meet with a patient individually. The counselor should assure the other members that the patient's safety is of prime importance and will be attended to.

Group Leaders:

> *TIP 41* identifies a number of tasks and techniques of the group leader (CSAT, 2005, Chapter 6). A partial review is included below. Counselors are encouraged to read *TIP 41* for more information.

- **Vary therapeutic styles with the needs of the patient.** During early and middle stages of treatment, the counselor will be more active than in later stages. Counselors should consider a patient's ability to manage affect, their level of functioning, social supports, and stability when placing a patient in a group. Patients with higher levels of functioning and support may need less structure and a less active counselor to be successful in a group.
- **Model behavior.** Counselors model active listening, giving accurate feedback, and curiosity about discrepancies in behavior and intent. Self-disclosure may be used to meet the tasks of the group with discretion as the counselor does not want to use self-disclosure to meet their own needs in the group.
- **Can be co-therapists.** Co-leading a group requires thought, planning, and coordination. Co-leaders should not go into a group without discussing their expectations for the group. Time should be allotted after the group for debriefing. Co-leading can offer an opportunity for modeling healthy communication, but it can also be destructive when conflicts between co-leaders play out in the group process.
- **Know when to override group agreements.** For example, a common group rule is to not discuss a member who is not present. If someone is missing due to a relapse, suicide attempt, or other issue that members become aware of, counselors need to allow the group to process their feelings about the circumstances, while not breaking the confidentiality of the person who is missing.
- **Handle emotional contagion.** Powerful emotions can arise in a group when one member is sharing a painful life experience. It is up to the counselor to moderate the interactions by protecting individuals, boundaries, and regulating affect. Members have the right to not get involved in a discussion. Neither the group nor the leader should pressure a person to disclose information or emotions that they are not ready to share. The leader can regulate affect by intervening and helping the group to look at the impact that an emotional disclosure has had on the group.
- **Work within professional limitations.** Counselors have an obligation to not use therapeutic techniques for which they have not received training and supervision.
- **Monitor physical contact and maintenance of boundaries.** Group leaders should not initiate or ask for physical contact. Physical contact such as a group hug should be discussed with the group as a whole and decided on by the group. The leader models the discussion of strong emotions and demonstrates how to share them through the use of words, not action.

Members should be assured that physical contact is not required and should not be forced to participate in a closing group hug, holding hands, or other physical touch.

Difficult Types of Group Members

Group therapy can be a beneficial and effective form of treatment, but it can also present challenges when certain types of members are present. It is important for therapists and group facilitators to be aware of these challenges and to have strategies in place to address them. Here are some difficult types of group therapy members:

1. **Dominating Member:** This individual tends to monopolize discussions, often talking excessively and interrupting others. They may hinder the participation of quieter members and create an imbalanced dynamic within the group.
2. **Withdrawn Member:** On the opposite end, this person may be extremely quiet, reluctant to share, and may resist opening up. Their silence can impact the group's cohesion and effectiveness.
3. **Negative/Critical Member:** This member consistently expresses negative viewpoints, criticizes others, or focuses on problems without contributing constructively. Their attitude can create a tense atmosphere and discourage open sharing.
4. **Overly Talkative Member:** While sharing is encouraged, an overly talkative member can dominate the conversation, leaving little room for others to contribute or share their experiences.
5. **Resistance to Feedback:** Some individuals might struggle with receiving constructive feedback from others, becoming defensive or dismissive. This can hinder the group's ability to provide support and help members grow.
6. **Competitive Member:** This person may try to "outdo" others in sharing or present themselves as having more severe issues. This competitive behavior can create a sense of one-upmanship and disrupt the supportive atmosphere.
7. **Non-Compliant Member:** Some members might consistently fail to complete assignments, engage in exercises, or follow group guidelines. Their non-compliance can hinder the group's progress and disrupt the therapeutic process.
8. **Attention-Seeking Member:** This individual may intentionally draw attention to themselves through dramatic stories, emotional outbursts, or attention-seeking behavior. This can detract from the group's focus and create an unbalanced environment.
9. **Boundary Violator:** A member who consistently oversteps personal boundaries by sharing inappropriate or triggering content, making others uncomfortable.
10. **Fragmented Member:** This person might struggle with maintaining consistent attendance or engagement, making it challenging to establish a sense of continuity within the group.
11. **Fixated Member:** Someone who becomes overly fixated on one issue or topic, often at the expense of other group members' needs and concerns.

Managing these challenging group dynamics requires skillful facilitation by the therapist. Techniques such as setting clear expectations, establishing group norms, addressing disruptive behavior, and fostering open communication can help create a more positive and productive group therapy

environment. It is important to remember that each patient's behavior may stem from their own unique struggles, and compassionate and empathetic handling is crucial.

Describe and Document Patient Progress (93)

As the group grows in cohesion and patients take risks to share about themselves, new issues may arise within the group. The counselor is responsible for tracking the process of the group interactions and helping the patients to see how any interchanges between members parallel issues in their individual lives. Addressing these issues requires balancing the needs of the group and the needs of each patient. Some issues that may initially arise in the group may require further exploration individually. Counselors need to consider the dynamics of the group, the cultural diversity within the group, and the needs of the individuals when deciding how far to pursue an individual issue in a group. Some patients may benefit from the strength of the group, and others may not yet be ready to use the group process.

Although, over time, it is easy to adopt the attitude that all patients in the treatment program go to a group, counselors must remember that patients are assigned to a group as part of their individualized treatment plan. It is incumbent on the group counselor to be aware of the patient's treatment goals and how a group can assist the patient in meeting those goals. This can usually be accomplished by participating in the multidisciplinary treatment team, pre-briefing group with the case managers of the members, and by having the patient bring their treatment plan to the group. Following a group, the counselor is responsible for tying the group process back into the treatment plan through the use of progress notes in the patient record.

An old adage in treatment is "if it's not in the record, it did not happen." In many treatment settings, the counselor who runs the treatment group may not be responsible for the case management and individualized treatment planning for any or all of the group members. The clinical or medical record maintained by the treatment program is an important tool to be used by the group counselor to keep the treatment team informed and connect the group experience to the individualized treatment plan. In some settings, the failure to tie the group participation to the treatment plan may result in a third-party payor not approving payment for group services. In addition, failure to adequately document group participation can impede appropriate response to a crisis or a patient's behavior by the rest of the treatment team.

Consider the following:

Patients X and Y are assigned to group based on the goals and interventions on their treatment plans. Patient X has been asked to discuss his marital conflicts with the group and shares that he and his wife have been arguing loudly. He grew up in a home where his father abused his mother, and he does not want his marital conflicts to become physical. He asks the group for feedback. Patient Y discloses that he understands just what X feels because he too grew up in an abusive home. He then goes on to discuss how it felt to watch his father beat his mother. The counselor responds empathically to this interchange, and the group closes with both members expressing some relief over having expressed their feelings and thanking the group for the support they received. After the group, the counselor debriefs with his preceptor and says that Patient Y's disclosure must be new information since it's not in the record.

Question: What should the counselor do with the information that Patient Y shared in group?

a. Find Patient Y's case manager and tell her what happened in group.
b. Nothing, since he is sure that the case manager must have known about it, even if it is not in the record.
c. Document the group interchange in Patient Y's record.
d. a and c

The best answer is d. It is always worthwhile to try and verbally pass on an eventful group experience to a team member who is responsible for a patient's care. This provides an opportunity for the two of you to discuss the group and how the disclosure might impact treatment. It is vital, however, that the group interchange be documented in the patient's record for several reasons.

If you did not know this, it is possible the case manager did not know. Should you not see the counselor that day, she will be able to see the documentation in the record. Group members may think about a disclosure long after the day's group has ended. If the patient enters into a crisis at some point before returning to group, it is very important that the treatment team be able to look in the record and find out what happened in group that day.

Even if the program policy only requires a weekly entry on group participation in the patient record, any time a patient discloses significant information or is involved in an emotionally impactful discussion, a progress note should be entered in the record before leaving work for the day.

CASE STUDY 9.1

Ryan is now progressing toward reaching the goals and objectives of his treatment plan and has been openly discussing his progress in group. However, he is beginning to monopolize group and, at times, even seems to be exaggerating his progress and minimizing that of other group members, thus creating tension between him and others in the group. Other group members have expressed anger toward Ryan and his behavior in group.

What strategies would you use to intervene with Ryan's behavior in group and to prevent him from continuing his negative attitude toward other group members?

How would you facilitate group interaction, and the anger group members have toward Ryan?

How can you use this situation as a means of shifting group process to move toward the goals of the group?

Summary

Group Counseling is a powerful modality that can assist a patient in making progress in his treatment goals. The size of your treatment population, recovery goals of the patients, and experience and skill level of the counselors are all important factors to consider when designing and assigning patients to groups. The preceptor is a valuable resource to assist counselors in developing the knowledge and skills to effectively facilitate a variety of group modalities. Counselors are encouraged to continue their study of group counseling skills, techniques, and modalities to best meet the needs of the patient community.

Learning Activities

1	Observe another counselor conducting a treatment group. While observing, consider the model of group being used, its purpose, its characteristics, and the techniques being used. Discuss with your preceptor whether the techniques were consistent with the group's purpose.
2	Keep a log of four groups you conduct. Make note of the model and goals you had set before the group, model, and techniques you used during the group, and comment on whether a movement between different models was therapeutic.

3	Choose one culture that is different from your own. Research and identify at least five cultural practices, norms, or expectations that you need to be aware of when a person from that culture is in your group. Share with your preceptor.

Self-Study Questions

1. Match the description with the therapeutic factor:

1. Sense of togetherness	a) Instillation of hope
2. Interpersonal interactions	b) Universality
3. Self-responsibility	c) Imparting information
4. Applies to all	d) Altruism
5. Role-modeling	e) Corrective recapitulation of family
6. Look toward the future	f) Development of socializing techniques
7. Release of emotions	g) Imitative behavior
8. Corrects behavior patterns	h) Interpersonal learning
9. New data	i) Group cohesiveness
10. Feedback	j) Catharsis
11. Caring about others	k) Existential factors

2. List the six different types of group therapy used in substance use disorder treatment:
   a. _____
   b. _____
   c. _____
   d. _____
   e. _____
   f. _____

3. **True or False?** It is one of the counselor's roles to build group cohesion and establish therapeutic alliance among treatment group members.

4. The three criteria to consider before placing a patient in a group are:
   a. _____
   b. _____
   c. _____

5. The counselor should set group rules regarding:
   a. Confidentiality
   b. Length of group sessions
   c. Use of recording equipment
   d. All of the above

6. Complete the three forms of countertransference common to substance use disorder treatment groups:

   Feelings of _____
   Feelings of _____
   Feelings of _____

7. Define 4 of the 11 therapeutic factors that operate in group therapy as defined by Yalom:
   a. Universality: _____
   b. Hope: _____
   c. Imparting Information: _____
   d. Group Cohesiveness: _____

7b. In which stage of treatment might these factors be more important?

8. **True or False?** The counselor should be monitoring the energy and reactions of group members throughout the group session.

9. **True or False?** The counselor leading the treatment group is not responsible for documenting the patient's progress as a part of the patient's treatment plan.

Self-Study Answers

1. Match the descriptions with the therapeutic factor:

    1. Sense of togetherness: Group cohesiveness
    2. Interpersonal interactions: Development of socializing techniques
    3. Self-responsibility: Existential factors
    4. Applies to all: Universality
    5. Role-modeling: Imitative behavior
    6. Look toward the future: Instillation of hope
    7. Release of emotions: Catharsis
    8. Corrects behavior patterns: Corrective recapitulation of family
    9. New data: Imparting information
    10. Feedback: Interpersonal learning
    11. Caring about others: Altruism

2. The six different types of group therapy are:

    a. Psychoeducational groups
    b. Skills development groups
    c. Cognitive-behavioral groups
    d. Support groups
    e. Interpersonal process group psychotherapy
    f. Specialized groups

3. **True.** The counselor can help the group discuss issues of diversity and help to build trust.

4. The three criteria to consider before placing a patient in a group are:

    1. The patient's characteristics, needs, preferences, and stage of recovery
    2. The program's resources
    3. The nature of the group or groups available

5. The counselor should set group rules regarding (d) all of the answers listed.

6. The three common forms of countertransference in substance use disorder treatment groups are (1) Feelings of having been there, (2) Feelings of helplessness, and (3) Feelings of incompetence.

7. a. Universality: *The person feels she has a problem common to others*.
   b. Hope: *The person feels there is hope to solve her problem*.
   c. Imparting Information: *An informed person is better able to cope with and think through problems*.
   d. Group Cohesiveness: *When members feel a sense of togetherness, they are more willing to participate and help other group members*.

7b. These factors may be more important during the *beginning stage of recovery*.

8. **True.** The counselor should be making a silent note of the reactions of group members as other members share information in the group.

9. **False.** The patient may be assigned to a group as part of their treatment plan. It is important to document all progress and interactions as part of their treatment.

Chapter 10 Counseling: Counseling Families, Couples, and Significant Others

Purpose of This Chapter

This chapter reviews the Practice Dimension of Counseling by focusing on its third element: counseling families, couples, and significant others.

Learning Objectives

The learning objectives directly correlate with Competencies 94–98 as listed in the *TAP 21* (p. 117–119) and IC&RC Domain III: Evidence-Based Treatment, Counseling, and Referral. Each competency is accompanied by a set of knowledge, skills, and attitudes that define the standard.

- Understand the characteristics and dynamics of families, couples, and significant others affected by substance use. (94)
- Be familiar with and appropriately use models of diagnosis and intervention for families, couples, and significant others, including extended, kinship, or tribal family structures. (95)
- Engage selected members of the family or significant others in the treatment and recovery process. (96)
- Assist families, couples, and significant others in understanding the interaction between the family system and substance use behaviors. (97)
- Assist families, couples, and significant others in adopting strategies and behaviors that sustain recovery and maintain healthy relationships. (98)

Introduction

A review of studies of models of integrated and concurrent family therapy during substance use treatment show that involving the family increases treatment compliance and completion rates, reduces substance use, and improves family functioning. In Navy treatment programs, the level of a family's involvement is influenced by the age of the patient, the location of the SARP, and the staffing and training level of the team. The counseling practice dimension encourages you to expand your vision of substance use disorders and understand where the patient fits in their family system. To do so, we must understand how families influence substance use and how substance use influences families.

Understand Characteristics and Dynamics of Families Affected by Substance Use (94)

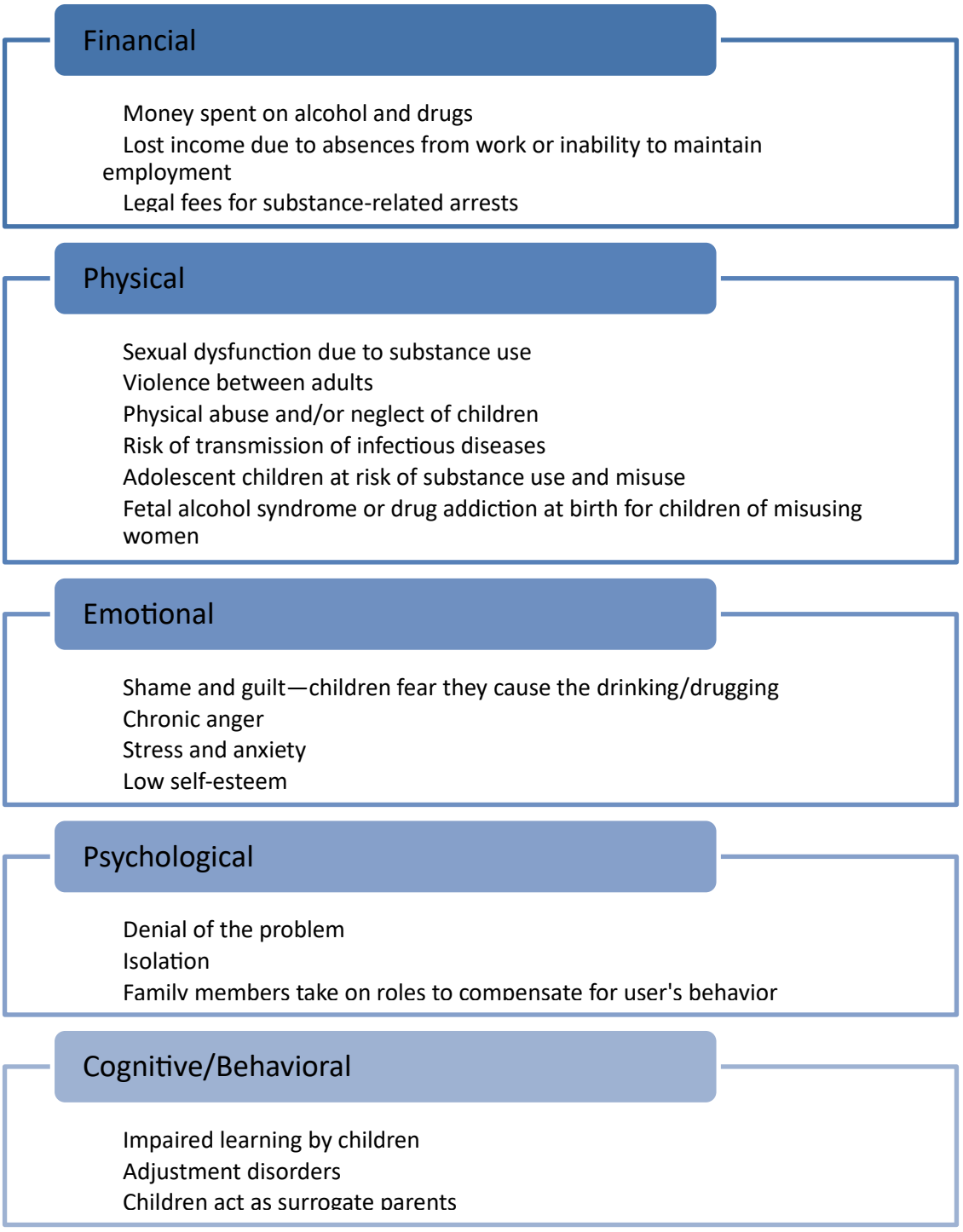
Dynamics Associated with Substance Use and Recovery in Families, Couples, and Significant Others

The dynamics in families experiencing substance use are influenced by the family makeup, the extent of the use, its longevity, and the consequences. Two adults living together without children in which one or both partners use substances will have different dynamics than a family in which a mother uses alcohol with small children in the home.

Substance use affects the family across all domains.

> As a person forms an attachment to a substance and its effects, the partner/spouse develops complex psychological and behavioral ways to control themself and others close to them, in an effort to control the substance user. Increasing amounts of time, "strategic" planning, and emotional energy are expended in this process. The children also spend time and energy figuring out how to handle their fears and anxiety and how to deal with their parent's behavior "under the influence" (McIntyre, 2004, p. 237).

Domains including Financial, Physical, Emotional, Psychological, and Cognitive/Behavioral are described on the next page.



TIP 39 (CSAT, 2020) identifies common characteristics of families with substance use disorders:

- Family factors affecting SUD initiation: Exposure to substance use by a family member (social learning)
    - Parental control that is either very rigid or very permissive

  - Lack of family connectedness and support (especially during times of stress and difficulty)
  - Certain socioeconomic factors, like families where both parents work and have little time to spend with (and thus monitor) their children
- Family factors affecting SUD maintenance:
  - High use of substances during family events, like gatherings and celebrations (social learning)
  - Weak bonds between family members (especially between parents and children)
  - Ineffective, inconsistent, or otherwise low-quality communication between family members
  - Low-quality parenting skills, including use of severe punishment
  - Both excessive control and excessive permissiveness
- Family factors associated with less successful recovery from SUDs:
  - Any dysfunctional pattern in the family's dynamics, including problems with family boundaries, family cohesion, and family roles
  - Lack of open and consistent communication
  - Low-quality parenting skills
  - Lack of parental warmth and involvement; parental rejection
  - Divorce or death of a parent

Effect of Interaction Patterns on Substance Use Behaviors

The factors that influence a person's substance use can begin very early in life. Family, social, cultural, and economic factors all influence the risk of someone using substances. Messages about drug and alcohol use received in the home and community can positively or negatively influence a family member's decision to use.

In a report on preventing drug use, the National Institute of Drug Abuse identified risk and protective factors across five domains (NIDA, 2003).

Risk Factors	Domain	Protective Factors
Early Aggressive Behavior	Individual	Self-Control
Lack of Parental Supervision	Family	Parental Monitoring
Substance Abuse	Peer	Academic Competence
Drug Availability	School	Anti-Drug Policies
Poverty	Community	Strong Neighborhood Attachment

Adapted from NIDA, 2003

The risk of using substances increases when there is a lack of attachment and nurturing by caregivers, ineffective parenting, and/or caregivers use substances. Risks in the home or community can be balanced when parents are involved in their children's lives, set limits, and are consistent with

enforcing those limits. A review of the literature on children of parents with substance use disorders found an increase in resiliency and reduced risk of substance misuse for children who had certain protective factors, including: (Wlodarczyk, et.al., 2017)

- Secure attachments to parents
- Flexible use of multiple coping strategies
- A high degree of parental support
- A high degree of family cohesion
- Low levels of parent-related stress
- High levels of social support for the child.

Hawkins (1997) found that young adults from alcoholic families were less likely to use alcohol if their families were able to maintain structure, have daily routines, and preserve rituals despite the alcohol use.

Cultural Factors Related to the Effect of Substance Use Disorders on Families, Couples, and Significant Others

What cultural norms influenced your personal choices regarding substance use? How might these influences affect your ability to explore culture and family life with your patients? Discuss with your preceptor.

The broad phrase "cultural factors" can encompass many areas of a person's life. Some view culture as an ethnic or racial group; some as a particular social group or age group. Many people use the term *culture* when discussing the military lifestyle. Social science researchers refer to culture as "all of life's patterns, socialization practices, religious ideals, habits in thinking, and organizations, which groups of persons pass on from one generation to the next" (Hastings, 2009, p. 23). A person may be influenced by the norms of more than one cultural group. For example, a 22-year-old sailor's substance use may be strongly influenced by the military culture and his peer group. He may, however, also experience feelings of shame if his mother views his drinking as unacceptable based on the norms of the culture she defines as her own. His mother's influence on his feelings regarding treatment may not be disclosed readily and will require you to have an inquiring mind. You are encouraged to avoid stereotyping and making assumptions regarding a person's experiences based on their racial, ethnic, or cultural background. Allowing a patient to share the influence his or her culture has had on substance use choice is a good place to start.

Systems Theory and Dynamics

Marriage and family therapists first explored the family as a system in the 1950s. Systems theory as applied to the family recognizes the following:

The family as a system is more than the sum of its parts. Individual family members affect the system as a whole, and the system affects individual members.

Changes in any part of the system affect the entire system. Any change, whether positive or negative, affects the system.

Families exist within a larger social environment context. Families are affected by events that occur within the community, school, workplace, cultural systems, and society.

Subsystems are embedded through the larger family system. Some of the most common subsystems are the couple subsystem, parent-child subsystem, and sibling subsystem. Subsystems can also develop between grandparent-grandchild and across blended families.

Families are multigenerational. Family systems are influenced by their histories, as well as by an awareness of their futures. Families are affected by inherited qualities across generations and may be influenced by multiple generations that are actively involved in the family system (NIAAA, 2005).

Signs and Patterns of Intimate Partner Violence

Intimate partner violence has long been associated with substance use. Although research has not found a causal link between the two problems, there is a correlation between them. The Consensus Panel of *Treatment Improvement Protocol (TIP) 25* recommends that all patients be questioned about intimate partner violence. This would include not only a current history, but also a history of childhood physical, emotional, and sexual abuse.

Screening instruments used by substance use programs may include questions regarding a history of childhood or relationship abuse. Some perpetrators and victims may deny this history due to fear of consequences should it be discovered, shame, or not recognizing the behavior as abusive. You can be alert to other symptoms of abuse that may be present. These include:

- Physical injuries
- History of relapse or noncompliance with treatment
- Inconsistent explanations or evasive answers when questioned about injuries
- Complications in pregnancy

- Stress- and anxiety-related illnesses or conditions
- Documented child abuse perpetrated by the partner of the patient

If a counselor suspects abuse and the patient denies this in initial assessment interviews, one approach is to explore these issues a few days later after the patient has become more comfortable in treatment and a therapeutic alliance has been established. Consultation with a treatment team that includes members of the Family Advocacy Program (FAP) would be appropriate. When child abuse is suspected, notification must be made to the appropriate authorities based on state laws in the region.

Families experiencing intimate partner violence have additional issues to consider besides substance use. Although removing the substance use may reduce the risks, it will not resolve the intimate partner violence issues. In fact, in some instances, the risk for violence may increase as the balance of power and control shifts as one or more people enter recovery and seek changes in the family system. Methods for addressing family relationships must take into account the history of violence.

In the Navy, the FAP addresses issues of intimate partner violence. Consultation with the FAP team will help you identify when a referral to that program is appropriate and may be required under Navy regulations. Victim safety and the reaction of a suspected perpetrator to the FAP referral must be considered as the referral is planned and implemented.

Effects of Substance Use Behaviors on Interaction Patterns

TIP 39 (CSAT, 2020) outlines how using certain substances can impact families differently:

Alcohol

- Problems with communication
- High levels of conflict
- High risk of chaos and disorganization (e.g. inconsistent parenting practices)
- Breakdown of family rituals, rules, and boundaries
- High potential for emotional, physical, or sexual abuse, or a combination thereof
- Efforts by family members to “cover up” for the family member with alcohol misuse

Opioids

- High potential for illegal activities (e.g., buying illicit opioids like heroin; diverting prescription opioid medications)
- Increased risks of chaos and unpredictability
- Greater risk of contracting an infectious disease, such as HIV/AIDS and hepatitis, which can affect family members’ roles and responsibilities (e.g., parenting children, caring for dependent others, working to earn a livable income, fulfilling school-related duties)
- Increased risk of engaging in sex work to support the cost of opioids, which can affect the family member’s health, roles, and responsibilities

- High potential for SUDs

Cocaine

- High potential for illegal activities (e.g., buying or selling cocaine)
- Increased risk of stealing from family, work, or others to purchase cocaine (which, in certain forms, can be high cost)
- Increased changes of legal problems
- High potential for SUDs

Be Familiar with and Use Models of Diagnosis and Intervention (95)

Intervention Strategies Appropriate for Family Systems

NIAAA (2003) offers guidelines for working with families in which substance use is identified as an issue. Three general therapeutic principles are offered.

1. Use accurate empathy. By communicating in an empathic manner, counselors are more likely to help patients discuss their substance use, identify the problems associated with it, and prepare to change.
2. Enhance motivation by focusing on patient goals.
3. Give patients choices.

Potential pitfalls to discussing the substance misuse in a family session can include:

- Defensiveness of the substance user,
- Family trying to ally with counselor against the substance user,
- Negative reaction of family to counselor, empathy toward the substance user.

During contact with family members, should the need for a substance use assessment for other family members be identified, they can be assessed at the SARP or referred to another provider for services.

Intervention Strategies, Laws, and Resources for Violence Against People

Substance use disorder counselors have a responsibility to take action when it is determined that a patient and/or their family is experiencing violence in their relationships. This may include partner violence, child abuse, and elder abuse. Questions to consider include where the family members are, the legal status of the family relationships, willingness of the patient to have the family involved in treatment, and resources available to family members. A patient's family cannot be considered safe just because the patient is aboard ship or on an unaccompanied tour overseas. Many a SARP counselor has inquired as to why a patient did not enter treatment as scheduled only to learn they went on emergency leave and is now in the same community as the family members who are considered to be at risk. The treatment team, clinical chain of command, and preceptor are valuable resources for identifying appropriate strategies for dealing with risks of violence.

When exploring family issues, counselors are reminded of the legal and ethical requirements regarding the risk of violence. Counselors who believe a patient is a threat to themselves or another person must take steps to protect the patient and those who are in possible danger. Specific steps to take will depend on whether services are being provided in the United States or on a foreign base and whether the patient is active duty or a family member. Counselors who suspect child abuse have a duty to report this to the appropriate authorities for investigation. Counselors should seek supervision when concerned about the risk of violence or child abuse within a family system. These issues are also discussed in Part III, Chapters 8 and 13.

Develop a checklist of the steps to take if you identify violence as an issue in a patient's treatment. Items to include are who the perpetrator is, who is at risk, legal or ethical requirement to notify authorities, agencies to be notified, etc. Include agency contact information when available. Review checklist with your preceptor.

Culturally Appropriate Family Intervention Strategies

When involving the family in the treatment process, counselors need to consider the cultural background of the patient and their family. If the patient is in a bicultural relationship, the culture of their partner will need to be explored. TIP 39 (CSAT, 2020) offers eight questions to consider when offering SUD treatment for families of diverse racial/ethnic backgrounds:

1. How is this family structured?
2. What is the role of the extended family?
3. What is the role of religion or spirituality within this family?
4. What is the family's immigration/nativity status? How does this affect family members' level of acculturation?
5. Are there culture-specific family values to be aware of?
6. How does the family's culture affect their communication style?
7. How does this family experience racism and discrimination? How do those experiences, along with historical trauma, affect the family?
8. Has the family experienced any periods of separation (particularly between parent and child)?

TIP 39 (CSAT, 2020) also offers additional information on working with various cultural and racial populations, including African Americans, Hispanic/Latinos, Asian Americans, and Americans Indians.

Appropriate and Available Assessment Tools for Use with Families, Couples, and Significant Others

When working with families, it is important to determine if anyone else in the family has a substance use disorder or any other behavioral health issue that might affect the ability of the members to support recovery. Any of the assessment tools discussed in Part III, Chapter 2, can be used with adult family members or significant others. Other tools and models are available to address the needs of the family and children.

Substance Abuse and Child Welfare: In the last decade, the National Center on Substance Abuse and Child Welfare established a model for assessing family functioning. The *Screening and Assessment for Family Engagement, Retention, and Recovery (SAFERR)* model takes into consideration the expertise of the substance use disorder profession, child welfare experts, and family courts (Young, et al., 2006). The model asks four basic questions:

1. Is there a substance use or child abuse or neglect issue in the family, and if so, what is the immediacy of the issue?
2. What are the nature and extent of the substance use or child abuse or neglect issue?
3. What is the response to substance use or child abuse or neglect issue? Are there demonstrable changes? Is the family ready for transition and what happens after discharge?
4. Did the interventions work?

The *SAFERR* model offers guidelines for assessment, case management, and treatment for families with the goal of increasing family stability, reunification, and well-being for families dealing with substance use and child welfare issues.

Adolescent Substance Use: Specific assessment tools have been designed for use with adolescents. Examples include the Adolescent Drinking Index (ADI), Drug and Alcohol Problem (DAP) Quick Screen, and the Drug Use Screening Inventory-Revised (DUSI-R). More information on the screening of adolescents can be found in *Treatment Improvement Protocol 31: Screening and Assessing Adolescents for Substance Use Disorders* (CSAT, 1999).

Facilitate the Engagement of Family Members and Significant Others (96)

How to Apply Appropriate Confidentiality Rules and Regulations

Military family members are civilians and, therefore, the military Privacy Act does not apply to their involvement in treatment. Counselors need to obtain consents to release and obtain information in order to discuss treatment concerns with family members. For instance, counselors cannot tell a sailor's spouse about their treatment without written consent. Likewise, a sailor's commanding officer cannot be told about a spouse's involvement in treatment without the spouse's consent. The command legal office can be consulted if you have questions regarding the applicability of confidentiality regulations to family members.

Methods for Engaging Members of the Family or Significant Others to Focus on Their Concerns

Counselors can encourage families to participate in treatment based on the individual needs of each family. Some families will be concerned about the welfare of the children, some will be motivated to help the identified patient maintain sobriety, and others will respond to an offer of a chance to have someone listen to them for a change. Identify what will motivate the family, as well as the obstacles that may get in the way.

- A spouse who has been left at home to raise young children while their husband was deployed for 6 months, only to have him come home and tell them that he has to go to AA meetings 5 days a week, may not be particularly supportive of his new life.

- A husband who does not want his command to find out about his wife's marijuana use may not disclose this obstacle to his own ability to stay sober.
- A service member who is in a same sex relationship may not tell their counselor about the relationship, so the potential ally in their recovery is never offered services.

The astute counselor will look for opportunities throughout the course of treatment to educate the identified patient, family members, and significant others about the recovery opportunities available to all of them.

Assist Members in Understanding the Interaction Between Family System and Substance Use Behaviors (97)

When substance use is present in a family, the family relationships and interaction patterns are modified in response to the user's behavior. Whether it is from a place of worry, fear, shame, or anger, family members react to the behavior. At a minimum, family members may be worried about the health of the user, afraid they will drive while intoxicated, or be scared that they will get arrested for using marijuana. Other members will be ashamed of the user's behavior and work to hide the behavior or shield the world from finding out what is going on in the home.

Claudia Black (2002) defines the behavior of the co-dependent person in the household, frequently the second adult. The term *codependent* is used to describe a person who has a diminished sense of self in response to the addictive family system. The codependent person typically experiences:

- Loss of sense of self, how they feel, and what they need.
- Being obsessed with another person facilitates not dealing with own life.
- Reacting to someone else's behavior instead of personal motives.
- Being all-consumed with another and putting own priorities on hold.
- Taking responsibility for other people, tasks, and situations.
- Engaging in a denial system.

Children growing up in dysfunctional families tend to adopt one of several roles. These roles were originally described by Virginia Satir (Bandler, Grinder & Satir, 1976) and further adapted and applied to alcoholic families by Sharon Wegscheider-Cruse (1989) and Claudia Black (2002). Some children will move from one role to another as the family dynamics change when children leave the home or new ones are added. Each role serves a function in the family and has both long-term benefits and limitations for the child as they reach adulthood.

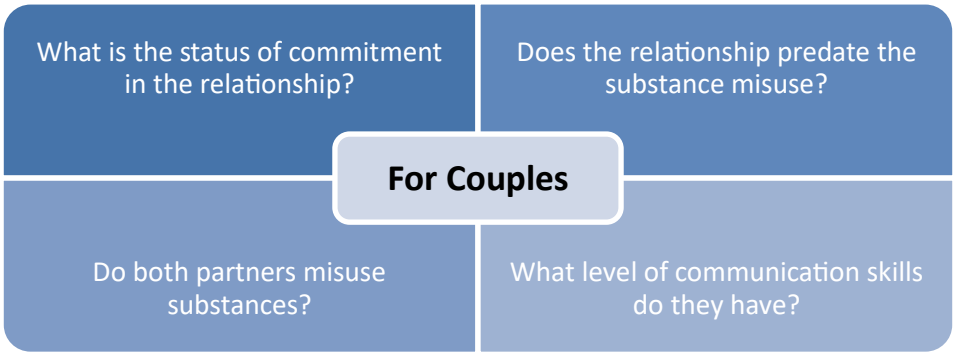
Role	Function	Benefits	Limitations
Hero/Responsible One	Keeps the family working, looks for positive attention through achievement	Responsible, organized, high achiever, leader, directive, goal oriented	Perfectionist, controlling, unable to relax, not spontaneous
Mascot	Entertainer, keeps things light, takes focus off parent, family pet	Flexible, sense of humor, able to release stress	Immature, hyperactive, difficulty focusing
Placater/People Pleaser	Tries to keep everyone happy, ease tension	Caring, empathic, good listener, sensitive to the needs of others	Anxious, denies personal needs, inability to receive help
Scapegoat/Acting Out	Diverts attention from parental dysfunction, seeks attention though negatively	Creative, more honest about problems, more in touch with feelings	Social problems—addiction, truancy, drop out; self-destructive, irresponsible
Lost Child/Adjuster	Hides out, does not bring attention to self	Independent, quiet, easy going	Withdrawn, follower, fearful, lacks direction, ignored

Family members can begin to look at their place in the family system and the role substance use has played in their family of origin and adult family life, regardless of whether the identified patient makes progress in treatment. Self-help resources such as Al-Anon and Adult Children of Alcoholics (ACOA) groups can be a good place to start for some. The benefit to the identified patient is that treatment outcomes are likely to improve if the family also receives help. For more information on specific research on family approaches to substance use treatment, see Chapter 2 in *TIP 39* (CSAT, 2020).

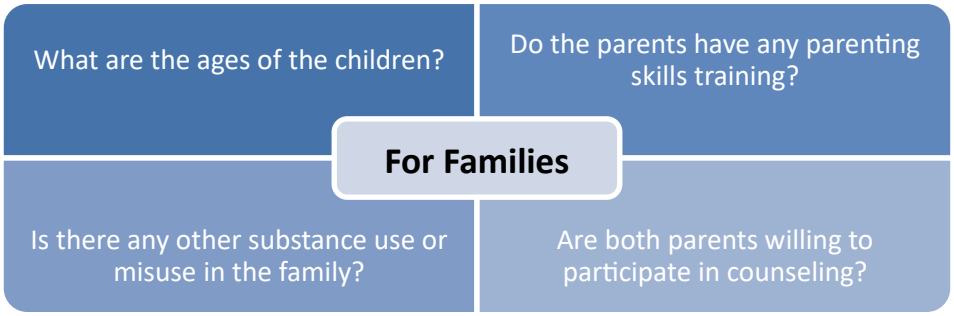
Assist Families, Couples, and Significant Others in Adopting Strategies and Behaviors That Sustain Recovery and Maintain Healthy Relationships (98)

Healthy Behavioral Patterns for Families, Couples, and Significant Others

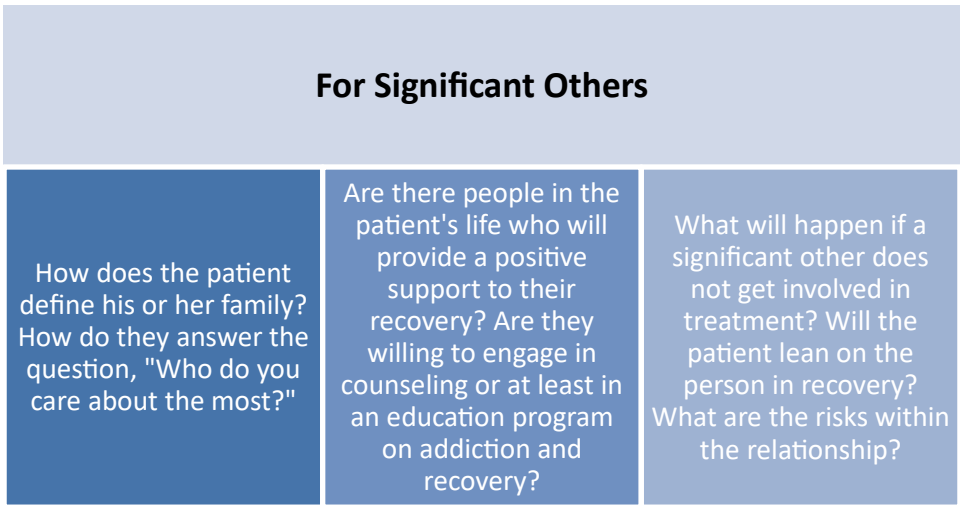
The specific behavioral changes that need to be made in a family system will depend on the makeup of that system. Issues to consider include the following:



You can design a treatment plan to include couples counseling based on the interest and motivation of the partners.



Treatment services can include building on parenting skills and other factors that will help protect children from substance use and support parental sobriety.



You need to be open to the patient's definition of who is significant in their life and the level of involvement that they want that person to have in their treatment and recovery.

Empirically Based System Counseling Strategies Associated with Recovery

TIP 39 identifies several family therapy models that have demonstrated effectiveness in treating substance use disorders (CSAT, 2020), including:

- Structural/strategic family therapy—The therapist works to change behavior patterns that support substance use and other family problems.
- Multidimensional family therapy—Developed to treat adolescent substance misuse problems, strategies are used to reduce the effect of negative factors and increase protective factors in the teen's life.
- Multisystemic family therapy—A strengths-based orientation that provides therapy in the home.
- Behavioral and cognitive-behavior couples and family therapy—These models work to modify behaviors and distorted beliefs that lead to substance misuse and dysfunctional behavior.
- Systemic motivational therapy - Combines elements of systemic family therapy and motivational interviewing (MI).
- Psychoeducation - Engaging family members in treatment, providing information, enhancing social support networks, developing problem-solving and communication skills, and providing ongoing support and referrals to other community-based services.
- Brief strategic family therapy - Draws on structural and strategic family theory and interventions for adolescent substance misuse. It assumes that the adolescent substance misuse and other risk behaviors are linked to dysfunctional family interactions.
- Functional family therapy - Behaviorally based family counseling approach based on an ecological model of risk and protective factors.

- Solution-focused brief therapy - Pinpointing the cause of problematic family functioning is unnecessary; counseling focused on solutions to specific problems is enough to help families change.
- Community reinforcement and family training - Structured, family-focused approach that assumes environmental contingencies are important in promoting treatment entry.

Stages of Recovery for Families, Couples, and Significant Others

The Stages of Change (as discussed in Part III, Chapter 7) is one model that is used to assess the progress of patients in addressing substance use issues. Those stages can be applied to the family as a whole or individuals in the family. In addition to the Stages of Change model, another useful model for understanding how families change outlined in TIP 39 (CSAT, 2020) was originally developed by Virginia Satir and includes six stages (Gehart, 2018):

1. **Status quo:** Homeostasis for the family - family members have roles that are organized around the person in the family that has a mental health disorder or SUD.
2. **Foreign element:** A foreign element shifts the family off-balance, such as a crisis or counseling intervention that provides the family with additional information or a new perspective.
3. **Chaos:** The counseling intervention throws the family system into a temporary state of chaos. The family most often experiences discomfort and tries to get back to the stage 1 status quo.
4. **Integration:** Eventually, the family system interprets the new information in a meaningful way, which opens up new possibilities for change.
5. **Practice:** The family system develops new ways to interact/communicate based on new information.
6. **New status quo:** This is a new state of homeostasis that supports all family members to grow and contribute to enhanced family functioning.

TIP 39 goes on to identify specific family therapy techniques that are effective at each stage of sobriety. For example, multidimensional family therapy has been found to be helpful in motivating the family to engage the patient in detoxification as they work to attain sobriety. Structural and strategic systems therapy has been helpful in reestablishing boundaries between the family and the outside world as they adjust to sobriety. And finally, network therapy has connected families to support groups that help them to maintain sobriety. More information on these phases and the specific techniques associated with them can be found in Chapter 3 of *TIP 39* (CSAT, 2020).

CASE STUDY 10.1

Ryan continues to express frustration over the problems in his marriage and what he claims is his wife's influence over her sister, who is still refusing to let Ryan spend time with her son. Ryan feels strongly about the importance of being a father figure for his nephew (whose father, Ryan's brother-in-law and best friend, is currently deployed and will be for another 6 months. He blames his wife for this and cannot understand why she does not trust him when he says he is working on his problems in counseling and has stopped drinking.

You decide to arrange a session where Ryan will be joined by his wife. What do you see as your role in this session? How can you ensure that you will remain neutral and not appear to take sides?

What can you do to assist Ryan and his wife in gaining an understanding of the role their interaction plays in Ryan's drinking and recovery?

How can you assist Ryan's wife in adopting strategies and behaviors that sustain recovery and maintain healthy relationships?

Summary

In this chapter, we have focused on the third element of the counseling practice domain. The systemic nature of substance use disorders makes family counseling a critical element in substance use counseling. All of the work an individual does in treatment can be sabotaged by a family that does not receive the necessary support and services. A treatment team that includes the substance use counselor and a family counselor can offer a range of resources that promote recovery and serve as prevention for substance use disorders in future generations. Some families will welcome and/or need more support than others. Some families who need more support may resist it. Counselors are reminded of the foundations of effective counseling—the therapeutic relationship. Helping the patient and the family establish relationships with caregivers who understand the issues families with substance use face will start them on the path to recovery.

Learning Activities

1. Review the material in your NDACS student guide on family roles, as well as the material in this chapter. Identify one or two roles about which you would like more information. Read about family roles and discuss with the preceptor.

   If you have been working for a while, what have been your struggles working with family members? Discuss with your preceptor a recent situation that you had with a family member that was difficult. What do you wish you would have done differently? How would you like to handle a similar situation in the future?

2. Make a list of available resources on your base and in your community for families. Include counseling programs, self-help resources, and educational workshops. Contact the FFSC and see if there is a trained family therapist on their team.

Self-Study Questions

1. Name three protective factors that can help prevent children from using substances.

   a. _____
   b. _____
   c. _____

2. **True or False**? Family systems therapy assumes a balance of power and control in the family and, therefore, may not be appropriate for families experiencing intimate partner violence.

3. Name three guidelines NIAAA provides for working with families.

   a. _____
   b. _____
   c. _____

4. Which of the following is not a characteristic of interaction among substance using families?

   a. Negativism.
   b. Limits are enforced.
   c. Parents set unrealistic expectations.
   d. Members express anger inappropriately.

5. **True or False**? As long as there is a signed Privacy Act, the counselor can contact family members and engage them in treatment.

6. Match the role to the characteristic:

a. Mascot	___ responsible, high achiever
b. Hero	___ empathic, denies personal needs
c. Lost child	___ acts out, creative
d. Scapegoat	___ humorous, immature
e. Placater	___ loner, withdrawn

7. Name the three phases of the Family Change Model offered in *TIP 39*.

   a. _____
   b. _____
   c. _____

Self-Study Answers

1. Protective factors that can help prevent children from using substances include self-control, parental monitoring, academic competence, antidrug use policies, and strong neighborhood attachment.

2. **True.** Family systems therapy does assume a balance of power and control in the family and, therefore, may not be appropriate for families experiencing intimate partner violence or other violence in the home.

3. Guidelines provided by NIAAA for working with families include (1) use accurate empathy, (2) enhance motivation by focusing on patient goals, and (3) give patients choices.

4. Enforced limits (b) is not a characteristic of interaction among substance using families.

5. **False.** Family members are civilians and not covered by the Privacy Act. Consents to obtain and release information must be signed by the service member and the family members to share information between family members.

6. The following roles have been matched to their characteristics:

b. Hero	responsible, high achiever
e. Placater	empathic, denies personal needs
d. Scapegoat	acts out, creative
a. Mascot	humorous, immature
c. Lost child	loner, withdrawn

7. The three phases of the Family Change Model are attainment of sobriety, adjustment to sobriety, and long-term maintenance of sobriety.

Chapter 11 Patient, Family, and Community Education

Purpose of This Chapter

This chapter reviews the Practice Dimension of Patient, Family, and Community Education.

The learning objectives directly correlate with Competencies 99–107 as listed in the *TAP 21* (p. 133–138) and IC&RC Domain III: Evidence-Based Treatment, Counseling, and Referral. Each competency is accompanied by a set of knowledge, skills, and attitudes that define the standard.

Learning Objectives

- Provide culturally relevant formal and informal education programs that raise awareness and support substance use prevention and the recovery process. (99)
- Describe factors that increase the likelihood for an individual, community, or group to be at risk for, or resilient to, psychoactive substance use disorders. (100)
- Sensitize others to issues of cultural identity, ethnic background, age, and gender in prevention, treatment, and recovery. (101)
- Describe warning signs, symptoms, and the course of substance use disorders. (102)
- Describe how substance use disorders affect families and concerned others. (103)
- Describe the continuum of care and resources available to the family and concerned others. (104)
- Describe principles and philosophy of prevention, treatment, and recovery. (105)
- Understand and describe the health and behavior problems related to substance use, including transmitting and preventing HIV/AIDS, TB, STDs, Hepatitis C, and other infectious diseases. (106)
- Teach life skills, including but not limited to stress management, relaxation, communication, assertiveness, and refusal skills. (107)

Introduction

In the Navy SARP setting, counselors are called upon to offer educational programs to various groups. Counselor duties may include providing outreach to a command, conducting educational intervention at the lowest level of the continuum of care, and/or providing educational programs to people diagnosed as having a substance use disorder. When designing and planning an educational program, it is important to know the audience, share information that is relevant for the group being served, and present information in a professional manner. As a service member, you may already

have a great deal of experience in providing educational programs to other sailors. Skills in writing a class outline, speaking in front of an audience, and answering questions will serve you well. This chapter will discuss additional factors that are important when delivering educational programming to patients, their families, or the community.

Provide Culturally Relevant Formal and Informal Education Programs (99)

It is important to be aware of the cultural differences in diverse communities when developing educational programming. It is beyond the scope of this book to provide information on the different ethnic groups that make up the military population and their families. As a counselor committed to providing appropriate services, you are encouraged to seek out information about your population and work to integrate culturally relevant material into your work. The SAMHSA website, https://www.samhsa.gov/ is a good place to start.

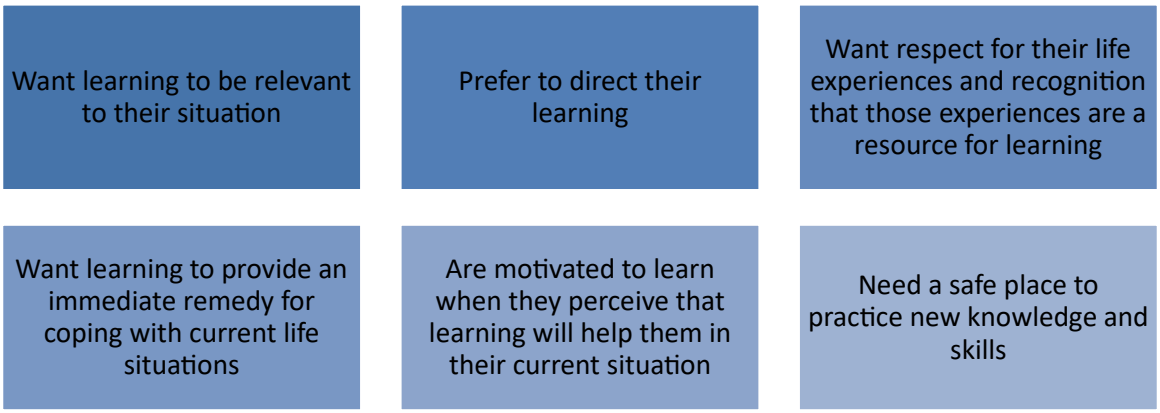
Information is available in the literature regarding the adaptation of prevention programming to diverse communities. Navy counselors may work with a packaged program or training outline that has been developed by another counselor or purchased by the Navy. These materials may need to be adapted to make them applicable to your target audience and to come across in your voice, while still ensuring the educational session is meeting the goal of the program.

Castro, et al. (2004) describes two ways that programs can be modified to account for cultural diversity of the audience:

1. Modification of content—This may be necessary to ensure that all relevant information is being covered. For example, your class may include a discussion on several drugs of abuse. If you know that methamphetamine use is a major issue in your community, you may choose to spend more time discussing this drug than another, such as heroin. Another option is to add a supplemental module to your training to address culturally specific issues, such as coping with living in a country as a non-native.
2. Modification of delivery—This adaptation includes delivering all of the content in the original program, but changing the way it is delivered. Changes may include:
    a. Characteristics of the delivery person(s)—Choosing speakers who may have more relevance to the audience, such as having active-duty counselors present to an active duty audience or a military spouse present to a family audience.
    b. Channel of delivery—Using alternative methods, such as the internet versus a classroom, if that will make your class more available to your target audience. In the Navy, you might develop a pamphlet explaining the treatment process that young sailors can send to their parents.
    c. Location of delivery—Some populations are more willing to attend an educational program if it is offered in a familiar location. Consider scheduling an outreach program at the base chapel or a local school, depending on your target audience. Providing an educational event online via videoconferencing software may make it more accessible to both sailors and their families.

Learning Styles

When developing an educational program, it is also necessary to consider the learning styles of the audience. Unless working in an adolescent treatment program, the learners will be adults. Malcolm Knowles, an expert in adult education, offers the following characteristics of adult learners (Knowles, Holton, & Swanson 2005):



Applying these factors to a substance use treatment program will cause you to ask questions like:

- Does the patient need to attend this class?
- Do the classes give patients the opportunity to apply new information to their life? Do the classes include discussion sessions and practice exercises or are they just lectures?
- Do we offer opportunities for patients to tell us about their experiences with addiction and what they have learned from it?
- Do we use solution-focused techniques and help patients recognize their successes in recovery that can be built onto?

Describe Risk and Protective Factors (100)

Risk factors and protective factors are the attitudes and behaviors that influence the likelihood that a person will develop a problem with alcohol or drugs. Prevention programs work to reduce the risk factors in a person's life and increase the influence of protective factors so that the protective factors outweigh the risk. Factors cross several domains, including:

- Community—Availability of illicit drugs in the community
- Family—Family discipline, family conflict, and parental attitudes about substance use
- School—Attendance, grades, participation in anti-drug education
- General—Religious observance, social support network

The National Institute on Drug Abuse (NIDA) and many other organizations offer resources on prevention, including risk and protective factors. Search NIDA's website for more information if you are called to develop a prevention program: www.nida.nih.gov.

Sensitize Others to Issues of Cultural Identity, Ethnic Background, Age, and Gender in Prevention, Treatment, and Recovery (101)

The training at NDACS began the process of sensitizing counselors to the role that culture, ethnicity, age, and gender play in substance use issues. Just as these issues are important in the counseling relationship, so too are they important in educational and outreach programs. As a member of the treatment team, you will have many opportunities to ensure the team considers culture, ethnicity, age, and gender in treatment. A counselor does not have to share the unique characteristics of a person to demonstrate to them that they are open to learning what it means to be them. A simple statement such as, "I don't know what it is like growing up in an urban environment. Can you please tell me what it was like for you?" or, "Tell me what it was like growing up in your neighborhood." The old adage "it takes one to know one" may not be true but can be reworded to read "it takes an interest in one to know one."

Describe Warning Signs, Symptoms, and the Course of Substance Use Disorders (102)

Previous competencies measured the ability to identify the signs, symptoms, and the course of substance use disorders in the people assessed in your program. This competency states that counselors need to have the ability to share what they know with their patients, and when possible, the patients' families.

- Can you tell a patient or a group of people the warning signs of alcohol use?
- Can you describe the symptoms of substance use disorders for other mood-altering chemicals?
- Can you describe to a patient what they can expect to happen if they continue to use alcohol the way they are currently using it?

If you are not ready to present a class on the signs, symptoms, and course of substance use disorders, seek out additional information. Review your NDACS material. One helpful primer on alcohol use disorder is *Loosening the Grip*, by Jean Kinney. The 12th edition was published in 2020.

Describe How Substance Use Disorders Affect Families and Concerned Others (103)

The effect of substance use disorders has been addressed in Chapter 10. This current competency takes it a step further and addresses counselors' ability to educate patients and families on these effects. Depending on the SARP program resources, availability of family members and/or concerned

others, and their willingness to participate, the only opportunity you as a Navy counselor may have to reach families and concerned others could be through an informational session or pamphlet.

CASE STUDY 11.1

In your sessions with Ryan, you have determined that his extended family lacks knowledge regarding substance use disorders and recovery.

What can you do to see that Ryan and his family receive education regarding substance use disorders and recovery?

Describe the Continuum of Care and Resources Available to the Family (104)

This competency is based on the belief that patients and their families benefit from being provided information regarding the range of services available in a community to address substance use issues. Information regarding the continuum of care can be provided in a patient or family orientation session, during a community outreach program, or in written material. Part III, Chapter 2, provides information about the continuum of care offered by the Navy, following the guidelines of the American Society of Addiction Medicine (ASAM). You are encouraged to review this information when preparing educational programming related to the continuum of care.

Patients should be made aware of other resources available in the local community for them and/or their families. Not all members will choose to participate in the Navy system of care. Although active-duty personnel identified by the Navy as needing substance use services may be required to participate in Navy programming, others may seek out professional or self-help before the problem comes to light within their workplace. Offering information as part of public outreach may help you to reach some members who might otherwise be missed.

Navy SARPs vary in the extent of outreach and programming they offer to families. Sites that may lack the resources to offer family counseling may be able to reach families by offering an educational session or pamphlets on substance use and families. These materials can include information on free and low-cost services available in your community. Encouraging patients to share information with their families and significant others may benefit those unwilling or unable to participate in services at the SARP.

Describe Principles and Philosophy of Prevention, Treatment, and Recovery (105)

Substance use disorders are complex disorders that affect a person across the biopsychosocial spectrum. Throughout the course of history, the response of our society has been to respond to people who use substances through medical, social, and legal interventions. The prevention or

treatment models offered in a community at any particular time may be influenced by political and economic factors, along with current understanding of the nature of addiction. You should be aware of the different models of treatment and the science, social responsiveness, and political motivations behind the models.

Identify two treatment models you would like to learn more about and discuss with your preceptor. Add it to your IDP now or down the road.

Since the turn of the 21st century, emphasis in the behavioral health profession has been on identifying and using evidence-based practices (EBPs). An EBP is a model of prevention or treatment that has been studied and has demonstrated through research to bring about the desired response for which the practice was designed. Funding entities are reluctant to fund treatment and prevention models just because they sound good. The SAMHSA website, https://www.samhsa.gov/ is a useful resource to identify and examine EBPs for substance use disorders.

The Veterans Health Administration (VHA) and DoD collaborate with leading professional organizations to develop clinical practice guidelines. The VHA and DoD are committed to utilizing evidence-based practices to provide the highest quality care. *The VA/DOD Clinical Practice Guideline for the Management of Substance Use Disorders* is a reference for the Defense Health Agency (DHA) Procedural Instruction for the Management of Problematic Substance Use by DoD Personnel (DHAPI-6025.15), as well as the BUMED Instruction 5353.4C: Standards for Alcohol and Substance Misuse Services. Counselors need to be familiar with the current versions of the VA/DOD guidelines and military instructions.

Understand and Describe Health Issues Related to Substance Use, Including Transmission and Prevention of HIV/AIDS, TB, STDs, Hepatitis C, and Other Infectious Diseases (106)

Through the National Institutes of Health (NIH) (http://www.nih.gov), the federal government offers many resources that are in the public domain and readily accessible. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) (http://www.niaaa.nih.gov) focuses research efforts on alcohol, and the National Institute on Drug Abuse (NIDA) (http://www.nida.nih.gov) conducts research on other drugs of abuse. Pamphlets and educational material can be downloaded or ordered for distribution to your team, patients, and their families.

Infectious Diseases

Alcohol and drug misuse increases the risk of transmitting infectious diseases, including HIV/AIDS and other sexually transmitted illnesses, hepatitis, tuberculosis, and many other infections. Abusing chemicals weakens the immune system, increasing the likelihood that exposure to an infectious disease will result in transmission. Additionally, infectious diseases can be spread through needle sharing and unsafe sex. A person under the influence of chemicals may make choices regarding sexual partners and/or practices that increase their risk, assuming that they are safe because they are not injecting drugs. You have a responsibility to educate your patients on the risks associated with

infectious diseases and substance use and to encourage testing. More information on HIV/AIDS and infectious disease issues can be found at www.nida.nih.gov/ .

> Review the material you have from NDACS on health issues related to substance use disorders. Gather additional resources from NIAA and NIDA. Develop an outline for a class you would give to patients in IOP. Include organ systems affected, diseases that can be caused by or exacerbated by alcohol and drug use, and effect on infectious disease transmission. Review with your preceptor.

Teach Life Skills, Such as Stress Management, Relaxation, Communication, Assertiveness, and Refusal Skills (107)

Teaching life skills is a component in most prevention, treatment, and continuing care programs. Prevention programs primarily work to help children build resilience and develop the personal and social skills needed to move through developmental tasks of childhood. The ability to express feelings, make positive choices, and use effective stress management skills are protective factors against early substance use.

In treatment and early recovery programs, life skills help patients deal with the physical and emotional responses they experience when they stop using mood-altering chemicals. Assertiveness and refusal skills training will help patients navigate the changes they will need to make in relationships, recreational activities, and establishing a lifestyle supportive of abstinence and recovery. Additionally, teaching stress management and relaxation techniques help patients learn how to navigate life stresses that they will experience throughout the rest of their lives.

Post-Acute Withdrawal: Many people who experience physical dependence on a chemical will experience post-acute withdrawal (PAW). PAW may start 30–90 days after initial abstinence. It generally lasts for a few days at a time and is a result of the brain chemistry continuing to adjust to the absence of the substance that has been misused. These phases of PAW may continue on and off for 1-2 years. Symptoms of PAW include mood swings, anxiety, low energy, sleep disturbance, and confusion. These episodes can be a great trigger for relapse. Using life skills such as exercise, relaxation techniques, meditation, and other skills can help a person get through these episodes. It is important for patients to learn these skills and practice them throughout recovery, so they are available when most needed.

> *What life skills are being taught in your SARP? What classes are available at the Fleet and Family Support Center (FFSC)? If you do not have enough patients for a class at your site, do you use the FFSC? Discuss with your preceptor.*

Summary

When you signed on to be an alcohol and drug counselor, you may not have thought of yourself as an educator; however, treatment for substance use disorders will require new learning and practice for your patients. Whether in a one-on-one setting sharing information or in a classroom setting, you will find yourself functioning as an educator. When facilitating a therapy group, you will find many teachable moments when the group needs information. Your educational skills will then be useful in the group. When in the classroom, you will find individuals respond to new information with raw emotions, nervousness, and fear. Your empathy and attending skills as a counselor will then be a benefit in the classroom. Together, these skills will contribute to your ability to provide quality components of substance use treatment and recovery services.

Learning Activities
1. Observe another counselor give a class. Keep a list of information they provide or methods they use to include all people in the audience. Was there any culturally specific material discussed? Did they attempt to meet the individualized needs within the audience? Discuss with the presenter and your preceptor. If your site does not give classes, ask your preceptor to assist you in arranging to observe a class at a civilian location.
2. Write an outline for a class on the signs and symptoms of substance use disorders. Prepare to present this to patients. Review your outline with your preceptor. Ask your preceptor to observe you delivering the class.
3. Write a list of all of the methods your site uses to educate the people in the patients' lives. If needed, develop a new outreach class or information sheet to share with families. Discuss with your preceptor.
4. Contact your local Fleet and Family Support Center (FFSC) to see what services or supports they offer to families. Obtain any informational pamphlets they have or create your own to have at SARP to give to patients or their family members as needed.

Self-Study Questions

1. Which one of the items below is not one of Knowles characteristics of adult learners?

    a. Want learning to be relevant to their situation.
    b. Prefer to direct their learning.
    c. Want respect for their life experiences and recognition that those experiences are a great resource for their learning.
    d. Want learning to provide an immediate remedy for coping with current life situations.
    e. Are motivated to learn when they perceive that the learning will help them get a promotion.

2. What four domains are considered when discussing risk and protective factors?

3. What are the two ways that programs can be modified based on the cultural diversity of the audience?

4. What does EBP stand for?

5. **True or False?** The VA/DOD Clinical Practice Guideline for the Management of Substance Use Disorders lists contingency management/motivational incentives as an evidence-based practice for alcohol use disorders.

6. **True or False**? Alcohol and drug counselors need educational skills even if they do not conduct classes for patients.

Self-Study Answers

1. Answer (e), "Are motivated to learn when they perceive that the learning will help them get a promotion," is not one of Knowles' characteristics of adult learners.

2. The four domains to consider when discussing risk and protective factors are family, community, school, and general.

3. Two program modifications based on cultural diversity of the audience include modification of content and modification of delivery.

4. EBP stands for "Evidence Based Practices."

5. **False.** Based on the guidelines published in 2021, there was insufficient evidence that contingency management is effective in treating alcohol use disorders.

6. **True**. Counselors may perform an educational role in individual, group, and family counseling settings.

Chapter 12 Documentation

Purpose of This Chapter

This chapter reviews the Practice Dimension of Documentation and its importance in the delivery, tracking, evaluation, and support of quality treatment.

Learning Objectives

The learning objectives directly correlate with Competencies 108–114 as listed in the *TAP 21* (p. 143–147) and IC&RC Domain IV: Professional, Ethical, and Legal Responsibilities. Each competency is accompanied by a set of knowledge, skills, and attitudes that define the standard.

- Demonstrate knowledge of accepted principles of patient record management. (108)
- Protect patient rights to privacy and confidentiality in the preparation and handling of records, especially in relation to the communication of patient information with third parties. (109)
- Prepare accurate and concise screening, intake, and assessment reports. (110)
- Record treatment and continuing care plans that are consistent with agency standards and comply with applicable administrative rules. (111)
- Record the progress of patient in relation to treatment goals and objectives. (112)
- Prepare accurate and concise discharge summaries. (113)
- Document treatment outcome, using accepted methods and instruments. (114)

Introduction

The *TAP 21* defines the Practice Dimension of Documentation as "the recording of the screening and intake process, assessment, treatment plan, clinical reports, clinical progress notes, discharge summaries, and other patient-related data" (CSAT, 2006, p. 143). This definition is consistent with the IC&RC definition of the Core Function of Reports and Record Keeping. "All aspects of [patient] treatment require some form of a report or record to be kept" (Herdman, 1997, p. 78).

To maintain adequate documentation of a patient's care, it is important to consider why records exist. Medical records document the patient's history, diagnosis, and treatment plan; contribute to continuity of care; serve as a historical record of interventions and responses to treatment; are evidence in the case of legal proceedings; and serve as backup to an invoice for care to a third-party payer. They can only fulfill these purposes, however, if they are maintained in a thorough, adequate, ethical, and legal manner. An old adage says: *if it isn't in the record, it didn't happen*. It is the responsibility of every substance use counselor to document their clinical care thoroughly, in a

timely fashion, and in accordance with all laws and regulations governing the records. The competencies outlined in this chapter provide a detailed framework to achieve those goals.

Demonstrate Knowledge of Accepted Principles of Patient Record Management (108)

TAP 21 includes the following documents as essential components of a patient record:

- Release forms
- Assessments
- Treatment plans
- Progress notes
- Discharge plans
- Discharge summaries

A thorough record includes at least these documents, but frequently will include much more. The DHA sets standards for information to be included in the medical record through the use of a standardized electronic record. The DHA electronic medical record requirements may change over time. Counselors will be oriented to current policies upon arrival at SARP. DHA allows for the uploading of site-specific documents. No secondary medical record is to be maintained at any clinic.

According to the *TAP 21* (CSAT, 2006, p. 143), to be considered competent in the area of record keeping, a substance use counselor must demonstrate the ability to:

- Compose timely, clear, complete, and concise records.
- Document information in an objective manner.
- Write legibly and/or type documents.
- Use new technologies when producing patient records.

Compose Records

Information in a clinical record is only worthwhile if it is available when it is needed. A general rule of thumb is that counselors should complete their charting requirements before they leave their workplace for the day. Local policies and hospital accreditation requirements will dictate the deadline to submit documentation, but general rules include:

- Progress notes for individual sessions are completed on the same day as sessions.
- Group notes for treatment or continuing care groups are completed within 48 hours of the group session, or by local policy. When a significant event occurs in a group, such as progress or disclosure that will modify the treatment plan, a progress note is completed the same day.
- Crisis intervention progress notes are completed the same day.
- Intake, assessment, and discharge reports are completed within 48 hours or by local policy.

Document in an Objective Manner

When writing clinical documents, care should be taken to differentiate between facts, observations, and assessments. Sources used to gather data and history of the patient's condition will include the patient, family members, the command, official military and/or legal records, medical test results, assessment questionnaires, and screening tools. When writing reports or record entries, it is necessary to identify the source of the information as that may influence the value of the data when making a diagnosis or considering the likely effectiveness of a treatment intervention. Opinions versus facts should be clearly distinguished. More information on formatting progress note entries is provided below.

Write Legibly

The patient record serves as the primary documentation of the course of a patient's treatment and is only as valuable as the usability of the information by other providers. Entries need to be made in a manner that makes them readable. Although the DHA utilizes an electronic health record, providers may be called upon to make a handwritten entry or to provide documents such as a written referral form.

Use New Technologies

At the time of this writing, DHA was implementing the use of MHS Genesis for the Military Health System (MHS). It is incumbent upon the counselor to be proficient in efficiently using the software. Ask for additional training in the use of the software from your LIP or department head.

Protect Patient Rights to Privacy and Confidentiality in Handling Records (109)

As discussed in Part III, Chapter 5, the privacy of patients who participate in substance use treatment is protected by Federal law. Various regulations govern handling patient records and disclosing information to third parties, including family members, employers, insurance companies, and other health care providers. It is imperative that counselors understand the differences imposed by different regulatory bodies and the limits on disclosing patient information.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 established guidelines for maintaining privacy of all patient records and for communication between healthcare providers. HIPAA, however, is superseded by Code 42 Confidentiality of Alcohol and Drug Abuse Patient Records. Substance use counselors need to obtain written consent from the patient in order to disclose any information except in the instances covered by the exceptions outlined in Part III, Chapter 5. Counselors need to be aware that while other health care providers are likely educated about the privacy rights of patients under HIPAA, they may not be aware of the more stringent regulations that govern substance use treatment. Counselors need to ensure proper authorization has been given by the patient before disclosing any information.

You receive a phone call in your office from Mr. Jones. He reports to be a counselor from a local church. He states on the phone that Mrs. Smith, wife of your patient AZ3 Smith, is seeing him in counseling and he understands that AZ3 Smith is in treatment for alcohol use disorder.

How should you respond to Mr. Jones?

What if your patient had told you Mr. Jones would be calling? What should you do? Discuss with your preceptor.

Confidentiality Regarding Infectious Diseases

All States have regulations that mandate the reporting of communicable diseases to the local health department. Federal regulations offer an exception to the confidentiality requirements that allow substance use treatment providers to follow state guidelines regarding communicable diseases. Counselors need to be familiar with these regulations to be considered competent in this performance domain.

The Legal Nature of Records

Patient records serve as the permanent document of what happened while a patient was in treatment. Counselors need to complete documentation with the knowledge that the records may be used by other providers to continue providing care but also by legal authorities. A well-documented record can provide support to you if called upon in a legal proceeding to recall what happened in a patient's treatment. The legal nature of the record increases the importance of completing charting in a timely manner. Programs have had legal authorities arrive with proper court orders at 5 p.m. on a weeknight and confiscate all records pertaining to a particular case. Timely documentation prevents the regret, *"If only I had put that note in the record*."

Safeguarding Records

Every treatment program and provider must have stringent procedures for safeguarding the privacy of patients, their personal information, and the actual physical record, whether it is electronic or a hard copy. Counselors need to be diligent about logging out of their computers when they leave their office. If a counselor receives written documentation from a provider or the command, best practices include scanning the documents into the electronic record and destroying the written material. Navy clinics are not to maintain secondary records.

Prepare Accurate and Concise Screening, Intake, and Assessment Reports (110)

The *TAP 21* (CSAT, 2006, p. 145) identifies the following elements as essential to screening, intake, and assessment reports:

- Psychoactive substance use and abuse history,
- Physical health,
- Psychological information,
- Social information,
- History of criminality,
- Spiritual information,
- Recreational information,
- Nutritional information,
- Educational or vocational information,
- Sexual information, and
- Legal information.

The DHA electronic record offers assessment tools and questionnaires that gather this history and is used by counselors to interview the patient. Navy SARPs may use additional screening tools not included in the DHA package. Counselors will be oriented to the specific assessment tools used at their site by program staff. The counselor is responsible for reviewing the provided information, interviewing the patient, and synthesizing the relevant material into the required reports. Care is taken to summarize the patient history in the report, while including specific information that is pertinent to the patient's diagnosis and treatment. Keep in mind that members of the treatment team will use the assessment reports as their primary source of information, counting on the counselor to have included the most pertinent information.

Record Treatment and Continuing Care Plans Consistent with Agency Standards (111)

Recording treatment and continuing care plans is influenced by two factors: quality care and regulations. Treatment programs establish standards for developing, implementing, and updating patient treatment plans based on the regulatory bodies that oversee each program. Facilities that seek accreditation under the standards of The Joint Commission on Accreditation of Healthcare Organizations may have different guidelines than those that do not. Counselors are required to identify and follow all regulations that apply to their organization.

Commitment to providing the highest quality of care means counselors will maintain current treatment plans based on the patient's clinical needs and progress in treatment and recovery. Different levels of treatment require different timelines for updating the treatment plan. For example, Level 3 patient treatment plans are often updated weekly, while Level 1 treatment plans may be updated monthly. Each site and program level will have guidelines for a counselor to follow regarding when the treatment plan should be updated for each patient.

Although military counselors do not at this time worry about third-party payers, in other settings it is vital to document the connection of the treatment plan to the assessment. Insurance companies will

not pay for treatment components that are not clearly documented as being necessary based on the patient's condition. Ongoing documentation of the purpose and patient response to treatment interventions is required.

Informed Consent

Patients have a right to understand the treatment that has been recommended to them and have any questions about their care answered by the treatment team. Counselors have an obligation to inform patients about the treatment methods being used, if they are being tested for drug or alcohol use via urine or blood samples, what use will be made of their medical records, and if they are being audio or videotaped for any reason. Patients must provide informed consent for these activities. Counselors should consult with senior program staff for training on the approved standard documents to be signed by patients and included in their records.

Observe or conduct a patient intake session. Discuss with a senior counselor or your preceptor questions that may come up when asking patients to sign the Informed Consent documents and methods for responding.

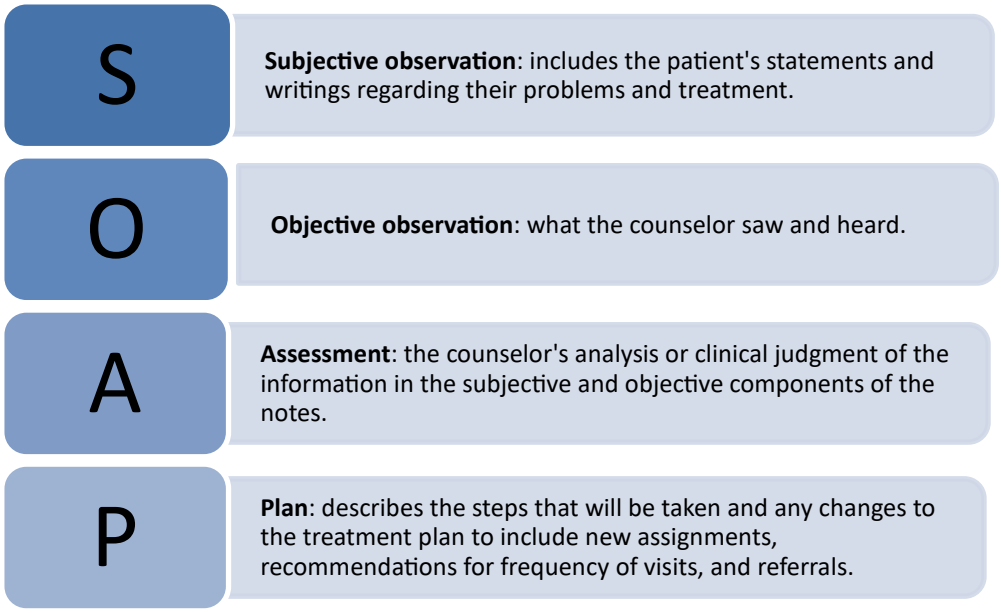
Record Progress of Patient in Relation to Treatment Goals and Objectives (112)

TAP 21 (CSAT, 2006, p. 146) states that the following skills are required to meet competency 112:

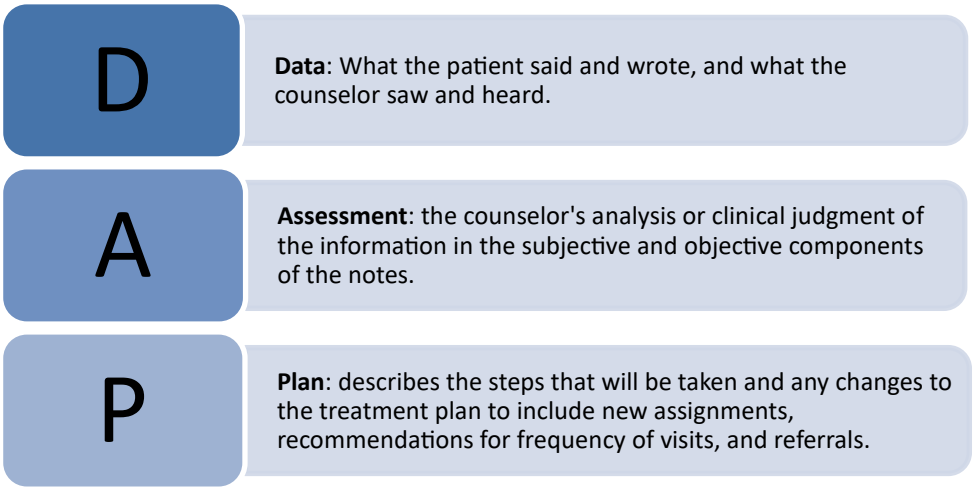
- Preparing clear and legible documents
- Documenting changes in treatment
- Using appropriate clinical terminology and standardized abbreviations
- Noting patient's strengths and limitations
- Recording patient's response to and outcome of interventions
- Recording changes in patient's status, behavior, and level of functioning
- Noting limitations of treatment provided to patient

Treatment programs use progress notes to track patient progress and connect treatment interventions and responses back to the treatment plan. Agencies generally have a standardized format for progress notes. NDACS students are trained in several note-taking methods, including the SOAP and DAP note-writing methods. Individual Navy SARPs will train counselors on the progress note format used locally.

SOAP Notes: The SOAP method has four components:



DAP Notes: The DAP method has three components:



When writing progress notes, take care to use appropriate clinical terminology and only standardized abbreviations. Another healthcare provider should be able to understand what you have written. In the case of crisis intervention, the record should clearly indicate the steps that were taken to ensure the patient's safety and that of any people affected by the crisis, as warranted. Remember the adage, *"If it isn't in the record, it didn't happen."* Should your actions and quality of care come under scrutiny, the record needs to clearly stand up as documentation of the care provided to the patient.

Prepare Accurate and Concise Discharge Summaries (113)

TAP 21 (CSAT 2006, p. 147) states that a discharge summary includes:

- Patient profile and demographics,
- Presenting symptoms,
- Diagnoses,
- Selected interventions,
- Critical incidents,
- Progress toward treatment goals,
- Outcome,
- Continuing care plan,
- Prognosis, and
- Recommendations.

The discharge summary allows the counselor to pull together the admitting data, assessment and diagnosis, treatment plan, course of treatment, recommendations, and disposition at time of discharge into one document. It serves as a summary to third parties, such as the referral sources and insurance companies, on what happened while the patient was in treatment, any additional services that may be recommended, and what can be expected to happen in the future as a result of the treatment provided. Should the patient require future services, the discharge summary may be requested by another provider in order to understand the history of prior treatments. Finally, the discharge summary can serve as a record of continuing care recommendations that can be referred to by the patient or other authorized parties concerned about their condition.

In the Navy treatment system, discharge summaries are a valuable tool. Patients may be temporarily transferred to another location to receive intensive treatment, and the referring SARP will rely on the discharge summary to relay what happened to the patient in treatment. In addition, the mobile nature of military service means that a service member may need continuing care or other services at subsequent duty stations and, again, the discharge summary will be an important method for relaying history and needs.

When writing discharge summaries, counselors should take care to summarize important information, complete the report in a timely manner, and include all measurable results and recommendations for future support or services.

Document Treatment Outcome, Using Accepted Methods and Instruments (114)

For many years, substance use treatment professionals said that treatment works, but they lacked the empirical data to demonstrate what worked, which methods were the most effective with which populations, and under what circumstances. Substantial resources have been dedicated in the last 20 years toward rectifying the lack of evaluation data. Through the establishment of competencies, such as this one, the treatment field has now formally stated that understanding, gathering, and applying the insight learned from outcome measurement data is a professional responsibility of all counselors.

When making a decision regarding outcome measurement, the counselor needs to consider what they would like to know about their program. There are several types of evaluation that can occur. One is process evaluation. Process-based evaluations are geared toward understanding how a program works and whether services are provided and implemented according to established requirements. Another is outcome-based evaluations, which seek to determine whether target populations changed their behaviors as your program had hoped and whether the program interventions had anything to do with those changes. The choice of your measurement tool and design of any measurement program is influenced by what you are trying to learn.

If you are interested in finding out if your treatment program is effective, one of the first questions that needs to be answered is how you define success. Is treatment only successful if a patient stays sober 6 months, 12 months, or 2 years? Should a 21-year-old diagnosed with an alcohol use disorder who stops abusing alcohol, has no further alcohol related incidents, and never drinks more than two drinks on any one occasion be considered a treatment failure? Can we say treatment did not have any benefit if a wounded warrior decreases their prescription pain reliever use by 50 percent, but is still considered physically dependent on the medication?

The Federal government has dedicated significant resources to educating the profession on the principles of outcome measurement and conducting studies on best practices and effective treatment. SAMSHA's *TIP 46, Substance Abuse: Administrative Issues in Outpatient Treatment* provides extensive information on outcome monitoring in Chapter 6 (CSAT, 2006). The document can be retrieved electronically at http://www.ncbi.nlm.nih.gov/books/NBK25680/.

CASE STUDY 12.1

Early on in your clinical relationship with Ryan, he questioned why you were taking so many notes during your sessions with him. He felt that what is discussed should only be between the two of you and did not like the idea that others would have access to your notes. He also asked, "What else goes into my file—what other information do you have on me besides the notes you are taking?"

How would you respond to Ryan's question? How would you explain to Ryan that any notes or records on his treatment are protected by confidentiality regulations? How can you ensure that all of your recordkeeping is concise, accurate, and relevant to the care of your patients?

Summary

No survey of treatment will find that substance use counselors joined the profession because they love to write reports and live to maintain proper medical records. The reality is, however, that reports must be written, and thorough record keeping allows us to continue to provide service to those who need help. Spending the time to develop the writing skills and establish the management techniques that will keep your records current will assist you as you progress in the counseling profession. Along

with meeting the regulatory obligations set before you, patient records are tools that can help you learn from your experience and the experience of others and, when written well, will enhance the care provided to your patients.

Learning Activities
1. Obtain your site's "Release of Information" form. Consider Case Study Patient "Ryan." Fill out the form so that you may share information with a marital counselor he is being referred to with his wife. In a role play with a senior counselor or your preceptor, request that Ryan sign the release of information.
2. Review three records of patients recently assessed at your program. Review the reports, history, and questionnaires that were available at the time that the case manager wrote the biopsychosocial assessment. Read the assessments and discuss with your preceptor how decisions are made regarding what to include in the written assessment.
3. Review 10 SARP closed records. Read the case notes, assessment, and all counselor written documentation. Make a list of statements and phrases that describe patient behavior or problems that you find useful. Review these phrases with your preceptor.
4. Review with your preceptor two discharge summaries that you have written. Discuss choices you made for including or not including information in your report. If you do not write discharge summaries in your setting, review two summaries in records of patients who received treatment at another program and have returned for continuing care.

Self-Study Questions

1. What are the six essential components of a record as identified by the *TAP 21*?

2. **True or False**? Counselors do not need to have legible handwriting if their records are electronic.

3. Which regulation was adopted to provide guidelines on communication between health care providers?

4. **True or False**? One reason for counselors to connect the treatment plan to the assessment is to demonstrate to third parties that treatment components are needed to address the patient's problems.

5. **True or False**? Counselors are obligated to inform patients of the kinds of treatment methods that will be used and the potential benefits and risks of those methods.

6. Match the following:

   a. S ___ Steps that will be taken following the patient session

   b. O ___ The counselor's analysis

   c. A ___ What the patient said

   d. P ___ What the counselor saw and heard

7. Identify three parties that might use the discharge summary.

   a. _____

   b. _____

   c. _____

8. Which type of evaluation study (process or outcome) should be conducted if you want to see if your patients have changed their behavior as a result of your treatment? Explain why.

Self-Study Answers

1. *TAP 21* identifies **release forms**, **assessments**, **treatment plans**, **progress notes**, **discharge plans**, and **discharge summaries** as the six essential components of a record.

2. **False**. Even in a system with electronic records, handwritten notes will be required for documents such as referral forms, releases of information, and others.

3. The Health Insurance Portability and Accountability Act (HIPAA) was adopted to provide guidelines on communication between healthcare providers.

4. **True**. Counselors often need to connect the treatment plan to the assessment to demonstrate to third parties that certain parts of treatment are necessary.

5. **True**. The patient always has a right to know what will be involved and the benefits and risks that are included in the methods that will be used.

6.

a.	S	__d.__ Steps that will be taken following the patient session
b.	O	__c.__ The counselor's analysis
c.	A	__a.__ What the patient said
d.	P	__b.__ What the counselor saw and heard

7. Parties that might use the discharge summary include **referral sources**, **insurance companies**, **continuing care counselors**, and **future care providers**.

8. An **outcome evaluation** is typically used to chart behavioral change.

Chapter 13 Professional and Ethical Responsibilities

Purpose of This Chapter

This chapter explores the Practice Dimension of Professional and Ethical Responsibilities.

Learning Objectives

- Adhere to established professional codes of ethics that define the professional context within which the counselor works to maintain professional standards and safeguard the patient. (115)
- Adhere to Federal and State laws and agency regulations regarding the treatment of substance use disorders. (116)
- Interpret and apply information from current counseling and psychoactive substance use research literature to improve patient care and enhance professional growth. (117)
- Recognize the importance of individual differences that influence patient behavior and apply this understanding to clinical practice. (118)

The learning objectives directly correlate with Competencies 115–123 as listed in the *TAP 21* (p. 153–158) and IC&RC Domain IV: Professional, Ethical, and Legal Responsibilities. Each competency is accompanied by a set of knowledge, skills, and attitudes that define the standard.

- Use a range of supervisory options to process personal feelings and concerns about patients. (119)
- Conduct self-evaluations of professional performance applying ethical, legal, and professional standards to enhance self-awareness and performance. (120)
- Obtain appropriate continuing professional education. (121)
- Participate in ongoing supervision and consultation. (122)
- Develop and use strategies to maintain one's physical and mental health. (123)

Introduction

TAP 21 defines professional and ethical responsibilities as "the obligations of an addiction counselor to adhere to accepted ethical and behavioral standards of conduct and continuing professional development" (CSAT, 2006, p. 153). The competencies included in this dimension provide the guidelines to maintain required standards of professionalism. The activities in this chapter will provide opportunities to identify tools to help meet these standards. Questions will be asked that will challenge you to consider circumstances that thousands of counselors have faced. The ethical

codes that are discussed offer you a framework from which to explore the many ways working in this profession will affect your life.

Adhere to Established Professional Ethical Codes (115)

There are various ethical codes counselors are obligated to adhere to based on their training, credentials, and work setting. Navy counselors sign a Code of Ethics when completing training at NDACS and again when applying for certification at the initial and advanced levels. Additionally, professional organizations and credentialing bodies require counselors to abide by a code of ethics. Examples of ethical codes that may be applicable to a substance use counselor include:

1. Code of Ethics for ADCI and ADCII Counselors
2. NAADAC—The Association for Addiction Professionals Code of Ethics: www.naadac.org
3. American Counseling Association Code of Ethics: www.counseling.org
4. State Credentialing Boards

Patient Rights and Responsibilities

All patients have rights and responsibilities related to their care that are outlined by individual SARPs. It is the counselor's responsibility to ensure that the patient is briefed on their rights and responsibilities and that any questions the patient has are answered.

Scope of Practice

Counselors have an ethical obligation to work within the scope of practice established by their credentialing body, agency, and/or government regulations. The IC&RC Domains and *TAP 21* Competencies identify the activities that are considered to be within the scope of practice of substance use counselors. State or agency policy may limit the scope of practice based on specific guidelines established in that locale. When signing the Navy Alcohol and Drug Counselor Code of Ethics, the counselor agrees to "limit my services to the areas in which I am trained and competent. I will not offer services or use techniques outside the scope of services for drug and alcohol counselors." The State of Virginia offers an example of a legislative policy which differentiates the scope of practice of licensed substance use disorder practitioners, certified substance use disorder counselors, and certified substance use disorder counselor assistants. Part of Virginia's professional code is on the following page:

"A certified substance abuse counselor shall be (i) qualified to perform, under appropriate supervision or direction, the substance abuse treatment functions of screening, intake, orientation, the administration of substance abuse assessment instruments, recovery and relapse prevention planning, substance abuse treatment, case management, substance abuse or dependence crisis intervention, client education, referral activities, record keeping, and consultation with other professionals; (ii) qualified to be responsible for client care of persons with a primary diagnosis of substance abuse or dependence; and (iii) qualified to supervise, direct and instruct certified substance abuse counseling assistants. Certified substance abuse counselors shall not engage in independent or autonomous practice."

—Code of Virginia, Title 54.1 Professions And Occupations, Section 54.1-3507.1
http://law.onecle.com/virginia/professions-and-occupations/54.1-3507.1.html

CASE STUDY 13.1

During one of your sessions with Ryan, he begins to talk about being a victim of child abuse when he was about 8 or 9 years old. You are not sure what to do or what to say, and the training you received did not include much about helping victims of child abuse.

What would you say to Ryan? Do you feel you could help Ryan despite your lack of experience? Why or why not? To whom would you go for support and/or advice?

Boundary Issues

Counselors have a professional and ethical obligation to maintain appropriate boundaries with patients and to keep a check on the possibility of dual relationships. "Dual or multiple relationships, either sexual or nonsexual, occur when counselors assume more than one professional role or combining professional and nonprofessional roles." (Corey, 2020, p. 49). Not all dual relationships are avoidable. For example, when serving as a counselor on an aircraft carrier, a counselor may well find that they are on duty with a person who was screened in the shipboard SARP.

Counselors need to be aware of the complexities of dual relationships and the risks to the counselor/patient relationship. When possible, counselors should avoid engaging in dual relationships. When they cannot be avoided, as in the situation described above, it is important to seek supervision and monitor your behavior closely.

Consider your SARP, the command and installation where you work, and your personal lifestyle. Identify at least three circumstances in which you might experience a dual relationship with a SARP patient. Discuss these situations with your preceptor and develop a plan for addressing them, if needed.

Roles of Counselors, Peer Counselors, and Sponsors

People seeking recovery from addiction may come in contact with many helpers serving in different roles. It is important for counselors to understand the differences in these roles and to adhere to the assigned role when working at a Navy SARP. This is of specific importance to any counselors who are in recovery themselves and active in a 12-Step Fellowship. The chart below is a simple guide to role differentiation (CSAT, 2009).

Role	Activities	Training/Credentials
Sponsor	A member of a mutual aid group, such as Alcoholics Anonymous, who guides a person through the steps or principles of a particular recovery program. This is a volunteer role and, per the principles of 12-Step Programs, does not involve the exchange of money.	Is a member of the support group, generally with significant period of recovery.
Recovery Coach/Peer Counselor	An individual who serves as a mentor and provides encouragement, support, and motivation to another who is seeking to establish or strengthen their recovery. Although using their own recovery as a model, a recovery coach does not generally advocate any one road to recovery but supports the person as they seek the changes they want to make in their life. Peer counselors may be volunteers or be paid for their service by the individual or through an agency.	None mandated. Training programs are being developed by different organizations. No government oversight at the present.
Counselor	A professional role delivered by a trained person under the guidelines of a state credentialing body. Tasks of a counselor include screening, assessment, treatment, and counseling with the counselor in the "expert" role.	Training ranges from several hundred hours to graduate level. Use of title regulated by state government.

Policies for Addressing Alleged Ethical Violations

Patients have the right to file a complaint with the Navy command or a counselor's credentialing board should they believe a counselor has behaved in an unethical manner. Additionally, counselors have a professional and ethical obligation to report another member of the team if there is evidence that ethical violations have occurred. In the Navy, allegations of ethical violations may be reported to the head of the Navy Certification Board. Counselors should also be aware of the procedures of the applicable credentialing bodies for reviewing allegations of ethical violations.

CASE STUDY 13.2

When checking your Facebook page, you notice that one of your fellow counselors has a picture on his "wall" that shows him at a party with what clearly looks like a beer in his hand.

Are you obligated to report this? If so, to whom would you report this? What would you report? What would you say to this counselor?

Nondiscriminatory Practices

The ADCI and ADCII Code of Ethics states:

> *In the execution of my duties, I will not discriminate against any person(s), e.g., patients, staff, or any recipient of professional services. I will not engage in any action that violates the civil and/or legal rights of person(s).* (Para b.5)

It is important for counselors to understand how subtle behaviors may influence a patient's perception regarding a counselor's ability to be fair, open, and nondiscriminatory. For example, a patient who has no religious affiliation or beliefs may perceive that they will be judged by a counselor who has a religious image on their wall or a scriptural text open on their desk.

In addition, a patient may carry viewpoints or attitudes about particular kinds of behaviors or beliefs which the counselor finds unacceptable. A counselor may find it difficult to listen to a patient disclose a history of violent abuse or may have difficulty interviewing a patient accused of a violent crime. It is important to discuss limits to objectivity in supervision. If a counselor cannot suspend judgment when working with a patient, it is imperative that this be discussed with the program director or clinical preceptor.

Mandatory Reporting Requirements

As discussed in Part III, Chapter 5, Service Coordination: Implementing the Treatment Plan, the information disclosed by military members in a treatment setting is protected by federal confidentiality regulations, except in the case of certain areas covered under The Privacy Act Statement.

Adhere to Federal and State Laws and Agency Regulations Regarding Treatment (116)

Counselors have an ethical responsibility to know and apply all federal and state laws and agency regulations that apply to the delivery of substance use treatment. The lack of knowledge of an applicable confidentiality regulation does not relieve a provider of their requirement to follow such regulations. Counselors should seek out information on the regulations that apply in the setting and the population you serve. This is especially true when working in a setting that serves military family

members and retirees. Additionally, counselors should seek supervision as policies change. The Clinical Preceptor can serve as a resource, as well as the military legal officer for the SARP's command.

CASE STUDY 13.3

One evening when you are off duty, you and your partner are shopping at a local mall. While you are walking through the mall, Ryan appears and walks up to you and starts talking, expecting you to introduce your partner to him.

What do you do? What do you say to Ryan, and how do you explain who he is to your spouse?

Interpret and Apply Research Literature to Improve Care and Enhance Professional Growth (117)

Substance use counseling is a dynamic area of study in which progress is made almost weekly with the release of the latest scientific findings regarding brain chemistry, effective treatment interventions and protocols, innovations in prevention and intervention, and an understanding of the nature of psychoactive substance use. Counselors have a professional obligation to seek out new information and remain current on research literature. Membership in professional organizations, such as NAADAC—The Association for Addiction Professionals, is one means for receiving communication regarding advances in the profession. Additionally, many email lists and news e-blasts are available to addiction professionals through SAMHSA and other government entities.

Identify one professional organization and three sources for research updates that would offer you current information on addiction research. Discuss with your preceptor and register for at least one email list.

Recognize and Apply Individual Differences That Influence Patient Behavior (118)

Counselors have an ethical responsibility to become knowledgeable about individual differences among people that may influence behavior. Careful consideration must be made to not make clinical judgment that a patient's behavior indicates illness when, in fact, it is merely indicative of a person's individual or cultural differences:

While counselors share being part of the military culture with their Navy patients, they will find themselves working with patients who are culturally different from themselves. Additionally, counselors need to understand that being part of the same ethnic group does not immediately ensure an understanding of the cultural uniqueness of a patient. For example, a patient of Asian

heritage who was born and raised in California will have experienced different cultural influences than a person who grew up in the Philippines and immigrated to the United States as an adult. Counselors will benefit from ongoing training on the ethnic groups that comprise the U.S. military. A variety of sources report annually on the ethnic make-up of the Department of Defense by service. These can be found through a routine internet search.

Cultural Competency

TIP 27 (CSAT, 1998) identifies five elements to becoming culturally competent:

- Valuing diversity
- Making a cultural self-assessment
- Understanding the dynamics when cultures interact
- Incorporating cultural knowledge
- Adapting practices to the address of diversity

In addition, *TIP 27* references that culturally competent case managers have the

- Ability to be self-aware
- Ability to identify differences as an issue
- Ability to accept others
- Ability to see patients as individuals and not just as members of a group
- Willingness to advocate
- Ability to understand culturally specific responses to problems

Becoming culturally competent is not something that just happens, but requires study, dialogue, and practice across your lifespan as a counselor. Your willingness to explore your cross-cultural knowledge and integrate learning about diverse groups will not only affect your work as a counselor but will broaden your horizons throughout your life.

It is useful to conduct a self-assessment of your thoughts and attitudes regarding cultural differences as you establish a therapeutic foundation and style. Three tools are provided in Supplemental Chapter 7: Cultural Competency to assist you in exploration of your cultural competence. Each was developed by Peter Bell, a nationally recognized speaker on substance use in the African American community. The tools are:

1. Working with Diversity: Your Personal Assessment Tool
2. The Cultural Adjustment Questionnaire
3. The Racial Identity Questionnaire

Dynamics of Family Systems in Diverse Cultures

When examining families and family life, assumptions regarding what defines "family" must be explored. The components of a family and the dynamics that make up a healthy family system vary across cultures. As an ethically competent counselor, it is important to consider your biases and seek additional information, training, and supervision to prepare yourself for working with families.

> In the 21st century, much public debate has occurred regarding the definition of family. *Does family mean two opposite sex parents and their biological children? Does it include more than two generations? Can it include a same-sex couple with adopted children?*
>
> Your personal viewpoint on these issues becomes relevant when a patient enters your office whose family makeup is different from the way you have traditionally defined family.

Signs, Symptoms, and Patterns of Violence Against People

Research indicates that using alcohol and other substances has a strong correlation with violence. A meta-meta-analysis published in 2017 found a significant relationship between substance use and violence. The study found a medium size effect across different populations, substances, and types of violence. The relationship existed both for perpetrators and victims of violence (Duke, et.al., 2017).

A discussion of violence against people in a chapter on professional responsibilities is warranted due to the significant correlation with substance use. A substance use assessment provides an opportunity to identify a history or risk of violence that may not have received previous attention. To ignore this topic in the assessment process would be neglecting an issue that could have a significant effect on the patient's recovery. Part of a thorough assessment includes asking questions about a patient's experience as a victim or perpetrator of violence. Patients may bring a history of victimization as a child or spouse, or they may have a history of perpetrating violence within the home.

Counselors also need to be aware of risks of violence toward others outside the home, such as in a bar or in the barracks. When completing a biopsychosocial history, it is important to identify the role of alcohol or other substances in a patient's history of violence and consider the ongoing risks based on the patient's response to treatment and ability to remain abstinent.

> *How does your program address issues of dating violence and alcohol use? Do you discuss the risk of being a victim of date rape when drinking? Do you discuss the risk of being accused of date rape when drinking? Identify how/if these issues are addressed in your program. If they are not being addressed, discuss methods for integrating these issues with your preceptor.*

Risk Factors Related to Potential Harm to Self or Others

Counselors have an obligation to be aware of the risk factors related to a person potentially harming themselves and others. Questions regarding a history of violence as either a perpetrator or victim and whether substances were involved in the history should be included in the initial assessment. If such

a history exists, it should be documented in the patient record and discussed during case presentation, so you receive support and supervision regarding taking steps required in regard to safety. Generally, in the Navy treatment system, a person with a history of violence could be referred for a full mental health evaluation by a Licensed Independent Practitioner. If a patient is at risk for harming themselves or another, the counselor should seek immediate supervision through the clinical chain of command or follow SARP procedures. A counselor should not wait for the clinical preceptor to return to the site later in the week or month to discuss proper procedures.

Patient Needs and Motivation

When working with patients, it is important to consider what motivates their behavior and their presence in treatment. Evaluating a patient's needs, values, stage of change, and motivation for treatment are important in the screening process as well as ongoing throughout treatment. A patient who has many unpaid bills and is afraid they will lose their job if they go to treatment may be focused on these basic needs. Asking them to talk about their self-esteem and how they take care of their inner child will not help you connect with that patient and/or motivate them for treatment. Asking a woman who is being physically abused by her spouse to participate in couples counseling not only does not help meet her safety needs but may put her at increased risk of danger.

Ethical guidelines require counselors to not impose their values and priorities on their patients. Section A.4.b of the 2014 Ethical code of the American Counseling Association states "Counselors are aware of their own values, attitudes, beliefs, and behaviors and avoid imposing values that are inconsistent with counseling goals" (American Counseling Association). Counselors need to continually engage in self-evaluation in order to be aware of their own values, biases, beliefs, and behaviors that could impact the counseling relationship with patients. Engagement with a team of other providers and supervision relationships assist a counselor in this process of self-evaluation and guidance for how to handle any issues that may arise. Considering the patient's needs and working to offer treatment services that meet their goals and needs is in keeping with this ethical guideline.

Use a Range of Supervisory Options to Process Concerns about Patients (119)

This competency addresses the need for supervision in order to process feelings about patients. In many instances, the very personal characteristics that lead someone to want to work in a helping profession may also lead them to over identify with or hold onto feelings and concerns about the people they are trying to help.

Effective supervision provides many opportunities for counselors to explore motivations, thoughts, and feelings regarding the counseling profession and individual patients in particular. This self-exploration may have started while training at NDACS. Corey, et al. (2010, p. 53) provide some questions to ask regarding your openness to self-exploration:

- What kind of self-exploration have I experienced prior to or during my training?
- How open am I to examining my own personal characteristics that could be either strengths or limitations in my role as a counselor?
- At this time, what am I doing about my personal problems?

How would you answer the questions posed by Corey et al.? Are you taking full advantage of the clinical supervision opportunities offered at your SARP? If not, what is getting in the way? Discuss with your preceptor.

Supervision can help counselors identify blinders worn when assessing patients, emotions experienced when working with different types of people, and reactions when treatment outcomes may not be what were hoped. Reactions to patients may easily be processed in individual or group supervision or may be an indication of areas that require further exploration in therapy. A clinical preceptor can help identify options to further explore issues of career choice, personal growth, and countertransference issues. Preceptors are not meant to provide counseling but can help facilitate a referral or identify professional resources in the community.

Conduct Self-Evaluations of Professional Performance (120)

Built into the Navy Clinical Preceptorship Program is the opportunity to meet this counselor competency. The program calls for Navy counselors to be evaluated quarterly based on the competencies detailed on the Quarterly Feedback Form (QFF.) This evaluation is designed to be a cooperative process between the counselor and preceptor, whereby strengths and weaknesses are identified, and a skill development plan is established to meet professional goals. Just as best practices for treatment planning suggest the process is most effective when "patient driven," so should the counselor evaluation and skill development plan process be "counselor driven."

Obtain Appropriate Continuing Professional Education (121)

Navy counselors are provided opportunities to participate in ongoing education regarding addiction and the counseling profession. The U.S. Navy Certification Board establishes the standards for certification as an Alcohol and Drug Counselor, Levels I and II, and Certified Clinical Supervisor. To obtain these credentials, minimum standards regarding education, delivery of clinical hours, and receipt of clinical supervision must be met. Annual continuing education must be completed to maintain the credentials. It is the responsibility of each counselor to identify the requirements for credentialing and to keep those credentials current. Ethical practices require that a counselor not claim any credential that has not been granted or kept current.

Key materials needed for the Navy counselor to plan for obtaining and maintaining credentials are the credential application, Individual Development Plans, Quarterly Feedback Forms, and certificates of completion of educational sessions. Education may include conferences, seminars, home-study programs, or some college courses. This manual does not provide the complete list because requirements can change over time.

Additional Practice

Obtain the current ADCI or ADCII application and review the requirements for certification.

Put together a Credentials Portfolio. This can be an electronic portfolio or a binder or notebook. This is a place where you can maintain records of your clinical supervision, skill development plans, and completed continuing education.

Review the materials you have assembled and compare them to the requirements on the certification application.

Discuss with your preceptor the additional milestones that must be achieved for you to apply for the next level of certification.

Participate in Ongoing Supervision and Consultation (122)

Participation in clinical supervision is the obligation of every substance use counselor. Certification and licensing boards require that counselors participate in clinical supervision to become credentialed. Additionally, many state credentialing bodies and the ethical codes of professional organizations call for the ongoing receipt of clinical supervision. The Navy's Code of Ethics for Alcohol and Drug Counselors states:

> I will continue to be involved in the assessment of my personal strengths, limitations, and effectiveness. I agree to continue professional growth through education, training, clinical supervision, and clinical preceptorship (Para d.3).

In addition to being a standard in the ethical code, Navy counselors are mandated by military instructions to participate in clinical supervision. These include DoD INST 1010.04 and DHA-PI 6025.15.

Supervision options may include individual and/or group supervision, obtaining additional training on specific skills or content areas, working with a senior co-facilitator to help build group skills, and direct observation of clinical work by a preceptor. All of these options are available in the Navy SARP program. A list of those who may play a role in clinical supervision is outlined below.

Clinical Preceptor

The Clinical Preceptor's role is to provide training, mentoring, and supervision. Preceptors work with counselors to develop an individualized development plan to achieve competency in the core functions and domains. The preceptor is available to assist in specific skill development and to discuss issues related to professional development and transition to a new profession. The preceptor has no direct responsibility for patient care or records.

SARP Program Director

The role of the SARP Program Director in clinical supervision depends on the structure of the SARP and the credentials of this staff member. A Certified Clinical Supervisor (CCS) or clinician with other advanced credentials may provide clinical supervision.

Licensed Independent Practitioner (LIP)

This Navy officer or civilian licensed professional is responsible for the clinical care delivered in the SARP. The LIP makes the final diagnosis on each patient, reviews and signs off on patient records, and approves the treatment plan. The LIP may work with the preceptor to identify competencies that need additional skill development.

Interdisciplinary Team Members

The Interdisciplinary Team is made up of a variety of different professionals and could include a psychologist, chaplain, legal representatives, and family advocacy counselors, in addition to the SARP counselors. Although these team members may not provide supervision, they support professional growth through the team discussions.

Develop and Use Strategies to Maintain One's Physical and Mental Health (123)

The final competency listed in *TAP 21* is number 123. It may deserve a more prominent location because the ability to meet this competency will have a direct effect on your ability to master the many demands of alcohol and drug counseling. Maintaining good physical and mental health is important for your personal well-being and to help prevent burnout.

It is helpful to conduct regular self-assessments of the degree of balance in your life. Consider the following questions:

- Are you in good health? Do you get routine health exams? Have you had the routine preventive exams recommended for your sex and age group; e.g., prostate exam, mammogram, etc.?

- Do you have a regular physical fitness program? How many times a week do you exercise? Are you enjoying your routine, or has it become stale? When was the last time you changed your exercise routine?
- Are you eating a balanced diet? Is your weight within a healthy range? Would you benefit from seeing a nutritionist?
- Are you in recovery from substance use? If so, are you working your recovery program? If not, what steps do you need to take? See NAADAC Ethical statement below.
- If you drink alcohol, do you maintain moderate, social limits to your intake?
- Do you spend time with family or friends? Would your loved ones answer the question the same way? When was the last time you and your loved ones had fun together?
- What do you do to relax? Do you have any hobbies? When was the last time you participated in them?
- Do you have a spiritual program in your life? Are you actively using the components of that program? Such components might include meditation, reading, prayer, religious observances, etc.

The Central East Addiction Technology Transfer Center (CEATTC) published a pamphlet titled *Work and Well-Being: A Guide for Addiction Professionals* in 2017. You can download this manual at https://attcnetwork.org/centers/central-east-attc/product/work-and-well-being-guide-addiction-professionals.

As a helping professional, you are a key player as your patient learns what it means to become healthy and live free of drug and alcohol use. Whether in recovery from addiction yourself or not, your use of substances has the potential to affect the way you work with others and the way others see you. The NAADAC Code of Ethics includes a standard directly related to the use of substances by addiction professionals:

Addiction professionals, whether they profess to be in recovery or not, must be cognizant of ways in which their use of psychoactive chemicals in public or in private might adversely affect the opinion of the public at large, the recovery community, other members of the addiction professional community or, most particularly, vulnerable individuals seeking treatment for their own problematic use of psychoactive chemicals. Addiction professionals who profess to be in recovery will avoid impairment in their professional or personal lives due to psychoactive chemicals. If impairment occurs, they are expected to immediately report their impairment, to take immediate action to discontinue professional practice, and to take immediate steps to address their impairment through professional assistance.

Summary

Although this chapter covers the last of the Practice in the *TAP 21* manual, it is very likely the most important. A rule of thumb in the helping professions is to "do no harm." The ethical codes of your profession provide you with the guidelines from which to operate. Clinical supervision and continuing education, along with maintaining a healthy lifestyle, are the tools that will assist you in achieving your goals in an ethical and professional manner. With these tools at your disposal, you will have the opportunity to guide your patients toward lasting change.

Learning Activities
1. Download copies of the Code of Ethics for ADCI & II counselors, NAADAC, and ACA. Review the three codes and identify any differences between the three documents. Discuss with your preceptor. Are there any areas of these codes of ethics that are a challenge for you? Discuss with your preceptor.
2. Contact the Family Advocacy Program on your base. Ask if they are offering any educational programs on intimate partner violence and make arrangements to attend.
3. Complete the questions under Competency #123 and share your answers with your preceptor or a person close to you. If you need to get on track with maintaining balance in your life, reach out for assistance.
4. Review the current Privacy Act document used by your site. Discuss all reportable information with your Preceptor. Role play how you would tell a patient that you had to disclose some information they have shared with the command.

Self-Study Questions

1. Match the following ethical standard with the correct organization:

a. NAADAC	__The primary responsibility of counselors is to respect the dignity and to promote the welfare of patients.
b. American Counseling Association	__The addiction professional understands that the ability to do good is based on an underlying concern for the well-being of others.
c. ADCII Navy Counselor	__I am responsible for my own conduct at all times. This includes, but is not limited to, my physical, emotional, and mental well-being as well as the use of alcohol and other mood-changing substances.

2. Which of the following is not one of the five elements to becoming culturally competent as defined in *TIP 27*?
    a. Valuing diversity
    b. Making a cultural self-assessment
    c. Making friends with people from another culture
    d. Incorporating cultural knowledge
    e. Adapting practices to the address of diversity

3. **True or False**? If a patient threatens violence, the counselor should first contact their preceptor to ask for guidance.

4. Participating in your own individual counseling can help you…
    a. Explore your feelings about patients
    b. Deal with countertransference issues
    c. Both (a) and (b)

5. Identify three kinds of documents that could be maintained in a Credentials Portfolio.
    a. _____
    b. _____
    c. _____

6. The Navy mandates participation in clinical supervision through
    a. Navy Instructions
    b. Counselor Ethical Codes
    c. Both (a) and (b)

Self-Study Answers

1. Match the following ethical standard with the correct organization:

   a. **NAADAC**: The addiction professional understands that the ability to do good is based on an underlying concern for the well-being of others.
   b. **American Counseling Association**: The primary responsibility of counselors is to respect the dignity and to promote the welfare of patients.
   c. **ADCII Navy Counselor**: I am responsible for my own conduct at all times. This includes, but is not limited to, my physical, emotional, and mental well-being as well as the use of alcohol and other mood-changing substances.

2. (C) Making friends with people from another culture is not one of the elements identified in *TIP 27*. The fifth element identified is "understanding the dynamics when cultures interact."

3. **False**. Navy counselors should receive supervision from their clinical chain of command when someone threatens violence.

4. (C) Participating in your own individual counseling can help you both (a) explore your feelings about patients and (b) deal with countertransference issues.

5. Documents that may be maintained in a Credentials Portfolio may include Credentialing applications, Individual Development Plans, Quarterly Feedback Forms, Certificates of Attendance for Continuing Education, and college transcripts.

7. (C) The Navy mandates participation in clinical supervision through (a) Navy Instructions and (b) Counselor Ethical Codes.

Part IV: Supplemental Chapters

The following chapters offer content on several topics that are of importance to the delivery of competent substance use services. These topics cover information that is either outside a specific domain, or crosses over many domains. When applicable, the corresponding TAP-21 competencies and IC&RC domain have been identified.

Supplemental Chapter 1: Substance Use Disorders and DSM-5 Diagnostic Criteria

Purpose of This Chapter

This chapter reviews the Practice Dimension of Clinical Evaluation by focusing on Competency 30 as it applies to new diagnostic criteria in the DSM-5.

The learning objectives directly correlate with Competency 30, as listed in the *TAP 21* (pages 43) and IC&RC Domain II: Evidence-Based Screening & Assessment.

Learning Objectives

- Apply accepted criteria for diagnosis of SUDs in making treatment recommendations. (30)

Introduction

Screening and assessment are defined in the *TAP 21* and covered in the Navy Counselor Workbook. As accepted diagnostic criteria for substance use disorders changes and evolves, counselors must maintain a knowledge base that is up to date with current accepted diagnostic standards and appropriate criteria, as well as care and treatment options available to patients, before applying a diagnosis.

The purpose of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM) is to describe mental health disorders in such a way that care providers with various educational backgrounds and professional contexts can communicate effectively about and make consistent diagnoses of behavioral health disorders. Counselors must be familiar with the most current diagnostic criteria as published in the DSM. This includes both substance use disorder diagnostic criteria as well as treatment of co-occurring disorders, measurement of cross cutting symptoms, and knowledge of the coding classification system.

Based on advancements and research in the field, the DSM has gone through multiple revisions. In the most recent addition, the DSM-5, not only have the diagnostic criteria for substance use disorders undergone changes, but so has the overall method of therapy and diagnosis. It is the counselor's responsibility to maintain the knowledge base in order to apply diagnostic skills and recommend treatment plans, effectively and with a high level of reliability, using the DSM-5.

History of the DSM

In the decades prior to the DSM, mental health diagnoses consisted of such classifications as "Insane," "Lunatic," "Imbecile," and "Idiot." The first attempt at collecting mental health information was published in 1844 and was based on a U.S. consensus of the frequency of institutionalized patients falling into the idiocy/insanity category.

It was not until 1952 that the first DSM was published. The purpose of this first document was to establish an understanding of human behavior and definition of behavioral health disorders and to promote research in the mental health field. During the first decade of use, the DSM was not well received. Eventually, a need to objectify the nature of diagnoses led to the development of the DSM-II in the mid-60's, which moved toward medicalizing, dehumanizing psychiatry. This movement was continued in the DSM-III, published in 1980, in which therapy was condition-focused, rather than patient-focused.

In the late 80's, the DSM III-R refocused on the person by creating a multi-axial diagnostic review in order to describe patients in a more individualized manner. Consistent with the coding physicians use in other medical specialties, the ICD-9-CM coding system was also developed for this version of the DSM. From 1994-2000, the DSM-IV and DSM-IV-TR were developed. The fourth version of the DSM reflected the rapidly growing field of epidemiology, and specifically how it relates to human behavior. The DSM-IV-TR was developed as a response to the overuse of the NOS (not otherwise specified) diagnosis and overlapping diagnostic categories present in the DSM-IV. The DSM-IV-TR also reflected, for the first time, cultural and ethnic sensitivity.

History of SUDs in the DSM

Just as each successive version of the DSM has evolved to account for shortcomings of the preceding manual(s), so too has the perspective of SUD's in the DSM. Alcoholism was a distinct diagnosis in the DSM-I and classified with personality disorders. The DSM-II recognized alcoholism in patients whose alcohol intake was great enough to damage their physical health, social function, or as a prerequisite to normal, daily functioning. Three classifications of alcoholism existed: Episodic excessive drinking, Habitual excessive drinking, and Alcohol addiction.

The DSM-III removed Alcoholism from the diagnostic categories and instead divided it into two categories of diagnosis: abuse and dependence. Substance Abuse and Dependence were the first diagnostic criteria in the DSM to be based on research data, and both the DSM-IV and DSM-IV-TR continued to spur research in the area of substance use which has become the basis of the Substance-Related Disorders category in the DSM-5.

Introducing the DSM-5

The DSM-5 defines a mental disorder as "a syndrome characterized by clinically significant disturbance in an individual's cognition, emotional regulation or behavior that reflects a dysfunction in the psychological, biological, or developmental process underlying these functions. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities." The goal of the DSM-5 is to correct several major criticisms of the DSM-IV-TR:

Conceptualizing Diagnosis. Diagnosis is recognized as a fluid process that can take up to, or more than, 6 months to define as therapists get to know patients rather than a one-time event.

Removing NOS. The removal of the Not Otherwise Specified category will eradicate overuse of this "catch-all" category. Instead, NEC (Not Elsewhere Classified) will be used, primarily for early diagnosis before a definitive category has been selected.

Emphasis on Better Treatment. The development of treatment plans are addressed with less medication. Awareness of at-risk behaviors is increased, with a priority on diagnosis accuracy and consistency, as well as reduced stigma associated with mental disorders.

Organization of the DSM-5

The DSM-5 unabridged version is organized into 4 sections (including a preliminary section) and an Appendix. The preliminary section instructs users on the classification system. Until October 2015, the ICD-9-CM and ICD-10-CM classification systems were used in conjunction with one another such that the ICD-10-CM code is listed in parenthesis next to the ICD-9-CM code and specifiers follow. ICD-11-CM classification system began being used as of January 2022 and has slowly been implemented. Future revisions of the DSM will include updated ICD classifications as both systems are revised and updated. The preface in the preliminary section of the DSM alerts users to changes in the chapter organization to reflect a lifespan approach and indicates how scientific advancements in areas related to neuroimaging, neuroscience, and pharmacology have impacted our knowledge of disorders, particularly that of SUDs.

Rational for significant changes to the DSM-5 and basic manual use is addressed thoroughly in Section I. The DSM-5 has moved away from a multi-axial system. Instead, principal diagnoses are made based on the issue(s) that brought the patient into therapy, with other diagnoses listed secondarily. Separate notations are entered to account for psychosocial and contextual factors and disability severity. Clinical case formulation is based on patient history and these social, psychological, and biological contributing factors. A clinical case is then used to create a comprehensive treatment plan.

Section II is likely the most useful section for Navy counselors. It includes diagnostic criteria and codes for 20 Disorder Categories. Disorder categories are arranged in order of the lifespan so that disorders associated with childhood come before adulthood and older age, and classifications that share similar symptoms are located near one another. For example, Substance-related & Addictive Disorders is located next to Disruptive, Impulse Control and Conduct Disorders and Neurocognitive Disorders as there is a tendency for patients to be comorbid or show cross-cutting symptoms. A section to assist with medication management in mental disorders is also included in Section II.

Section III consists of tools and techniques to make diagnoses more consistent and sensitive to cultural contexts. Measures of cross-cutting symptoms aid in the recognition of co-occurring

disorders and the determination of appropriate specifiers. However, the Navy will adapt public domain assessments other than those used in the DSM-5.

The Appendix highlights the differences between the DSM-IV and -5 and other helpful information such as definitions of terms and concepts present throughout the DSM-5. Also provided are an alphabetical and numerical listing of diagnoses and codes.

Substance-Related and Addictive Disorders in the DSM-5

Substance Related and Addictive Disorders in the DSM-5 includes both Substance and Non-Substance Related Disorders. Substance-related disorders cover 10 classes of drugs:

- Alcohol
- Caffeine
- Cannabis
- Hallucinogens
- Inhalants
- Opioids
- Sedatives, hypnotics, anxiolytics
- Stimulants
- Tobacco
- Other substances

Two categories of substance-related disorders exist: *substance-induced* disorders and *substance-use* disorders. Substance-induced disorders may include intoxication, withdrawal, and other substance/medication-induced mental disorders, such as substance-induced psychotic or depressive disorders.

Criteria for substance intoxication and withdrawal are included in the substance-specific sections of the DSM-5. The general criteria are below and can also be found in the DSM-5:

Substance Intoxication Criteria

The development of a reversible substance-specific syndrome due to the recent ingestion of a substance.

The clinically significant problematic behavior or physiological changes associated with intoxication are attributable to the physiological effects of the substance on the central nervous system and develop during or shortly after use of the substance.

The symptoms are not attributable to another medical condition and are not better explained by another mental disorder.

Substance Withdrawal Criteria

The development of a substance-specific problematic behavioral change, with physiological and cognitive concomitants, that is due to the cessation of, or reduction in, heavy and prolonged substance use.

The substance-specific syndrome causes clinically significant distress or impairment in social, occupational, and other important areas of functioning.

The symptoms are not due to another medical condition and are not better explained by another mental disorder.

The primary component of a substance use disorder is "a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems." There are four separate groupings of criteria for a substance use diagnosis. The presence of two or more substance use criteria occurring in the same 12- month period must be present for a diagnosis.

These groupings include:

- Impaired control
- Social impairment
- Risky use of the substance
- Pharmacological criteria (including tolerance and withdrawal)

Diagnostic Criteria in the DSM-5

The approach to therapy and diagnosis in the DSM-5 is a process, or relationship oriented one. Therapy begins much the same way as a relationship does, with unknowns. It is the counselor's job to get to know the patient and to treat diagnosis as an ever-present process in the therapeutic relationship. This means diagnostic impressions may change as new behaviors and information unfold.

A SUD diagnosis lies on a continuum in the DSM-5; severity is measured by number of criteria endorsed and is included in the ICD-10-CM codes. These range from: No disorder (0-1); Mild disorder (2-3); Moderate (4-5); to Severe (6 or more). This means a person can be in recovery from a substance use disorder for long enough to be removed from the continuum, or, in other words, have no SUD diagnosis.

Codes for SUDs indicate the class of substances, but the name of the specific substance should be recorded. This is also true if there is no category designated to a specific substance, i.e., spice or anabolic steroids; the diagnosis can still reflect a SUD and the specific substance should follow the code. In this way, diagnoses reveal more so counselors can communicate with one another about a patient more easily.

Specifiers are used to provide information about where the patient falls in the treatment process and, as such, may change during the course of treatment as a patient progresses. For SUDs, specifiers should indicate severity (mild, moderate, or severe), and whether a patient is in early remission, sustained remission, or in a controlled environment. Notations are used to indicate stressors. Common stressors include:

- Problems with primary support group
- Problems related to the social environment
- Educational problems
- Occupational problems
- Housing problems

- Economic problems
- Problems with access to healthcare services

A substance use disorder can be diagnosed for all 10 classes of drugs except for caffeine. Refer to the DSM-5 for specific criteria for different substances. Listed below are the specific criteria for alcohol use disorder, alcohol intoxication, and alcohol withdrawal.

Alcohol Use Disorder

Diagnostic Criteria. A problematic pattern of alcohol use leading to clinically significant impairment or distress, as manifested by at least 2 of the following, occurring within a 12-month period:

1. Alcohol is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control alcohol use
3. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
4. Craving (a strong desire/urge) to use alcohol.
5. Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
7. Important social, occupational, or recreational activities are given up or reduced because of alcohol use
8. Recurrent alcohol use in situation in which it is physically hazardous
9. Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of alcohol to achieve intoxication or desired effect
    b. A markedly diminished effect with continued use of the same amount of alcohol
11. Withdrawal, as manifested by either of the following:
    a. The characteristic withdrawal syndrome for alcohol (refer to Criteria A and B of the criteria set for alcohol withdrawal, pp. 499-500)
    b. Alcohol (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms

Specify if:

- **In early remission.** After full criteria for alcohol use disorder were previously met, none of the criteria for alcohol use disorder have been met for at least 3 months, but for less than 12 months (with the exception that Criterion 4 may be met).
- **In sustained remission.** After full criteria for alcohol use disorder were previously met, none of the criteria for alcohol use disorder have been met at any time during a period of 12 months or longer (with the exception that Criterion 4 may be met).

Specify if:

- **In a controlled environment.** This additional specifier is used if the individual is in an environment where access to alcohol is restricted.

Specify current severity:

- **Mild**. Presence of 2 – 3 symptoms
- **Moderate**. Presence of 4 – 5 symptoms
- **Severe**. Presence of 6+ symptoms

ALCOHOL INTOXICATION

Diagnostic Criteria.

A. Recent Ingestion of alcohol.

B. Clinically significant problematic behavioral or psychological changes (e.g., inappropriate sexual or aggressive behavior, mood liability, impaired judgment) that developed during, or shortly after, alcohol ingestion.

C. One (or more) of the following signs or symptoms developing during, or shortly after, alcohol use:
   a. Slurred speech
   b. Incoordination
   c. Unsteady gait
   d. Nystagmus
   e. Impairment in attention or memory
   f. Stupor or coma

D. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication with another substance.

ALCOHOL WITHDRAWAL

Diagnostic Criteria.

A. Cessation of (or reduction in) alcohol use has been heavy and prolonged.

B. Two or more of the following, developing within several hours to a few days after the cessation or (or reduction in) alcohol use described in Criterion A:
   a. Autonomic hyperactivity (e.g., sweating or pulse rate greater than 100 bpm)
   b. Increased hand tremor
   c. Insomnia
   d. Nausea or vomiting
   e. Transient visual, tactile, or auditory hallucinations or illusions
   f. Psychomotor agitation
   g. Anxiety
   h. Generalized tonic-clonic seizures

C. The signs or symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The signs or symptoms are not attributable to another medical condition and are not better explained by another mental disorder, including intoxication withdrawal from another substance.

Specify if:

- **With perceptual disturbances.** This specifier applies in the rare instance when hallucinations (usually visual or tactile) occur with intact reality testing, or auditory, visual, or tactile illusions occur in the absence of a delirium.

*The recurrence of substance-related legal problems has been removed from SUD criteria in the DSM-5. Most research on this topic suggests that recurrent legal problems have low discriminatory power for SUDs.
**Craving has been added as a SUD criterion, defined as “a strong desire or urge to use a specific substance.”

The discriminatory power of craving is unclear. The following questions will help counselors assess cravings in patients:

1. How frequently do you find yourself looking forward to your next drink/drug use?
2. How often do you find yourself drinking/using even when you know the consequences are going to be negative?
3. How regularly do you think about how good drinking/using would make you feel?
4. How frequently do thoughts about drinking/using seem to come out of nowhere and are unwanted?
5. How normal is it for you to find that sometimes you want to drink or use so badly that you can almost taste it?
6. What people, places, or things trigger a strong desire to drink?
7. How much of your time when you're not drinking/using do you find yourself distracted by ideas, thoughts, impulses, or images related to drinking/drug use?
8. How successful are you in stopping or resisting these thoughts when you're not drinking?
9. How overpowering does your desire to drink or use feel?

Recognizing Common Disorders Co-occurring with SUDs

Navy counselors should be able to recognize common mental health diagnoses that may be present in addition to a SUD, referred to as co-occurring disorders. Common co-occurring disorders include:

- Anxiety Disorders
- Bipolar and Related Disorders
- Depressive Disorders
- Neurocognitive Disorders
- Obsessive-Compulsive and Related Disorders
- Psychotic Disorders
- Sexual Dysfunction
- Sleep and Wake Disorders
- Stress- and Trauma-Related Disorders

Changes from the DSM-5 to DSM-5-TR

The following diagnoses were updated in the text revision of the DSM-5 published in 2022 in order to update the current criteria and research outlined as well as clarify some of the criteria, however, there were not enough field advances to justify a new edition (i.e., DSM 5.1 or 6). Since the DSM-5 was published in 2013, the text revision deals with updates in the field from 2013 up to publication in 2022.

- Attenuated Psychosis Syndrome
- Autism Spectrum Disorder
- Avoidant Restrictive Food Intake Disorder
- Bipolar and Related Disorders Due to Another Medical Condition
- Bipolar I and Bipolar II Disorders
- Delirium
- Depressive Disorder Due to Another Medical Condition
- Functional Neurological Symptom Disorder
- Gender Dysphoria
- Intellectual Disability
- Major Depressive Disorder
- Narcolepsy
- Olfactory Reference Disorder
- Other Specified Bipolar and Related Disorder
- Other Specified Delirium Disorder
- Other Specified Depressive Disorder
- Other Specified Feeding Disorder
- Other Specified Schizophrenia
- Persistent Depressive Disorder
- Prolonged Grief Disorder
- PTSD
- Social Anxiety Disorder
- Substance Medication Induced Bipolar Disorder
- Suicidal Behavior and Nonsuicidal Self-Injury
- Unspecified Mood Disorder

Impact of Co-occurring Disorders

Co-occurring mental health disorders are extremely relevant for Navy counselors working with military veterans and active military service members. The data on prevalence varies based on era served, exposure to combat, gender, and other factors. Specific prevalence data is not being offered in this document since it is updated regularly by federal agencies which research these issues, including the National Center for PTSD, SAMHSA, and National Institutes of Health (NIH). A simple

search on the internet will reveal multiple studies on the incidence of substance use disorders, PTSD, depression, and other mental health diagnoses.

Recent attention has also been given to research conducted on Adverse Childhood Experiences (ACE) and their impact on a person's risk for developing physical and psychological illnesses across their lifespan. Some SARP programs are utilizing the ACE questionnaire. More information about the ACE research can be found at https://www.cdc.gov/violenceprevention/aces/index.html.

The phrase "hidden wounds of war" is one seen frequently in the literature when exploring the impact of military service. The Hauenstein Center for Presidential Studies held seven conferences on the "Hidden Wounds of War." Materials from those events may found at https://www.gvsu.edu/hc/the-hidden-wounds-of-war-43.htm.

Hidden wounds may manifest themselves in a number of ways including:

- Difficulty controlling anger
- Irritability
- Self-medicating with alcohol and other drugs
- Reckless and high-risk behaviors

Best practices in mental health services are to treat both substance use disorders and mental health diagnoses simultaneously. Combat related PTSD and related disorders tend to develop over time. Results from a Post Deployment Health Assessment (PDHA) reassessment found that mental health and social problems are more likely to be reported three to six months after deployment (Milliken, Auchterlonie, & Hoge, 2007). For this reason, counselors need to be trained to identify early stages and signs of co-occurring and substance use disorders to implement more effective treatment and early intervention, if possible.

Suicidal thoughts are another clue to SUDs and other co-occurring disorders. Counselors should open the door for patients to share whether they have had suicidal thoughts by asking them about it directly. Asking about suicide does not give patients ideas or thoughts about suicide. (See chapter 8, Counseling: Individual Counseling)

The somatic (physical) and neurobiological impacts of addiction and co-occurring disorders are profound and multifaceted. It is important for counselors to screen and assess for these issues and refer patients for appropriate medical or psychiatric help.

Neurobiological Impacts

- **Changes in Brain Structure and Function:** Addiction and mental health disorders can lead to significant alterations in brain regions critical for decision making, impulse control, memory, and emotional regulation. For instance, substances can hijack the brain's reward system, leading to a diminished response to natural rewards and an increased focus on obtaining and using the substance.
- **Neurotransmitter Imbalances:** These conditions often involve imbalances in key neurotransmitters, such as dopamine, serotonin, and norepinephrine, which play crucial

roles in mood regulation, pleasure, and reward processes. Substance use can initially increase levels of these neurotransmitters, but chronic use often leads to a decrease in their natural production and sensitivity, contributing to the cycle of addiction and exacerbating mental health disorders.

- **Neuroinflammation and Neurotoxicity:** Chronic substance use and certain mental health conditions can lead to inflammation and neurotoxic effects in the brain, potentially causing cognitive deficits, reduced brain volume in certain areas, and further disruption of neuronal circuits.

Somatic Impacts

- **Cardiovascular Diseases:** Substance use, especially stimulants like cocaine and methamphetamine, can increase the risk of heart disease, hypertension, myocardial infarction, and stroke. Mental stress from co-occurring disorders can also contribute to heart disease.
- **Liver Disease:** Alcohol and certain drugs can cause liver inflammation, fatty liver disease, fibrosis, and cirrhosis, significantly impacting overall health.
- **Infectious Diseases:** The modes of substance use (e.g., injection) can increase the risk of infectious diseases such as HIV/AIDS and hepatitis C. Co-occurring mental health disorders can exacerbate these risks through impaired judgment and increased risky behaviors.
- **Respiratory Problems:** Smoking substances like tobacco, marijuana, and crack cocaine can lead to chronic bronchitis, emphysema, and lung cancer. Mental health disorders can complicate these conditions by affecting the individual's ability to seek treatment or engage in healthier behaviors.
- **Gastrointestinal Issues:** Substance use can lead to a variety of gastrointestinal problems, including acid reflux, gastritis, pancreatitis, and ulcers. Anxiety and depression can exacerbate these issues through stress-related mechanisms.
- **Endocrine and Reproductive Health Issues:** Substance use can impact hormonal balance, leading to issues such as erectile dysfunction, irregular menstruation, and infertility. Co-occurring mental health disorders can also affect sexual health and reproductive functions indirectly through stress and medication side effects.

Research on co-occurring disorders is consistently occurring. Doing an internet search on recent research in this area and reading peer-reviewed journals can help you stay current as this research evolves.

Cross-cutting Symptoms

Cross-cutting symptoms are symptoms that cut across diagnoses. Examples of cross-cutting symptoms include depressed mood, anger, anxiety, insomnia, and substance use. The DSM-5 includes measures of cross-cutting symptoms (Assessment Measures in Section III), but the Navy will designate its own measures for depression and anxiety. Refer to Sandra’s Case Study (below) to practice assessment and diagnostic skills in the presence of co-occurring disorders and symptoms.

CASE STUDY: Sandra

Sandra is a surgeon at a large naval hospital. She completed her undergraduate work at Annapolis and her medical degree at Cornell. She is attractive and has a stellar professional reputation. She was referred to SARP following a violent incident that occurred while both she and her husband were drinking. They were referred to family advocacy and to SARP for assessment. She is embarrassed that "everyone now knows about her personal problems."

During your interview with Sandra, she tells you about how hard her recent deployment was. She began drinking heavily while deployed. Prior to that she drank only one or two times per week, typically one or two glasses of wine, but occasionally she would drink beer or have a mixed drink instead of wine. While deployed, she recalls the horror of trying to put bodies back together and often having to settle for amputations to save a life. She began drinking more in order to sleep but she would still wake up with nightmares of surgeries she had completed. She would have vodka or beer to get back to sleep after waking up from nightmares. Loud noises produced a startled response in Sandra; she said her body felt like it was revved up all the time, ready to fight, dive for cover, or run.

Once Sandra returned to the states after her six-month deployment, she continued drinking because the nightmares came home with her. Loud noises still scare her; she once dove under a restaurant table when she heard dishes crash in the kitchen. Sometimes while doing surgery since her return, she "sees" a patient she operated on when deployed rather than the patient in front of her. She says this scares her so much that she finds herself running from the surgery unit as soon as she scrubs out in an effort to get the vision out of her mind.

Sandra's husband gets angry when she talks about her deployment experience and how it haunts her. He tells her, "Get over it. You're home now." He goes to the liquor cabinet and fixes them drinks when she talks about her deployment. She estimates that she is drinking at least four drinks a day. She usually starts with the first one her husband hands her then continues drinking until bedtime. When she brings up her problems after she and her husband have begun drinking, arguments are likely to start. She says they both get angry and very loud. She is here because a neighbor reported the noise during their last fight.

Is there any other information you need to know about Sandra before making an assessment? Does Sandra meet any diagnosis in the DSM-5? Is she demonstrating criteria for more than one diagnosis? Is Sandra demonstrating any cross-cutting symptoms? What level of care would best meet Sandra's needs?

Summary

This chapter addresses the *TAP 21* Competency #30 which requires counselors to apply accepted criteria for the diagnosis of substance use disorder. The DSM-5 criteria for substance use disorders significantly changed the framework through which counselors consider behaviors and symptoms when diagnosing SUDs. Behavioral health professionals, as well as the systems through which treatment is provided and paid for, are challenged to modify views and models used to deliver care. Counselors are encouraged to discuss these changes with their clinical preceptor and to contribute

to the profession by sharing thoughts and ideas on how treatment can effectively benefit those needing services, regardless of where they fall on the SUD spectrum.

Learning Activities

CASE STUDY: Tonya

Tonya is a 25 year old, married E-7 who was self-referred to SARP at her friend's urging following a party that ended with two of the male party participants getting into a fight over her. The males were detained, and Tonya was helped home to her barracks by a female friend who was at the party and was concerned Tonya was too drunk to make it home alone. Tonya had admitted to her friend, another Chief, that being deployed away from her husband and 2 year-old twins was depressing. She wants to get through this without damaging her career. She says she has a hard time getting out of bed to get to work and has no energy when she gets there. She has no interest in her normal recreational activities. She cries because she hates being away from the twins and sometimes for no reason at all. When asked, she said she was diagnosed with depression in high school.

During your interview with her, Tonya says she drinks just to get through her off hours when she has nothing to do but miss her family. She worries that her husband may find someone else to fill her place before her year-long deployment is over. She also worries she may do "something stupid" with one of the men on the base. This is the third time during Tonya's year-long deployment that she has been present for altercations when drinking has been involved.

In her assessment package, Tonya reveals that she has a family history full of alcohol problems. She remembers her mother drinking every afternoon after she got home from school and says she does not want to become her mother. She said her father, who left for parts unknown when she was 15, also drank regularly. On the weekends he would get drunk along with her mother and loud verbal arguments ensued. She said she started drinking occasionally with her mother at age 15 after her father left. When she was young, she would drink 1 – 2 beers throughout an evening and to feel "buzzed" she said it only took 2 beers. By her senior year of high school when she was 18, she was also drinking with friends at parties on the weekends. She reports drinking 4 to 6 beers or ½ to a full bottle of wine on most weekend nights and to feel buzzed took at least 4 beers.

When asked about her drinking now, she emphasizes she only drinks to deal with the stress of being away from her family. She admits drinking 3 – 5 16-ounce beers after work most days. On off days, she says she drinks 4 – 6 16-ounce beers during the day and a .75 liter bottle of wine in the evening. She counts the hours until she can get off and have a drink. She has tried to cut down to only one beer or glass of wine after work, but she gets back up to 3 – 5 beers or a bottle of wine within a couple of weeks. She said her friends are worried, but she knows she will be better as soon as she is home. She says her drinking doesn't cause problems when she and her husband drink together. They drink to relax after the twins are in bed.

What key factors would you consider in making a diagnosis? To complete your assessment, what else, if anything, would you need to know from Tonya? Does Tonya meet a DSM-5 Diagnosis? If so, what criteria does she meet for which diagnoses? What are your recommendations for Tonya?

CASE STUDY: Michael

Michael has been in the Navy for 11 years with a series of "must promotes" in his rate. He is an E-6 and dedicated to his career working on helicopters. He is a natural leader, and his Master Chief wants to see him make Chief. Last week, Michael received a DUI following an extended lunch with other sailors from his command. Three of them were in his car returning to the base when he was stopped. The police officer breathalyzed him and he had a BAC of .08. One of his passengers had to drive his car back to the hanger where they work.

Michael has only had two ARI's, both occurring this past year. In both cases, he was late to work after "a night out with the boys." This is his first DUI. He was surprised that his BAC was over the limit for safe driving. He wants to do whatever it takes to keep his career on track.

Michael seems candid in your interview. His assessment paperwork says he usually drinks one or two beers after getting off work while driving 35 miles to his home. Once he is at home, he usually finishes a six-pack of 12 oz. Bud Lights. He says it takes a six-pack to feel high, but he doesn't feel out of control. Occasionally on weekends or days off, he will have 2-4 mixed drinks. His favorite is Crown Royal and ginger ale, and he mixes each with 2 ounces of Crown Royal. He says it takes 3-4 drinks to feel "high."

Michael says both of his parents smoke "too much pot." According to him, their alcohol use is limited. While he was in high school, he said he smoked pot with his parents at home. His use increased from a hit or two in the evenings at age 14 to one or two joints at 18. He says his use caused uncompleted or poorly completed homework that sabotaged his grades. Sometimes, he left school to smoke with his friends at lunch. He knew it was causing problems and tried unsuccessfully to quit multiple times during his senior year. At nineteen when he decided he wanted to join the navy, he stopped using pot. He said it was hard for the first six months. Even now he occasionally craves pot but knows smoking it could destroy his career.

Michael is married and he and his wife are planning to start their family now that his deployment is over. He says his wife has expressed concern about his drinking, but he believes he drinks like an average person. He has tried to cut down on his use, but always goes to drinking more than he intends to. Sometimes this is the source of arguments with his wife.

What other information do you need from Michael to complete your assessment? Does Michael meet any DSM-5 SUD criteria? Does he meet any criteria for another DSM-5 diagnosis? Develop an Individualized Treatment Plan for Michael.

Supplemental Chapter 2: Other Substances of Abuse

Purpose of This Chapter

To become familiar with some of the other, current substances of abuse including club drugs, prescription drugs, synthetic marijuana, and steroids.

Learning Objectives

At the end of this course, participants will be able to identify the following:

- How the above drugs are abused.
- The signs and symptoms of misuse/abuse as well as the potential health impact and adverse consequences.
- Treatment implications with abusing these substances.

Introduction

This material will review several commonly abused drugs, including prescription drugs, marijuana, synthetic drugs (new psychoactive substances [NPS]), club drugs, and anabolic steroids. For each of these drugs, this material will provide a brief overview about the drug or drug class, describe the most common method(s) of abuse, and discuss the signs and symptoms of abuse and adverse health effects of drug use.

Prescription Medication Abuse/Misuse

Method of Use. Put simply, prescription drug abuse is one or more of the following:

- Using a medication that has been prescribed for someone else
- Taking a medication in a higher quantity or in a manner other than how that drug was prescribed (e.g., crushing a tablet and snorting it)
- Taking a medication for a purpose other than how it was prescribed (e.g., using ADHD drugs to improve academic performance)

There are a number of reasons why people misuse and/or abuse prescription drugs including to: feel good; get a high; relieve tension/pain; improve alertness, concentration, or school/work performance; avoid withdrawal; and reduce appetite.

Health Effects. Common physical signs and symptoms of prescription drug abuse have been summarized in **Table S-2.1.**

Table S-2.1

Signs and Symptoms of Prescription Drug Abuse		
Opioid Painkillers	**Sedatives and Anti-anxiety Medications**	**Stimulants**
• Constipation • Depression • Low blood pressure • Decreased breathing state • Confusion • Sweating • Poor coordination	• Drowsiness • Confusion • Unsteady walking • Poor judgment • Involuntary and rapid movement of the eyeball • Dizziness	• Weight loss • Agitation • Irritability • Insomnia • High blood pressure • Irregular heartbeat • Restlessness • Impulsive behavior

MayoClinic.com

Other signs of prescription drug abuse may include: stealing, forging, or selling prescriptions; taking higher doses of medications than what has been prescribed; exhibiting excessive mood swings or hostility; changing one's sleep patterns (either by increasing or decreasing sleep amount); poor decision making; appearing to be high, unusually energetic or revved up, or sedated; continually "losing" prescriptions to obtain more prescriptions; or seeking prescriptions from more than one doctor.

All prescription drugs have potential for addiction that increases when those drugs are misused or abused. All drugs can alter judgment or decision making and increase risky or dangerous behaviors when they are abused. Particular effects may include:

- **Stimulants**, when taken in high doses, can dangerously raise body temperature and cause irregular heartbeat or heart failure/seizures. High doses or repeated doses of stimulants may lead to hostility and paranoia.
- **Opioids** result in drowsiness, constipation, and possible depressed (or slow) breathing. There is an increased potential for depressed breathing particularly when snorted, injected, or combined with other drugs or alcohol. More people die from prescription opioid overdose than all other drugs including heroin and cocaine.
- **Depressants** can slow brain activity and lead to drowsiness and loss of coordination. Depressant use may result in physical dependence and withdrawal.
- **Dextromethorphan** found in OTC medications can impair motor function, increase heart rate/blood pressure, and cause numbness and nausea or vomiting.

Treatment Implications. Although behavioral or pharmacological treatments alone may be sufficient for treating some patients, studies show that a combined approach often is most effective. For ***opioid addiction***, several options are available—these options are drawn from research on treatment of heroin addiction and utilize medications, like naltrexone, methadone, and

buprenorphine, as well as behavioral counseling approaches. Abusers of ***prescription sedatives*** should not attempt to stop using on their own as withdrawal symptoms can be problematic or even life-threatening. They should undergo medically supervised detoxification, paired with inpatient and outpatient counseling, and/or cognitive-behavioral therapy. Treatment of ***prescription stimulant abuse*** is based on behavioral therapies proven effective in treating cocaine and methamphetamine such as contingency management, cognitive-behavioral therapy, and recovery support groups (in conjunction with behavioral therapy). To date, there are no medications approved by the U.S. Food and Drug Administration (FDA) for treating stimulant addiction.

Marijuana

Marijuana is a psychoactive, or mind-altering, drug produced from the Cannabis sativa plant. Although it contains more than 400 chemicals, tetrahydrocannabinol (THC) is believed to be the chemical responsible for producing the psychoactive effects. Marijuana can be consumed as a shredded, dry leafy product, or as "hash" or "hashish"—marijuana oil and resin. Hash is derived from the same plant but is dried and compressed into a variety of forms, such as balls, cakes, or cookie-like sheets. Pieces of the resin are broken off, placed in pipes, or mixed with tobacco, and smoked. Hash oil also may be sold in small glass bottles. A drop or two of hash oil on a cigarette is equal to a single marijuana joint.

Street Names: Blunt, Bud, Dope, Ganja, Grass, Green, Herb, Joint, Mary Jane, Pot, Reefer, Sinsemilla, Skunk, Smoke, Trees, Weed

Brand Names: Brand names vary by geographical area in states where the sale of marijuana is legal.

Signs of Use. Physical signs of marijuana use may include bloodshot eyes, increased heart rate, lethargy or sleepiness, lack of coordination, and an increase in cravings or appetite. When high, users may exhibit confusion or an inability to focus, may be unusually talkative, misjudge time, or be more secretive than usual. Euphoria, lowered inhibitions, and impaired judgment are also signs of marijuana use. These symptoms may last for 3–6 hours. Extreme fear, anxiety, panic, or hallucinations can be indications of a high level of THC in the marijuana, or consumption of a large amount.

Other signs of use may include paraphernalia in the individual's possession such as small pipes, larger complicated water pipes ("bongs"), rolling papers, or small ends of smoked hand-rolled cigarettes. In states that have legalized medical or recreational marijuana use, there may be "edibles" such as cookies, brownies, or tea. Of note, edibles must be labeled clearly with the amount of marijuana they have.

Method of Use. Marijuana usually is smoked as a joint, vape, in a pipe, or in a bong. It also is smoked in a "blunt," which is a cigar that has been emptied of tobacco and refilled with marijuana, sometimes in combination with another drug. It also can be mixed with food or brewed as a tea.

Health Effects. Chronic users may suffer lung irritation, bronchitis, emphysema, and bronchial asthma. Users may experience low blood pressure resulting from an increase in heart rate while

blood vessels simultaneously dilate. Continuous use also may suppress the immune system, resulting in more frequent illness. Other physical effects include urinary retention and constipation. Because marijuana contains toxins and carcinogens, users increase their risk of cancer. Frequent use in youth may result in the loss of IQ points.

Long-term chronic use of marijuana is associated with Amotivational Syndrome. It is characterized by apathy; impairment of judgment, memory, and concentration; and loss of motivation, ambition, and interest in the pursuit of personal goals. In addition, studies show an association between marijuana use and an increased risk of depression, earlier onset schizophrenia, and other psychotic disorders.

Treatment Implications. On average, adults seeking treatment for marijuana use disorders have used marijuana every day for more than 10 years and have attempted to quit more than six times. They also may abuse or be addicted to other substances, often and many suffer from comorbid psychiatric disorders. Studies show that effective treatment means treating the mental health disorder first with standard treatments like medications and behavioral health therapies. Promising behavioral treatments for treating marijuana use include cognitive-behavioral therapy, contingency management, and motivational enhancement therapy. Although there currently are no medications specifically used to treat marijuana use, medications may be used to treat symptoms of withdrawal. Symptoms of withdrawal may include irritability, depression, changes in mood, sleeplessness, decreased appetite or cravings, stomach pains, nausea, sweating, chills, restlessness, and anxiety.

Synthetic Drugs/New Psychoactive Substances

Bath salts and K2 or "spice" are included in a group of drugs called "new psychoactive substances" (NPS). NPS are unregulated psychoactive substances developed to copy the effects of illegal drugs. Some NPS may have been available for many years, but recently have reentered the market in altered chemical forms or due to renewed popularity. Synthetic in nature, NPS gained popularity in the last 10 years as more traditional drugs of abuse have been more difficult to obtain.

Bath Salts

Contrary to their name, "bath salts" are a synthetic stimulant, different from bathing products like Epsom Salts, which have no psychoactive properties. Typically characterized by a white or brown crystalline powder, bath salts contain one or more chemicals that are physically similar to amphetamines and MDMA (ecstasy). Chemicals most recently identified as bath salts include methylenedioxyyrovalerone and mephedrone, a Khat derivative.

The effects of bath salts on the brain are not fully known. While chemically similar to amphetamines and MDMA, there is much that is unknown about how the synthetic cathinones in bath salts affect the brain. The energizing and agitating effects are similar to stimulants that increase dopamine levels, which results in feelings of euphoria and increased activity. The hallucinatory effects reported by some users are similar to drugs like MDMA and LSD, which increase serotonin levels. Bath salts

are known to trigger strong cravings. The drug typically is sold online or in drug paraphernalia stores, often in small plastic or foil packages.

Brand Names: Blizzard, Bloom, Blue Sky, Cloud Nine, Ivory Wave, Lunar Wave, Ocean Burst, Pure Ivory, Purple Wave, Vanilla Sky, White Dove, White Knight, White Lightening,

Method of Use. Initially popular in the United States and in Europe as a "legal high," specific compounds of bath salts have since been banned by the Drug Enforcement Association (DEA). However, it is to be expected that manufacturers will modify their recipes to supply legal replacements. Bath salts are taken orally, inhaled, or injected.

Signs of Use. Bath salts produce feelings of euphoria, increased sociability, and sex drive. Users may experience anxious or jittery behavior, insomnia, lack of appetite, and nausea. Some users may experience paranoia, agitation, hallucinations, panic attacks, depression, agitation, erratic behavior, psychotic or violent behavior, suicidal thoughts, or self-harm. Physical symptoms may include rapid heart rate, seizures, or chest pain. Some users have reported symptoms lasting 2–3 days. Most current routine drug screens do not detect the presence of bath salts, potentially making this drug more appealing to users subject to mandatory drug screenings.

Health Effects. Bath salts have been linked to surges in ER and poison control center visits with severe cases of dehydration, kidney failure, and the breakdown of skeletal muscle tissue. There have been several instances of death linked to bath salts. Early indications of this drug show high potential for abuse and addiction. As manufacturers alter their recipes, compounds may include unknown ingredients with other harmful effects. Abusers who inject the drug may risk contracting or transmitting HIV or AIDS, hepatitis, or other blood borne diseases by sharing needles.

Treatment Implications. Examples of behavioral therapy that may be used to treat addiction to bath salts include cognitive-behavioral therapy, contingency management or motivational incentives, and motivational enhancement therapy. To date, there are no medications currently available to treat addiction to bath salts.

Synthetic Marijuana (synthetic cannabinoids)

K2 or "spice" is a form of synthetic marijuana. Users typically spray the drug onto a mixture of herbs or shredded plant matter to produce psychoactive, or mind-altering, effects when smoked. Synthetic marijuana users have noted the effects are similar to their experience with marijuana. Marketed as a safe, legal alternative to marijuana, spice is popular among teens and young adults.

Like synthetic cathinones, spice is an NPS. For years, spice has been easy to purchase from drug paraphernalia shops, novelty stores, and through the Internet. The DEA has designated five active chemicals often found in synthetic cannabinoids and have classified it as a Schedule I controlled substance, meaning that it is illegal to sell, buy, or possess. Manufacturers skirt this issue by substituting chemicals to achieve the same effects. Spice typically is sold in plastic bags filled with dried leaves and herbs and may resemble potpourri. It is sometimes sold as "incense" and is often sold at small retail outlets and via the Internet.

Brand Names: Spice, K2/K-2

Street Names: Bliss, Black Mamba, Blaze, Bombay Blue, Chronic, Fake Weed, Genie, Moon Rocks, Skunk, Spice Gold, Spike

Method of Use. Spice has become popular for its marijuana-like effects, ease of access, and the misperception that it is harmless because it is "natural." In addition, the chemicals typically used to produce spice are not easily detected in standard drug tests. Spice typically is smoked, by itself or mixed with marijuana, or may be prepared as an infusion to be drunk.

Signs of Use. Users report an elevated mood, altered perception, and/or a feeling of relaxation, similar to the effects of marijuana. Effects also can include extreme anxiety, paranoia, and hallucinations and may last anywhere from 1–8 hours. Physical symptoms of use may include an elevated body temperature and/or an elevated heart rate. In some cases, the effects of spice can be much stronger than marijuana. Overdose with spice looks very different from overdose with natural marijuana; while users may experience a bad trip on natural marijuana, spice overdoses often appear similar to signs of amphetamine use, with users appearing agitated and angry. At the date of this publication, there have not been any scientific studies on the impact of spice on the human brain.

Health Effects. Some users have had symptoms including increased heart rate, vomiting, agitation, confusion, and hallucinations. Some cases have been associated with increased blood pressure, heart attack, harmful thoughts or actions, and suicide. Regular users may experience withdrawal and addiction. As there have not been scientific studies and the chemical additives in spice are not altogether known, researchers do not yet know the entirety of the possible adverse health consequences of spice use.

Treatment Implications. To date, behavioral therapies and medications have not been evaluated specifically for treatment of addiction to spice.

Club Drugs (focus on GHB, Ketamine, and Rohypnol)

"Club drugs" refers to a group of pharmacologically similar psychoactive drugs typically used by teens and young adults at bars, nightclubs, concerts, and parties ("raves"). Effects common to club drugs as a group may include anxiety, panic, depression, euphoria, loss of memory, hallucinations, and psychotic behavior. Drugs, traces of drugs, and drug paraphernalia are direct evidence of drug abuse. Other indicators of club drug use include but are not limited to pacifiers, menthol inhalers, and surgical masks.

Two of the more well-known club drugs include MDMA ("ecstasy" or "molly") and methamphetamine. This section will focus on three specific club drugs: GHB, Rohypnol, and Ketamine.

GHB

GHB is the common name for the chemical compound Gamma Hydroxybutyrate, a central nervous system depressant approved by the FDA in 2002 for use in treating the sleep disorder narcolepsy.

Referred to as one of the "date rape" drugs, GHB can be used to sedate and incapacitate victims, rendering them unable to resist assault.

Generic Name: Sodium Oxybate

Trade Name: Xyrem

Street Names: Easy Lay, G, Georgia Home Boy, Goop, Grievous Bodily Harm, Liquid Ecstasy, Scoop

Signs of Use. Symptoms of GHB use typically include confusion, memory impairment, euphoria, drowsiness, excited or aggressive behavior, and visual hallucinations. In low doses, GHB also may produce nausea. Taken in high doses, GHB can result in overdose, loss of consciousness, seizures, slowed heart rate, slowed breathing, nausea, coma, and death. Doses of GHB begin to work in 15–30 minutes; effects may last from 3 to 6 hours.

Method of Use. GHB is ingested orally, either in liquid or powder form; it may be combined with alcohol or other beverages. GHB typically is abused for its euphoria-inducing and/or calming effects. Its ability to increase libido and cause amnesia led to its notoriety in the 1990s as a date rape drug. Alternatively, some bodybuilders use GHB to reduce fat, lose weight, and build muscle.

Health Effects. Regular use of GHB can lead to addiction and withdrawal. Symptoms of withdrawal can include insomnia, anxiety, tremors, increased heart rate and blood pressure, and occasional psychotic thoughts. Use of GHB can result in poisoning, date rape, overdose, and death. GHB's depressant effects on the central nervous system increase greatly when used in combination with alcohol or other depressant drugs.

Rohypnol

Rohypnol is a central nervous system depressant in the benzodiazepine class of drugs. It is similar to sedative hypnotics like Valium and Xanax but has not been approved for medical use in the United States. Although outside the United States Rohypnol is used to treat insomnia, importation of the drug to the United States has been banned. Like GHB, Rohypnol often is referred to as a "date rape" drug and has been used to commit sexual assault due to the drug's ability to sedate and incapacitate victims, rendering them unable to resist assault.

Commercial Name: Flunitrazepam, Rohypnol®

Street Names: Circles, Forget Pill, Forget-Me-Pill, Lunch Money Drug, Mexican Valium, Pingus, Rs, Roach, Roofies/Rophies/Ruffies, Wolfies

Signs of Use. Users typically become drowsy and may experience feelings of euphoria, decreased anxiety, and bouts of amnesia. A user also may experience increased or decreased reaction time, impaired mental function, impaired judgment, and increased levels of aggression, and may become easily confused or agitated. Physical signs of Rohypnol use can include slurred speech, loss of motor coordination, bodily weakness, headaches, and/or respiratory depression.

Method of Use. Rohypnol is manufactured in pill form; it can be swallowed whole, dissolved in liquid, or ground up and snorted. Although generic forms may not be as recognizable, manufactured pills are oblong, olive green on the outside with a blue-speckled interior. When added to a liquid, the pill

changes the color of the liquid to light blue; adding Rohypnol to alcohol increases intoxication effects. Some users may take Rohypnol with multiple substances of abuse to relieve the side effects of a drug binge.

Health Effects. High doses of Rohypnol can result in severe sedation, unconsciousness, slowed heart rate, and suppressed respiration leading to death. Any amount of Rohypnol mixed with alcohol or other central nervous system depressants can be lethal. Chronic use of Rohypnol can produce tolerance, physical dependence, and addiction. Treatment for chronic use follows a protocol similar to benzodiazepines. This may include in-patient detox with intense medical monitoring as withdrawal from benzodiazepines can be life-threatening.

Ketamine

Ketamine is a dissociative anesthetic, meaning that users feel detached from their pain and the environment when under its influence. It is an injectable, short-acting anesthetic for human and animal use, although it is primarily used in veterinary practice. It is popular among teens and young adults at clubs and "raves" for its hallucinogenic effects. Abused for its dissociative effects, Ketamine also has been used as a date rape drug.

Commercial Name: Ketalar®

Street Names: Cat Tranquilizer, Cat Valium, Jet, K, Kit Kat, Purple, Special K, Super Acid, Super K, Vitamin K

Signs of Use. Users may feel drowsy or confused, may become easily agitated or upset, and may experience decreased levels of anxiety, increased or decreased reaction time, impaired mental functioning, impaired judgment, hallucinations, and/or amnesia. Physical signs of Ketamine use can include slurred speech, loss of motor coordination, bodily weakness, headaches, or respiratory depression.

Method of Use. Ketamine is manufactured commercially in powder or liquid form. As a powder, Ketamine typically is snorted or smoked in cigarettes or marijuana; as a liquid, it is injected intramuscularly or mixed into drinks. The effects are short-lasting, typically around 30–60 minutes, and the onset of effects are rapid once ingested. Users may feel calm, relaxed, and relieved of pain.

Health Effects. Ketamine users can develop signs of tolerance and cravings for the drug. In high doses, Ketamine can impair motor function, cause high blood pressure, and lead to potentially fatal respiratory problems. Some users have reported flashbacks. Ketamine use also may cause agitation, amnesia, depression, and unconsciousness.

Other Hallucinogens/Psychedelics (Psilocybin, Ecstasy/MDMA, DXM, Peyote, Ayahuasca)

Psilocybin

Psilocybin is a naturally occurring psychedelic compound that is found in certain species of mushrooms. It is a chemical compound with psychoactive properties, meaning that it can induce altered perceptions, sensory experiences, and changes in consciousness when consumed.

Psilocybin is part of a broader group of compounds known as tryptamines. When ingested, psilocybin is metabolized by the body into another compound called psilocin, which is primarily responsible for the psychedelic effects.

People have been using psilocybin-containing mushrooms for centuries in various cultures for spiritual, religious, and recreational purposes. The effects of psilocybin can include altered perception of reality, changes in mood, hallucinations, and profound shifts in consciousness. These effects can vary widely depending on factors such as the individual's mindset, dosage, setting, and the specific species of mushroom consumed.

In recent years, there has been a resurgence of interest in studying the potential therapeutic benefits of psilocybin in clinical settings. Research has suggested that psilocybin, when administered in controlled and guided settings, could have positive effects on mental health conditions such as depression, anxiety, and PTSD. However, this research is still in its early stages, and more studies are needed to fully understand the safety and efficacy of psilocybin as a medical treatment. The U.S. state of Oregon recently legalized Psilocybin for medical use and has created a standardized treatment protocol for medical and mental health providers.

Psilocybin is classified as a Schedule I controlled substance in the United States. This means that its use, possession, and distribution are illegal under federal law. However, there is a growing movement advocating for the reclassification of psilocybin and other psychedelics based on their potential medical benefits.

Commercial Name: Psilocybin is not typically sold under a commercial name, as it is a naturally occurring compound found in certain species of mushrooms.

Street Names: magic mushrooms, shrooms, mushies, psychedelic mushrooms, and caps

Signs of Use: Signs of psilocybin use can vary, but they might include altered perception of reality, changes in mood and emotions, dilated pupils, altered sense of time, enhanced colors and patterns, and hallucinations. Users may also exhibit changes in behavior and speech patterns while under the influence.

Method of Use: Psilocybin is most commonly consumed orally by eating the dried or fresh mushrooms. They can also be brewed into a tea or mixed with other foods to mask their taste. In some cases, psilocybin is extracted from the mushrooms and used in capsule or powder form.

Health Effects: Psilocybin is a psychedelic compound that can produce a range of effects on perception, mood, and cognition. Short-term effects of psilocybin use can include euphoria, altered thinking patterns, sensory distortions, and spiritual experiences. However, it can also lead to anxiety, confusion, and potentially disturbing hallucinations. The intensity of the experience can vary widely depending on factors such as dosage, individual sensitivity, and environment.

Medical Use: Psilocybin has shown promise in clinical research for its potential therapeutic applications. Studies have suggested that it might be effective in treating conditions such as depression, anxiety, post-traumatic stress disorder (PTSD), and addiction. Research is ongoing, and some clinical trials have demonstrated positive outcomes, especially when used in conjunction with psychotherapy in controlled settings.

Ecstasy/MDMA

Ecstasy, also known as MDMA (3,4-methylenedioxymethamphetamine), is a synthetic psychoactive drug that is chemically similar to both stimulants and hallucinogens. It was originally developed in the early 20th century as a potential medication for psychiatric therapy, but it gained popularity as a recreational drug in the 1980s and 1990s due to its euphoric and empathogenic effects.

MDMA is known for its ability to produce intense feelings of pleasure, emotional closeness, and empathy towards others. It affects the brain by increasing the release of neurotransmitters such as serotonin, dopamine, and norepinephrine. Serotonin, in particular, plays a crucial role in regulating mood, emotions, and social interactions. The increased serotonin release is believed to contribute to the pleasurable and empathic effects experienced by users.

Ecstasy is often consumed in pill or tablet form and is frequently associated with social settings such as parties, concerts, and clubs. It is known for its energizing effects, as well as the heightened sensory experiences it can induce, including enhanced perception of lights, colors, and music. The effects of MDMA can last for several hours, typically around 3 to 6 hours, and users may experience a "comedown" period as the drug's effects wear off.

Commercial Name: MDMA (3,4-methylenedioxymethamphetamine)

Street Names: Ecstasy, Molly, E, X, XTC, Adam, Hug Drug

Signs of Use:

- **Physical Effects:** Increased heart rate, dilated pupils, elevated body temperature, clenching of jaw, teeth grinding, muscle tension, blurred vision.
- **Emotional Effects:** Intense euphoria, increased feelings of empathy and emotional closeness, enhanced sensory perception.
- **Behavioral Signs:** Increased sociability, talkativeness, desire for physical touch, dancing for extended periods, heightened sensory experiences.

- **Negative Effects:** Nausea, chills, sweating, dehydration, teeth clenching/grinding, confusion, anxiety, paranoia, depression (especially during the "comedown" phase).

Method of Use: MDMA is typically ingested orally in the form of tablets, capsules, or powder. It is often consumed as a pill known as "ecstasy" or as a purer crystalline form known as "Molly." Sometimes, users may crush the tablets into powder and snort it or dissolve the powder in water and drink it.

Health Effects:

- **Short-Term Effects:** The short-term effects of MDMA include intense feelings of pleasure, increased energy, enhanced sensory perception, and emotional closeness to others. However, it can also lead to adverse effects such as increased heart rate, elevated body temperature (which can lead to dangerous overheating), dehydration, and serotonin syndrome (a potentially life-threatening condition caused by excessive serotonin release).
- **Long-Term Effects:** Prolonged and heavy MDMA use can lead to various negative health consequences, including cognitive deficits (memory and attention problems), mood disturbances (depression, anxiety), sleep disturbances, and potential damage to serotonin-producing neurons in the brain.
- **Neurotoxicity:** MDMA use can cause damage to serotonin neurons in the brain, potentially affecting mood regulation, memory, and other cognitive functions.
- **Dependency:** While MDMA is not considered as physically addictive as substances like opioids, some individuals may develop psychological dependence and feel the need to use it regularly to cope with social situations or emotional difficulties.
- **Risks:** There is also a risk of consuming adulterated or misrepresented substances sold as MDMA, which can lead to dangerous effects due to unknown compounds.

DXM

DXM, or dextromethorphan, is a common active ingredient found in many over-the-counter cough and cold medications. It is used as a cough suppressant and is classified as a dissociative anesthetic, meaning it can cause feelings of detachment from reality. DXM has the potential for recreational use and abuse, often leading to various health risks.

Commercial Name: DXM is commonly found in various cough and cold medications, often labeled as "cough suppressant" or "DM" (for dextromethorphan). It may also be combined with other active ingredients like antihistamines or decongestants. Some well-known brand names include Robitussin, Vicks DayQuil, NyQuil, and Coricidin HBP Cough & Cold.

Street Names: Dex, Skittles, Robo, Triple C (referring to Coricidin HBP Cough & Cold), Tussin, Syrup

Signs of Use: Disorientation and confusion, altered perception of time and space, impaired motor coordination, slurred speech, euphoria or mood changes, hallucinations or distorted sensory perceptions, increased heart rate and blood pressure, nausea and vomiting, sweating and fever, cognitive impairment

Method of Use: DXM is typically consumed orally and is commonly found in the form of syrups, capsules, or tablets. It can be ingested directly or mixed with other substances.

Health Effects:

- Nausea, vomiting, and gastrointestinal distress
- Dizziness and impaired motor coordination
- Confusion and cognitive impairment
- Hallucinations and distorted perceptions
- Increased heart rate and blood pressure
- Risk of overdose, which can be life-threatening and result in respiratory depression
- Seizures
- Potential interactions with other medications or substances
- Psychological dependence and addiction
- Long-term or heavy use can lead to cognitive deficits and memory problems

Peyote

Peyote (*Lophophora williamsii*) is a small, spineless cactus native to North America, primarily found in the southwestern United States and northern Mexico. It is known for its psychoactive properties due to the presence of a compound called mescaline. Mescaline is a naturally occurring hallucinogenic alkaloid that induces altered states of consciousness, including visual and sensory distortions, as well as changes in perception and mood.

Peyote has been used for thousands of years by various Indigenous cultures, particularly in Mexico, for its spiritual and religious significance. It plays a central role in their traditional ceremonies and rituals. The use of peyote in these cultural contexts is often regarded as a way to connect with the divine, gain insights, and facilitate communication with the spiritual world.

The cactus itself is small, usually about the size of a golf ball, and it grows close to the ground. It consists of rounded "buttons" that are harvested for their mescaline content. These buttons can be eaten raw, brewed into a tea, or dried and ground into a powder for consumption. The effects of consuming peyote can vary widely depending on factors such as dosage, individual sensitivity, mindset, and environment.

Due to its psychoactive properties and cultural significance, peyote has garnered attention both for its potential therapeutic uses and for the challenges surrounding its legal status in different regions. Some Indigenous groups have legal protections allowing them to use peyote in their religious practices, while in other areas, it may be classified as a controlled substance due to its psychoactive effects.

The legal status of peyote varies by jurisdiction. In some places, peyote is legally protected and used in religious ceremonies by Indigenous communities. In other places, it is classified as a controlled substance due to its psychoactive properties.

Commercial Name: Peyote is a small, spineless cactus known scientifically as *Lophophora williamsii*. It is not commonly sold under a commercial name, as it is a natural plant rather than a product.

Street Names: Mescal, Buttons, Cactus, Peyoto

Signs of Use: Dilated pupils, altered perception of time and space, changes in mood and behavior, enhanced sensory experiences, hallucinations and visual distortions, nausea and vomiting

Method of Use: Peyote is traditionally used by Indigenous cultures in ceremonial and spiritual practices. It is usually consumed by ingesting the small, round "buttons" that are cut from the cactus. These buttons can be eaten raw, brewed into a tea, or dried and ground into a powder that is then consumed. The active compound responsible for the psychoactive effects of peyote is mescaline.

Health Effects:

- **Psychoactive Effects:** Mescaline is a hallucinogenic compound that can lead to altered perception, hallucinations, and changes in thought patterns and mood.
- **Physical Effects:** In addition to its psychoactive effects, peyote may cause physical effects such as nausea, vomiting, increased heart rate, and changes in blood pressure.
- **Psychological Impact:** The psychological effects of peyote can be unpredictable, ranging from euphoria and spiritual insights to anxiety and paranoia. The experience can vary greatly depending on the individual's mindset, environment, and dosage.
- **Long-term Use:** Regular or excessive use of peyote can potentially lead to psychological dependence and negative impacts on mental health. There is also a risk of developing a tolerance to the effects of mescaline, requiring higher doses to achieve the same effects.

Ayahuasca

Ayahuasca is a psychoactive plant medicine that has been traditionally used by Indigenous peoples in the Amazon rainforest for centuries as part of their spiritual and healing practices. It is a brew typically made from two main ingredients: the Banisteriopsis caapi vine and the leaves of the Psychotria viridis shrub. These plants contain psychoactive compounds, with the primary active ingredient being DMT (dimethyltryptamine).

DMT is a powerful psychedelic compound that can induce intense altered states of consciousness, including vivid visual and auditory hallucinations, deep introspection, and a sense of connection to the spiritual or metaphysical realm. However, DMT is normally broken down by enzymes in the digestive system before it can have any psychoactive effects when consumed orally.

The Banisteriopsis caapi vine contains MAO inhibitors (monoamine oxidase inhibitors), which are necessary to prevent the breakdown of DMT in the digestive system. This allows DMT to be absorbed and produce its psychedelic effects when consumed in the form of Ayahuasca.

Ayahuasca ceremonies are conducted under the guidance of experienced shamans or facilitators who lead participants through the experience. The rituals often involve chanting, singing, and various

forms of spiritual guidance. Many people who have participated in Ayahuasca ceremonies report having profound and transformative experiences that can lead to personal insights, emotional healing, and spiritual growth.

Ayahuasca is a powerful substance that can have both positive and challenging effects on individuals. The experience can vary greatly from person to person and even from session to session. Additionally, the use of Ayahuasca is not without risks, and it should be approached with caution and respect. Potential risks include psychological distress, physical discomfort, and interactions with certain medications or health conditions.

In recent years, Ayahuasca has gained popularity beyond its traditional use in Indigenous cultures, with some people seeking its therapeutic potential for treating various mental health issues and for personal growth. However, its use outside of traditional cultural contexts has led to discussions about cultural appropriation and the need for responsible and respectful engagement with the practice.

Commercial/Street Name: Ayahuasca does not have a commercial name or street names in the same way that some illicit drugs do. It is typically referred to by its traditional name, "Ayahuasca." However, in some contexts, it might also be called "Yagé" or "Daime," which are other names for the brew.

Signs of Use:

- **Changes in Behavior:** Individuals who have consumed Ayahuasca may exhibit altered behavior, introspection, and introspective thoughts.
- **Discussion of Profound Experiences:** People who have participated in Ayahuasca ceremonies might talk about their experiences, which can include intense visions, insights, and emotional processing.
- **Increased Interest in Spirituality and Personal Growth:** Ayahuasca experiences are often characterized by deep spiritual and introspective experiences, and users might become more interested in spirituality, self-discovery, and personal growth.

Method of Use: The method of using Ayahuasca involves ingesting the brewed mixture during a ceremony, often led by a shaman or experienced guide.

Health Effects:

- **Visual and Sensory Hallucinations:** Ayahuasca can induce vivid visual and sensory experiences, often described as hallucinations, which can range from beautiful and enlightening to unsettling or challenging.
- **Introspection and Emotional Release:** Many users report experiencing deep introspection and emotional processing during the Ayahuasca experience. This can lead to insights, catharsis, and emotional healing.

- **Nausea and Vomiting:** Ayahuasca often induces physical discomfort, including nausea and vomiting. This is considered a normal part of the experience and is sometimes referred to as "purging."
- **Increased Heart Rate and Blood Pressure:** Ayahuasca can cause physiological changes such as increased heart rate and blood pressure.
- **Potential for Positive Transformation:** Some users report long-term positive changes in their attitudes, behaviors, and perspectives after using Ayahuasca. These changes are often associated with personal growth, increased empathy, and spiritual awareness.

Medical Use: DMT's (dimethyltryptamine) potential medical uses are still being explored, and research in this area is relatively limited compared to other compounds. Current research studies are investigating the use of DMT for treatment of the following:

- **Depression and Anxiety:** Some researchers have suggested that DMT could have antidepressant and anxiolytic (anxiety-reducing) effects. Studies are being conducted to explore the impact of DMT on mood disorders, but more research is needed to understand its mechanisms and potential benefits.
- **Neuroplasticity:** There is interest in DMT's potential to promote neuroplasticity, which is the brain's ability to reorganize and form new connections. This could have implications for treating conditions related to brain health and neurodegenerative diseases.
- **Spiritual and Transcendent Experiences:** Some researchers are exploring DMT's ability to induce profound spiritual and transcendent experiences. These experiences might have therapeutic benefits for individuals dealing with existential distress or seeking personal insights.
- **Cluster Headaches:** There is anecdotal evidence suggesting that DMT might help alleviate cluster headache episodes. Cluster headaches are extremely painful and debilitating, and some individuals have reported experiencing relief after using DMT. However, rigorous scientific research is needed to establish its efficacy and safety for this purpose.

Kratom

Kratom (*Mitragyna speciosa*) is a tropical tree native to Southeast Asia, particularly in countries like Thailand, Indonesia, Malaysia, and Papua New Guinea. It belongs to the coffee family (Rubiaceae) and has been traditionally used for its stimulant and analgesic (pain-relieving) properties. The leaves of the kratom tree contain active compounds, primarily alkaloids, which interact with opioid receptors in the brain.

Kratom leaves have been consumed for centuries by chewing, making tea, or grinding them into a powder and ingesting it. Depending on the dosage and strain, kratom's effects can range from stimulant-like to sedative, and its effects can vary between individuals. Some people use kratom for pain relief, mood enhancement, and relaxation, while others use it to aid in managing opioid withdrawal symptoms.

However, kratom has been a subject of controversy due to concerns about its safety and potential for dependence. While it is legal in some countries and regions, it is regulated or banned in others due to its psychoactive properties and potential health risks. Kratom can lead to side effects such as nausea, vomiting, constipation, dry mouth, and in high doses, it can cause sedation, respiratory depression, and even overdose.

The U.S. Food and Drug Administration (FDA) has raised concerns about the safety and potential health risks associated with kratom, and it is classified as a botanical substance of concern. Researchers are continuing to study kratom to better understand its effects, potential benefits, and risks.

Commercial Name: Kratom is typically sold under its botanical name "Kratom" or sometimes as "Mitragyna speciosa." It might also be labeled with the specific strain name (e.g., Maeng Da, Bali, Thai) that corresponds to the region it is sourced from.

Street Names: Kratom does not have as many well-known street names as some other substances, but it is sometimes referred to as "ketum," "biak-biak," or "thang." These names are less common and can vary by region.

Signs of Use: Signs of kratom use can include increased energy, alertness, sociability, and pain relief. However, these effects can vary depending on the strain and dosage. People using kratom may also exhibit symptoms such as dry mouth, sweating, constipation, loss of appetite, and potentially pinpoint pupils.

Method of Use:

- **Chewing Leaves:** In traditional use, fresh leaves are chewed to release the active compounds.
- **Brewing Tea:** Dried leaves are steeped in hot water to make a tea.
- **Capsules:** Kratom powder is placed into gelatin capsules and swallowed.
- **Toss and Wash:** Kratom powder is quickly swallowed, often followed by a drink to wash it down.
- **Mixing with Food or Beverages:** Kratom powder can be mixed into foods or drinks.
- **Smoking or Vaporizing:** Less common, but some people have attempted to smoke or vaporize kratom.

Health Effects: The effects of kratom can vary widely depending on the strain and dosage. Low doses are associated with stimulant-like effects, including increased energy, sociability, and alertness. Higher doses can produce sedative and pain-relieving effects. However, it is important to note that kratom can also have negative effects, including nausea, vomiting, itching, constipation, sweating, dizziness, and in some cases, respiratory depression. Long-term use can lead to dependence, withdrawal symptoms, and potential risks to overall health.

Treatment Use: Some proponents of kratom suggest it might be used as a potential alternative to manage pain or opioid withdrawal symptoms, but more research is needed to understand its safety

and efficacy for these purposes. In some cases, people struggling with opioid addiction have used kratom to manage withdrawal symptoms, but this approach is controversial and potentially risky. Kratom is currently legal in most U.S. states.

Anabolic Steroid Abuse

Anabolic steroids are a group of synthetic variants of testosterone, the male sex hormone. Anabolic steroids promote skeletal muscle growth (*anabolic*) and development of male sexual characteristics (androgenic) in males and females. The proper term is "anabolic-androgenic steroids;" however, they typically are referred to as "anabolic steroids." Anabolic steroids are legally prescribed to treat delayed puberty, some types of impotence, and diseases that result in the loss of lean muscle mass or in which the body is wasting away, such as AIDS or some cancers. Steroids often are abused for their ability to build muscle mass quickly. **Table S-2.1** lists commonly abused steroids:

Table S-2.1

Commonly Abused Steroids	
Oral Steroids	**Injectable Steroids**
• Anadrol® (oxymetholone) • Oxandrin® (oxandrolone) • Dianabol® (methandrostenolone) • Winstrol® (stanozolol)	• Deca-Durabolin® (nandrolone decanoate) • Durabolin® (nandrolone phenpropionate) • Depo-Testosterone® (testosterone cypionate) • Equipoise® (boldenone undecylenate)

NIDA Research Report Series, Anabolic Steroid Abuse.

Steroidal supplements (such as THG and "Andro") wre legally available without a prescription in the United States until 2004. Although less is known about these supplements than anabolic steroids, researchers assumed that larger doses of these supplements would produce the same side effects.

Street Names: Gear, Juice, Pumpers, Roids, Stackers

Method of Use. Steroids are generally taken orally or injected into a muscle. Steroid gels and creams are also available and are applied topically. Steroid abusers may take doses that are 10–100 times greater than medically prescribed doses. Abusers may employ a number of methods in dosing to achieve their desired effects, including the following:

- Users frequently "**cycle**" steroid use, meaning they take steroids intermittently with periods of stopping and starting, to avoid unwanted side effects and to give their hormonal system a break.
- Anabolic steroids often are taken in combination with other steroids, steroidal supplements, or non-steroidal supplements. This is called "**stacking**" and is done to maximize drug effectiveness.

- Users may slowly increase the dose and/or frequency of use to a peak and then taper the dose in 6–12-week cycles, followed by a drug-free cycle of training. This is called "**pyramiding**."

Steroids are used to improve athletic performance, increase muscle size, and/or reduce body fat. For some adolescents, steroid use may accompany a pattern of high-risk behaviors such as drinking and driving or using other drugs, for example. Although steroid abuse does not cause the same high as other drugs of abuse, according to the National Institute on Drug Abuse, it can lead to addiction. Users may persist in abuse despite adverse consequences to their own health and to their relationships with friends and family. Steroid abusers may spend significant time and dollars in obtaining drugs. Abusers also may experience withdrawal-like symptoms when they stop using; these symptoms may include mood swings, fatigue, loss of appetite, insomnia, reduced sex drive, drug cravings, and depression. Risk factors for initiating or continuing steroid abuse include: a history of physical or sexual abuse; a history of engaging in high-risk behaviors; and muscle dysmorphia condition, a behavior syndrome that causes a distorted body image.

Health Effects. Case reports and small-scale research studies indicate that high doses of anabolic steroids may cause irritability and aggression. Long-term steroid use can lead to kidney impairment or failure, liver damage, severe acne, fluid retention, and cardiovascular diseases such as heart enlargement, high blood pressure, heart attacks, and strokes. Prolonged use by men can lead to testicular atrophy, reduced sperm count, infertility, baldness, breast development, and an increased risk of prostate cancer. Prolonged use by women can lead to changes in menstrual cycle, excessive body or facial hair growth, male pattern baldness, and a deepened voice. Adolescents who use anabolic steroids may experience stunted growth. Abusers who inject steroids may risk contracting or transmitting HIV or AIDS, hepatitis, or other blood borne diseases by sharing needles.

Treatment Implications. In many cases, supportive therapy is sufficient in treating steroid abuse. Some medications used in treating steroid withdrawal restore the body's hormonal system after its disruption from steroid abuse. Other medications may be prescribed to manage withdrawal symptoms, such as antidepressants to treat depression. Some patients may require treatment with behavioral therapies.

Learning Activities

1. Work with your Preceptor or a colleague to role-play symptoms and signs of use for a type of drug. In the role play, identify the drug or drug class of abuse, key symptoms, and the type of therapy or therapies that would best fit. Complete this exercise for at least two drugs/drug classes.

2. Develop a treatment plan for a young adult presenting for the first time with a substance use disorder. Choose two drugs or drug classes to hone in on in your treatment plan.

a. Choose one drug that has scientifically proven effective treatments. The other treatment plan should be for one of the synthetic drugs presented.
b. How do your treatment plans differ? Review these plans with your Preceptor and discuss the differences.

Self-Study Questions

1. Prescription drug abuse is:
   a) Using medication(s) prescribed for someone else
   b) Taking medication in higher quantities or in a manner other than prescribed
   c) Taking medication for a purpose other than prescribed
   d) All of the above

2. All of the following are indicators of marijuana use EXCEPT: Problems with balance
   a) Increased heart rate
   b) Euphoria
   c) Cravings for food
   d) Slowed reaction time
   e) Bloodshot eyes
   f) Respiratory depression

3. Problems focusingBath salts are chemically similar to: _____.
   a) amphetamines
   b) Epson salts
   c) MDMA/ecstasy
   d) amphetamines and MDMA/ecstasy

4. Spice, or K2, is appealing to users because:
   a) Effects are similar to marijuana
   b) Ease of access
   c) Chemicals are not easily detected by drug tests
   d) All of the above

5. Three physical indicators of club drug abuse are:
   a) _____
   b) _____
   c) _____

6. Anabolic steroids are taken to: _____.

Self-Study Answers

1. Prescription drug abuse is [d] all of the above: using medication(s) prescribed for someone else, taking medication in higher quantities or in a manner other than prescribed, taking medication for a purpose other than prescribed.

2. All of the following are indicators of marijuana use EXCEPT [g] respiratory depression

3. Bath salts are chemically similar to [d] amphetamines and MDMA/ecstasy.

4. Spice, or K2, is appealing to users because [d] all of the above: effects are similar to marijuana, ease of access, and chemicals are not easily detected by drug tests.

5. Three physical indicators of club drug abuse are: traces of drugs, drug paraphernalia, pacifiers, menthol inhalers, surgical masks

6. Anabolic steroids are taken to promote skeletal muscle growth, develop male sexual characteristics

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Supplemental Chapter 3: Process/Behavioral Addictions

Purpose of This Chapter

To become familiar with some of the other process/behavioral addictions that may co-occur with substance use disorders.

Learning Objectives

At the end of this chapter, participants will be able to identify the following:

- Common process/behavioral addictions
- The signs and symptoms of process/behavioral addictions as well as the potential health impact and adverse consequences
- Treatment implications

Process addictions, also known as behavioral addictions or non-substance addictions, are a type of addictive behavior that does not involve the use of drugs or alcohol but revolves around certain activities or processes. These activities can trigger pleasurable feelings and a sense of reward, leading individuals to engage in them repeatedly, often to the detriment of their well-being, relationships, and responsibilities. It is common for someone struggling with a substance use disorder to also have other addictive behaviors. A counselor should also assess clients for other addictive behaviors and treat them in a co-occurring manner with the substance use disorder. Several common process addictions involve engaging in specific activities or behaviors to the point where they become compulsive and have negative consequences on a person's life.

Basics of process addictions

1. **Definition**: Process addictions involve compulsive behaviors related to specific activities, such as gambling, gaming, shopping, eating, exercising, internet use, work, sex, and more. These behaviors become habitual and can lead to negative consequences.
2. **Similarities to Substance Addiction**: While process addictions do not involve ingesting substances, they share several similarities with substance addiction. Both types of addiction can lead to tolerance (needing more of the behavior to achieve the same effect), withdrawal symptoms, loss of control, and negative impacts on a person's life.
3. **Reward System**: Engaging in the addictive behavior activates the brain's reward system, releasing neurotransmitters like dopamine, which creates a sense of pleasure and reinforcement. Over time, individuals may become reliant on these behaviors to experience the same level of pleasure.
4. **Escalation and Loss of Control**: Just like with substance abuse, individuals with process addictions may find themselves engaging in the behavior more frequently and for longer periods than intended. They may also struggle to control their impulses to engage in the behavior, even when they are aware of the negative consequences.

5. **Negative Consequences**: Process addictions can lead to a range of negative consequences, including strained relationships, financial problems, neglect of responsibilities, physical health issues, and emotional distress.
6. **Withdrawal Symptoms**: People with process addictions may experience withdrawal symptoms when they are unable to engage in the addictive behavior. These symptoms can include irritability, restlessness, anxiety, and a strong urge to engage in the behavior.
7. **Co-occurring Disorders**: Process addictions often co-occur with other mental health disorders, such as depression, anxiety, or obsessive-compulsive disorder. The presence of these disorders can complicate diagnosis and treatment.
8. **Treatment**: Treating process addictions involves a combination of psychological therapies, behavioral interventions, and support. Cognitive-behavioral therapy (CBT), motivational interviewing, support groups, and mindfulness techniques are often used to help individuals understand the triggers for their addictive behavior and develop healthier coping strategies.
9. **Prevention and Management**: Developing healthy habits and routines, setting limits on the time spent engaging in the addictive behavior, seeking social support, and finding alternative activities to replace the addictive behavior can all contribute to prevention and management.
10. **Awareness and Understanding**: Recognizing the signs of process addictions and understanding their impact is crucial for individuals, families, and healthcare professionals. Raising awareness about these types of addictions can help reduce stigma and improve access to treatment.

It is important to note that not everyone who engages in a certain behavior excessively will develop a process addiction. However, when these behaviors begin to significantly interfere with a person's daily life and well-being, seeking professional help is recommended.

Common Process Addictions

Gambling Disorder (see DSM diagnosis criteria in next section): This involves compulsive gambling, whether at casinos, online platforms, or other venues. Individuals with gambling addiction may become preoccupied with gambling, experience difficulty controlling their gambling behavior, and continue despite negative consequences.

Gaming Addiction: Also known as internet gaming disorder, this addiction involves excessive and compulsive video gaming, often to the detriment of other responsibilities and activities. It can lead to social isolation, impaired sleep, and neglect of personal and professional obligations.

Internet and Social Media Addiction: Excessive use of the internet, social media, and online activities can become addictive. People may spend significant amounts of time browsing, checking notifications, and engaging in online interactions, often leading to reduced face-to-face social interactions and negative impacts on mental well-being.

Shopping Addiction (Compulsive Buying Disorder): People with this addiction experience an irresistible urge to shop, leading to excessive spending and accumulating items they may not need. This behavior can result in financial problems, clutter, and emotional distress.

Exercise Addiction: Also called compulsive exercise, this addiction involves an obsession with exercise and physical activity, often exceeding recommended guidelines and leading to physical injuries, exhaustion, and neglect of other important aspects of life.

Work Addiction (Workaholism): People with work addiction excessively focus on work to the detriment of personal relationships, leisure time, and overall well-being. They may find it difficult to disconnect from work-related activities and may experience burnout.

Sex and Pornography Addiction: This involves compulsive engagement in sexual activities or viewing pornography, often leading to negative consequences in personal relationships, social functioning, and emotional well-being.

Love and Relationship Addiction: Individuals with this addiction become overly dependent on being in relationships and may seek out new relationships impulsively. They may fear being alone and struggle with codependent behaviors.

It is important to note that while these behaviors can become addictive for some individuals, not everyone who engages in them will develop a process addiction. Factors such as genetics, environment, personal vulnerabilities, and coping mechanisms play a role in the development of these addictive patterns.

Additionally, Gambling Disorder is the only process/behavior addiction-related diagnosis currently recognized in the DSM-5-TR. There are task forces currently looking at other process/behavior addictions for possible inclusion in future editions of the DSM (APA, 2022).

Gambling Disorder

A. Persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress, as indicated by the individual exhibiting four (or more) of the following in a 12-month period:

1. Needs to gamble with increasing amounts of money in order to achieve the desired excitement.
2. Is restless or irritable when attempting to cut down or stop gambling.
3. Has made repeated unsuccessful efforts to control, cutback, or stop gambling.
4. Is often preoccupied with gambling (e.g., having persistent thoughts of reliving past gambling experiences, handicapping or planning the next venture, thinking of ways to get money with which to gamble).

5. Often gambles when feeling distressed (e.g., helpless, guilty, anxious, depressed).
6. After losing money gambling, often returns another day to get even ("chasing" one's losses).
7. Lies to conceal the extent of involvement with gambling.
8. Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling.
9. Relies on others to provide money to relieve desperate financial situations caused by gambling.

B. The gambling behavior is not better explained by a manic episode.

Specify if*:*

Episodic: Meeting diagnostic criteria at more than one time point, with symptoms subsiding between periods of gambling disorder for at least several months.
Persistent: Experiencing continuous symptoms, to meet diagnostic criteria for multiple years.

Specify if*:*

In early remission: After full criteria for gambling disorder were previously met, none of the criteria for gambling disorder have been met for at least 3 months but for less than 12 months.
In sustained remission: After full criteria for gambling disorder were previously met, none of the criteria for gambling disorder have been met during a period of 12 months or longer.

Specify current severity:

Mild: 4–5 criteria met.
Moderate: 6–7 criteria met.
Severe: 8–9 criteria met.

Treatment for Process/Behavior Addiction

Similar to substance use treatment, treatment for process addiction typically involves a combination of therapeutic approaches aimed at addressing the underlying causes of the addictive behavior, teaching healthy coping strategies, and helping individuals regain control over their lives. Here are some common treatment approaches for process addiction:

Figure S-3.1 Common Treatment Approaches for Process Addictions

Cognitive Behavioral Therapy (CBT)	CBT is a widely used therapeutic approach that helps individuals identify and challenge negative thought patterns and behaviors. It can help process addiction by addressing distorted beliefs about the addictive behavior, teaching healthier ways of thinking, and developing effective coping skills
Motivational Interviewing	This approach focuses on enhancing an individual's motivation to change their addictive behavior. Therapists work collaboratively with clients to explore their ambivalence toward change and help them find intrinsic motivation to make positive changes.
Mindfulness and Meditation	Mindfulness techniques can help individuals become more aware of their thoughts, emotions, and urges related to the addictive behavior. Meditation practices promote self-awareness and impulse control, reducing the likelihood of engaging in the addictive behavior.
Support Groups	Participating in support groups, such as 12-step programs (e.g., Gamblers Anonymous, Overeaters Anonymous), can provide a sense of community, understanding, and shared experiences. These groups offer a platform for individuals to connect, share their struggles, and learn from others who have successfully overcome process addictions.
Family Therapy	Process addictions can strain relationships with family members. Family therapy can help improve communication, understanding, and support within the family unit. It also addresses how family dynamics might contribute to or maintain the addictive behavior.
Behavioral Interventions	Behavior modification techniques can help individuals replace the addictive behavior with healthier alternatives. This may involve setting goals, tracking progress, and implementing strategies to manage triggers and cravings.
Relapse Prevention	Developing a relapse prevention plan is crucial for maintaining progress after treatment. This plan outlines strategies to cope with triggers, prevent relapse, and manage high-risk situations.
Psychoeducation	Learning about the nature of addiction, its underlying causes, and the brain mechanisms involved can empower individuals to better understand their condition and take proactive steps toward recovery.
Individual Therapy	Individual therapy sessions provide a safe space for individuals to explore their emotions, experiences, and challenges related to the addictive behavior. Therapists can help clients gain insight into their motivations and develop personalized strategies for change.
Holistic Approaches	Some individuals find benefit in incorporating holistic practices such as yoga, art therapy, exercise, and nutrition counseling into their treatment plan. These approaches can promote overall well-being and support recovery.

Medication (In Some Cases)	For certain process addictions, medication may be prescribed to address underlying mental health conditions that contribute to the addictive behavior, such as depression, anxiety, or obsessive-compulsive disorder.

The choice of treatment approach should be based on the individual's specific needs, preferences, and the severity of the addiction. It is important for individuals to work with qualified therapists, counselors, or addiction specialists who have experience in treating process addictions. Remember that recovery is a gradual process, and relapses may occur. However, with the right support and dedication, individuals can make positive changes and regain control over their lives.

Learning Activities

Review the case scenario below and answer the following questions.

Case Scenario:

Sarah is a 28-year-old Navy sailor who has been serving on a naval vessel for several years. She joined the Navy with a strong sense of duty and pride in her service. However, beneath her dedicated exterior lies a secret struggle that threatens to undermine her career and well-being.

Background:

Sarah's introduction to gambling occurred during one of her shore leave periods. She and her fellow sailors would often explore the nearby town's attractions, which included a casino. Initially, gambling was a way to unwind and have fun with her friends. The thrill of the games and the camaraderie made her feel a sense of belonging.

Early Signs:

As Sarah's deployments continued, she found herself thinking about the casino even while at sea. During her off-duty hours, she started spending more time online researching gambling strategies and learning about different games. She began budgeting a portion of her earnings for gambling, convincing herself that it was just a form of entertainment.

Escalation:

Sarah's gambling habit escalated over time. What began as occasional visits to the casino turned into regular and longer stays. She started spending larger sums of money, believing that she could eventually win back her losses. Her confidence was further fueled by occasional wins, even though they did not cover her mounting debts.

Impact on Relationships and Performance:

Sarah's addiction started to affect her relationships with fellow sailors and superiors. She became more withdrawn, often declining invitations to social activities. Her performance on the naval ship started to decline as well. She struggled to focus on her duties, and her colleagues noticed her fatigue and lack of enthusiasm.

Seeking Help:

One day, Sarah's supervisor noticed her struggling and asked if everything was okay. Sarah hesitated at first but eventually opened up about her gambling problem. Her supervisor referred her to the ship's mental health counselor, who had experience in addiction treatment.

Treatment and Recovery:

Sarah's counselor began working with her to address the underlying causes of her gambling behavior. Through counseling sessions, she learned that her gambling had become a way to cope with stress and feelings of isolation while at sea. Cognitive-behavioral therapy (CBT) techniques helped her challenge her distorted beliefs about gambling and develop healthier coping mechanisms.

Progress and Challenges:

Throughout her recovery journey, Sarah faced moments of intense temptation and cravings, especially during deployments. She learned to recognize triggers and implemented strategies to manage them. She also attended group therapy sessions with other sailors who were struggling with different types of addiction.

Discussion Questions: Answer the following questions and discuss with your preceptor

1. What are some of the early signs that Sarah's gambling behavior was becoming problematic?
1. Which criteria does Sarah meet from the DSM-5-TR Gambling Use Disorder?
2. Does Sarah meet criteria for Gambling Use Disorder? If so, what specifiers and severity level is she?
3. How did Sarah's addiction impact her relationships and performance on the naval ship?
4. What role did her supervisor play in helping Sarah seek assistance for her gambling addiction?
5. What are some potential reasons why individuals in high-stress environments like the military might be more susceptible to developing addictive behaviors?
6. How might Sarah's experience be similar or different from other sailors or military personnel struggling with addiction?
7. How does cognitive-behavioral therapy (CBT) help individuals like Sarah address and overcome addictive behaviors?
8. What are some strategies Sarah could use to manage cravings and triggers while at sea?
9. What types of support networks and resources are available within the military to assist service members dealing with addiction?
10. How might Sarah's recovery journey impact her future career prospects and overall well-being?
11. What steps can SARP take to raise awareness about addiction issues and provide better support for those who are struggling?
12. Develop a relapse prevention plan for Sarah. What ongoing resources does she need to be successful

Supplemental Chapter 4: Integrating 12-step Recovery into Treatment

Purpose of This Chapter

This chapter reviews the principles and practices associated with 12-step recovery programs and explores methods for integrating self-help recovery groups into substance use disorder (SUD) treatment.

The learning objectives in this chapter correlate with the components within *TAP 21* Competencies 5, 10, 45, 49, 83, and 105; and the IC&RC Domain III: Evidence Based Treatment, Counseling, and Referral.

Learning Objectives

- Describe why 12-step recovery is a generally accepted model of treatment and recovery. (5)
- Describe the helping strategies of self-help programs. (10)
- Describe the contributions of self-help support groups. (45)
- Describe the mission, function, resources, and quality of services offered by self-help groups. (49)
- Recognize that recovery involves more than the elimination of symptoms. (83)
- Describe models of recovery from SUDs. (105)

Introduction

In 1935, two alcoholic men met and talked about the negative impact drinking had on their lives and the struggles they experienced maintaining abstinence. Over time, they realized that these conversations—the sharing of their experience, strength, and hope—helped them stay sober. These meetings developed into the organization now known as Alcoholics Anonymous® (A.A.). Navy Substance Abuse Rehabilitation Programs (SARP) and many other providers have included education about and referral to A.A. and other 12-step groups as part of a comprehensive treatment program. A competent counselor needs to have an understanding of A.A. and other 12-step programs, and be able to orient patients to its history, value, and the reason they are introduced to the organization during treatment.

In addition to completing the activities in this chapter, counselors are encouraged to review the *Navy Drug and Alcohol Counselor School (NDACS) Student Guide* information on A.A. to integrate 12-step recovery into their work and to prepare for certification exams.

What is a 12-step Program?

Twelve-step programs include a variety of organizations in which persons who identify themselves as having an addiction come together to share their experiences and support each other in

maintaining abstinence from an addictive substance or behavior. The phrase "12-step program" refers to the twelve steps the founders reported they completed that enabled them to establish and maintain sobriety. The steps are designed to be worked in a specific order and guide persons to: accept that they have no control over their addiction; examine the consequences their use has had on their life and the lives of others; make changes to their behavior and recompense for their mistakes; and share what they have learned with others suffering from the same addiction.

Twelve-step programs are offered to deal with addiction to alcohol, drugs, gambling, sex, food, shopping, and more. Additionally, there are groups, such as Al-Anon and Al-a-Teen, which offer support to persons who have close relationships with people who have problems with an addiction. A.A. is the original and largest 12-step program. It has an organizational structure under its General Service Office (GSO). The GSO "serves as a clearinghouse and exchange point for the wealth of A.A. experience accumulated over the years, coordinates a wide array of activities and services, and oversees the publication, all translations of, and distribution of A.A. conference-approved literature and service materials" (A.A. World Services, 2013).

"Twelve-step groups emphasize abstinence and have 12 core developmental 'steps' to recovering from dependence. Other elements of 12-step groups include taking responsibility for recovery, sharing personal narratives, helping others, and recognizing and incorporating into daily life the existence of a higher power. Participants often maintain a close relationship with a sponsor, an experienced member with long-term abstinence, and lifetime participation is expected" (SAMHSA, 2008).

Components of 12-step Programming

The 12 Steps

The 12 steps listed below are taken from A.A. (A.A. World Services, 2001) Other groups substitute other substance use or behaviors in place of alcohol. Below each "step" is a brief explanation of the meaning of the step, as applied to alcohol (Kinney & Leaton, 1995).

1. *We admitted we were powerless over alcohol and that our lives had become unmanageable.*

   Acknowledges that alcohol is the problem and that it has impacted their entire life.

2. *Came to believe that a Power greater than ourselves could restore us to sanity.*

   Recognizes that continuing to drink despite problems is a form of insanity and gradually relies on an external source to guide them. A.A. uses the title God and Higher Power interchangeably. There is no insistence that members consider a spiritual being to be their higher power. The recognition that the answers are outside of themselves is an important part of this process.

3. *Made a decision to turn our will and our lives over to the care of God as we understood Him.*

   Decides to allow an outside influence (spiritual being, friend, sponsor, the A.A. group) provide direction for their life. This may simply mean making a decision to do what

they are supposed to do (go to a meeting, not drink, call their sponsor, go to therapy, etc.), rather than what they want to do (go to a bar, use, hang out with drinking buddies).

4. *Made a searching and fearless moral inventory of ourselves*.

   The member begins to look at their behavior when drinking and to take responsibility for the consequences.

5. *Admitted to God, to ourselves, and to another human being the exact nature of our wrongs*.

   By sharing their wrong doings with another person, members are able to deal with feelings of guilt.

6. *Were entirely ready to have God remove all these defects of character*.

   The member explores attitudes and behaviors that need to change to obtain sobriety. Getting ready to change is not the same as being comfortable. The support of a sponsor, other members, family, or any person who believes in recovery is vital.

7. *Humbly asked Him to remove our shortcomings*.

   The member asks for help in changing behavior. This step instills hope that change is possible. Although a spiritual approach is implied in the wording, a sponsor who keeps the member in check and accountable may support the process.

8. *Made a list of all persons we had harmed and became willing to make amends to them all*.

   This is a concrete step in the process of taking responsibility.

9. *Made direct amends to such people wherever possible, except when to do so would injure them or others*.

   The member apologizes, pays back debts, makes up for injuries. It stresses the importance of owning up to mistakes and may help relieve feelings of guilt. Completing this step does not require that the injured party accept the apology.

10. *Continued to take personal inventory and when we were wrong promptly admitted it*.

    This step keeps the recovery process active. Integrating a routine review of one's behavior helps prevent returning back to old habits.

11. *Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out*.

    This step continues spiritual development. It keeps the member focused on a positive view of the future.

12. *Having had a spiritual awakening as a result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs*.

This step asks members to share what they have learned and experienced with others. The founders of A.A. recognized that sharing their stories was key to maintaining their sobriety.

Meetings

Meetings are generally opened by a chairperson. If it is an A.A. meeting, the *Preamble of Alcoholics Anonymous* will be read. Participants may be given an opportunity to share their first name and what brings them to the meeting. A typical introduction will include a statement such as "my name is X (first name only) and I am an xxx (alcoholic, addict, sex addict, etc.)." No one is forced to share. The chairperson may read a prayer and then introduce the format or topic for the meeting.

There are different kinds of 12-step meetings with varying formats. Examples of these meetings include:

- **Open meetings—**anyone can attend. A speaker may share his or her story of their experience with substances and how they have used the program to obtain sobriety.
- **Closed meetings—**only those with the problem the group works to support are welcome, such as alcoholics at an A.A. meeting.
- **Big book meeting—**the book *Alcoholics Anonymous* is used as a text for discussion.
- **Discussion meeting—**a chairperson shares his or her personal story and may lead a discussion on a topic of his or her choosing.
- **Step meeting—**the meeting discussion addresses one or more of the 12 steps and may include reading a chapter out of the book *Twelve Steps and Twelve Traditions*.
- **Online meetings—**many 12-step programs offer online meetings that may be useful for patients in isolated duty stations and aboard ship.

The meeting may come to a close with participants gathering around in a circle and sharing a group hug, sometimes reciting The Lord's Prayer. They also may recite a 12-step slogan. No one is forced to participate in this process. Following the closing of the meeting, members may gather around in a social setting. New attendees will likely be offered a "hello" and opportunity to chat, but anyone who wants to leave quietly will not be pursued. Twelve-step programs are frequently referred to as fellowships, a community in which people seeking or stable in recovery experience support, camaraderie, and friendship among each other as they share the consequences of their addiction, the challenges of healing, and the joys of sobriety.

If you have not been to a 12-step meeting, ever or in a long while, attend one now—choose an open or closed meeting as appropriate to your personal circumstances. You do not have to be active in a fellowship to orient patients to 12-step programming. If you are not active in a fellowship, then attending a meeting from time to time may help you authentically discuss 12-step programs with your patients.

Write a list of questions or comments patients have made regarding attending 12-step meetings. Draft responses and review them with your Preceptor.

Sponsors

Members of 12-step programs are guided through the 12 steps by a "sponsor," a person who has stable sobriety and experience in the particular program. According to A.A. World Services, a sponsor is "an alcoholic who has made some progress in the recovery program and shares that experience on a continuous, individual basis with another alcoholic who is attempting to attain or maintain sobriety through A.A." (A.A. World Services, 1976).

Orientation to 12-step programming should include a discussion of what a person might look for in a sponsor. Some members benefit from sponsors who have very similar backgrounds to their own. Others look for someone very different who may challenge them in new ways. Patients who are nervous about attending meetings or have difficulty meeting new people may benefit from role-playing asking someone to be their sponsor.

Anonymity

Attendees at 12-step meetings do not identify themselves by full name, nor do they disclose anyone else who attends meetings. They also maintain confidentiality at the public level, by not sharing to the media that they attend 12-step meetings. According to A.A. World Services, "anonymity serves two different yet equally vital functions:

- At the personal level, anonymity provides protection for all members from identification as alcoholics, a safeguard often of special importance to newcomers.
- At the public level of press, radio, TV, films and other media technologies such as the Internet, anonymity stresses the equality in the fellowship of all members by putting the brake on those who might otherwise exploit their A.A. affiliation to achieve recognition, power, or personal gain" (A.A. World Services, 2011).

Literature

A.A. World Services, Inc., publishes GSO-approved literature, including books and pamphlets. *Alcoholics Anonymous* (2001) is the basic text of A.A. and was first published in 1939. It is known in A.A. as "The Big Book." The fourth edition was printed in 2001. According to A.A. World Services, in subsequent editions "Chapters describing the A.A. recovery program remain unchanged. New stories have been added to the personal histories." (www.aa.org) Counselors can use the books

Alcoholics Anonymous (2001) and *Twelve Steps and Twelve Traditions* (1952) to expose patients to the 12-step model.

Literature offered by other 12-step programs can be found online easily, including at sites such as www.na.org (Narcotics Anonymous), www.saa-recovery.org (Sex Addicts Anonymous®), and www.gamblersanonymous.org (Gamblers Anonymous®).

Many treatment programs offer patients copies of The Big Book and the *Twelve Steps and Twelve Traditions*. If your program does not give these materials to patients, then it is worthwhile to make them available for perusal and to have other pamphlets published by GSO available for review. Materials from other programs also can be ordered online to be made available for patients.

Slogans

Twelve-step programs have many slogans that help to inspire participants, create a sense of community, and serve as quick reminders of practices that many in recovery have found to be helpful (12Steppers.org, 2024).

Examples include:

- Easy does it.
- First thing first.
- Live and let live.
- Let go and let God.
- This, too, shall pass.
- Stick with the winner.
- We are only as sick as our secrets.
- One day at a time.
- Keep an open mind.

Competent counselors utilize opportunities to demonstrate cultural competency regarding 12-step programs. One way to reflect cultural competency is to utilize slogans in your interactions with patients. Consider asking patients what slogan they have heard in A.A. that might help them deal with a drinking trigger, stress, a crisis, etc.

Many programs also hang posters that list *The 12 Steps* and slogans of A.A. Hanging such materials reflects a treatment culture that sees 12-step programming as a valuable component of recovery.

Watch the video tape of a group you have facilitated. Identify opportunities when you could have integrated a slogan into your feedback.

How 12-step Recovery Works

Twelve-step programs involve "a series of steps and traditions that rely heavily on self-honesty, sobriety, group process, humility, provision of successful role models, self-care, and destigmatization of alcoholism as an illness" (Mack, et.al, 2010).

Participation in 12-step programming reinforces many treatment interventions:

- **Environmental cues—**attending meetings and spending time with people in recovery keeps people out of bars and places where they use drugs.
- **People—**sponsors and support group members serve as successful role models for abstinence and recovery, rather than current drinkers/drug users.
- **Self-efficacy—**not using one day at a time allows persons to experience small successes and build on feelings of self-efficacy as individual days add up to periods of sobriety.
- **Relapse prevention—**members learn how others say no to a drink/drug, make plans to deal with urges and cravings, and how to choose new activities to substitute time spent using.
- **Psychological/emotional regulation** (Kaskutas, 2009):
    - Step 1 addresses feelings of self-importance, narcissism, omnipotence.
    - Steps 2 and 3 recognize that one cannot do it alone, but that a Higher Power, which can be operationalized as the A.A. group, is there to help.
    - Steps 4–9 realize how one's behavior affected and affects others.
    - Step 10 addresses treating other people better.
    - Step 11 encourages finding meaning in life.
    - Step 12 focuses on relinquishing one's negative self-focus by helping others.

How can I help my patient who is resistant to attending A.A.?

- **Attend an open 12-step meeting.** You may have been required to do this in your schooling, but if it has been a while, then go again. A great way to help a patient overcome nervousness is to be able to share your own experience going to a meeting.
- **Use 12-step literature as bibliotherapy.** Those patients who are visual learners may benefit from reading up on what to expect at a meeting before they go.
- **Integrate the slogans into your therapeutic work.** Utilizing the language of 12-step programs in group or individual sessions will reinforce the integration of 12-step programming into recovery.
- **Share the data.** Research has shown that those who attend treatment programs that integrate 12-step programming are more likely to be attending 12-step meetings 3–6 months following treatment and also more likely to be abstinent (Laudet & Stanick, 2010). See additional data below.

- **Have treatment group members share their experience attending meetings.** Provide opportunities to role-play meeting new people or asking questions of a potential sponsor.

Co-occurring Disorders and 12-step Program Participation

Those who struggle with mental health disorders in addition to SUD may benefit from participation in 12-step programs. The appropriateness of the referral will be influenced by the mental health diagnosis, the patient's condition, and the preparation provided by the clinical team.

Some longstanding members of A.A., who may have never struggled with mental health challenges, may reflect the attitude that sobriety means being free of all drugs, whether prescribed or otherwise. This attitude may be informed by a member's own challenges with abusing other chemicals once they became abstinent from alcohol, a distrust of the medical community, or a lack of understanding of mental health disorders. Those on medications have been told by A.A. members to stop taking "those drugs." That attitude, however, is less prevalent now and A.A. as an organization reflects a greater understanding of the various health challenges its members may experience. Updated A.A. literature states the following: "*Because of the difficulties that many alcoholics have with drugs, some members have taken the position that no one in A.A. should take any medication. While this position has undoubtedly prevented relapses for some, it has meant disaster for others"* (A.A. World Services, 2011).

The pamphlet, *The A.A. Member—Medications and Other Drugs* (A.A. World Services, 2011), goes on to say, *"It becomes clear that just as it is wrong to enable or support any alcoholic to become readdicted to any drug, it's equally wrong to deprive any alcoholic of medication[that] can alleviate or control other disabling physical and/or emotional problems."*

Counselors working with persons with co-occurring disorders (COD) should explore the patient's questions and concerns about attending 12-step meetings before sending them off to their first meeting. Patients might be given opportunities to practice if/how they will discuss their mental health challenges in a meeting. Explore the qualities they might look for in a sponsor. Practice asking their sponsor for support in following all of their treatment requirements, including abstinence from alcohol and compliance with prescribed medications.

David Mee-Lee, M.D., a noted psychiatrist, and SUD expert, offers a monthly newsletter including tips for treatment providers. His May 2016 column encourages counselors to teach patients to:

- Identify those people at a meeting who are more open to talking about COD—listen for a speaker who mentions mental health issues and not just addiction. Approach them privately. If an A.A./NA member is more welcoming and understanding about mental health issues, then ask that person about other members who are similar.

- Handle an A.A./NA member who may confront them for being at the meeting because they have mental illness and not just addiction.
- Respect the others' opinion and not be defensive or antagonistic.
- Reassure the member that they are not there to disrupt the meeting and have the same needs for recovery support as everyone.
- Express that they will be careful not to detract from the main mission of the meeting.
- Recognize the similarities with other speakers even if the speaker does not drink or take drugs the same as they do.
- Note what speakers say about the effects of addiction on family, friends, and work; and how they are similar to the patient's family, friends, and work problems, even though the drug or substance used is different (Mee-Lee, 2016).

Review the list of 12-step meetings patients are referred to while in treatment. What do you know about them? Is there any knowledge of how open the group is to persons with a COD? If you do not know, then how can you find out? Discuss with your Preceptor.

Does A.A. Work?

Although the structure of A.A. does not lend itself to conducting scientific research on attendees, several studies of the role of A.A. in recovery have been conducted with persons presenting through treatment programs or medical service units. Many of these have shown that regular attendance at A.A. meetings has a positive correlation with abstinence over the course of time.

- Patients who participated in both outpatient treatment and 12-step groups fared the best on 1-year outcomes. Patients who did not participate in aftercare had the poorest outcomes. Better outcomes were associated with more outpatient mental health treatment, more frequent attendance at 12-step meetings, or more involvement in 12-step activities (Ouimette, et al., 1998).
- In a longitudinal study of previously untreated problem drinkers, persons who continued to attend A.A. regularly experienced better outcomes than those who did not. Seventy percent of those who attended A.A. for 27 weeks or more in any given year (whether at year 1, at years 2–3, or at years 4–8) were abstinent from alcohol at the 16-year follow-up. Persons with shorter lengths of A.A. attendance had lower rates of abstinence (Moos & Moos, 2006).
- Longer duration of attending A.A. and better drinking outcomes at the l-year follow-up was associated with a lower mortality rate in the subsequent 15 years (Timko, et al., 2006b).
- According to Witbrodt and Katsukas (2005), individuals who attended more 12-step group meetings in the first 6 months after seeking treatment were more likely to be abstinent at a 6-

month follow-up; those who attended more meetings in the subsequent 6 months were more likely to be abstinent at a 12-month follow-up.

- In Project MATCH, abstinence was closely associated with A.A. attendance, the number of steps completed, and self-identification as an A.A. member. The combination of these three items was more highly related to abstinence than just attendance at meetings by itself (Cloud, et al., 2004).
- In a study of persons in treatment for cocaine use disorders, active 12-step involvement in a given month predicted less cocaine use in the next month. Patients who increased their 12-step involvement in the first 3 months of treatment had better cocaine and other drug use outcomes in the next 3 months. Patients who regularly engaged in 12-step activities, even if their meeting attendance was inconsistent, had better drug use outcomes than those who attended consistently, but did not engage in 12-step activities. (Weiss, et al., 2005). Patients with SUDs and posttraumatic stress disorders who were more involved in 12-step groups during treatment relied more on approach and less on avoidance coping at discharge; they also had fewer psychological symptoms. The dually diagnosed patients who participated more in 12-step groups were more likely to be abstinent and experienced less distress; they also were more likely to maintain stable remission (Ouimette, et al., 2000).

Summary

Research has now shown that participation in 12-step programming is correlated with length of abstinence from alcohol. It is appropriate for counselors to offer patients opportunities to learn about and take advantage of this widely available, no-cost resource. Not every patient will find that 12-step programs meet their needs, and they may not continue once they have left treatment. Including education about and attendance at meetings as part of a comprehensive treatment program, however, is good practice. Just as a physician or physical trainer might ask a patient to try out a new diet or exercise regimen, so can a substance abuse counselor ask a patient to give A.A. or other support groups a try.

Learning Activities

1. Walk around your facility and review your program schedule. Make a list of any materials, artwork, literature, or program events that reflect endorsement of 12-step programs as being a worthwhile recovery resource. What other recovery resources are reflected in your physical setting? Review this with your Preceptor in clinical supervision.
2. Review the information about the Sisson and Mallams study published in 1981, referenced in Chapter 4 on Referral. What does your program do to facilitate patients' participation in self-help programming while in treatment, whether it is a 12-step or another support group? Does your continuing care program offer any additional support to help patients connect with support groups? Discuss with your Preceptor.

3.	Research self-help groups available in your community. Develop a list of programming to include any 12-step groups and non-12-step recovery meetings. Gather the information into a referral notebook to be utilized when developing treatment plans. Review with your Preceptor.
4.	Review the treatment records for three patients. • Was interest in 12-step recovery assessed? • Were any problems with attendance at A.A. meetings identified? • Was 12-step programming integrated into the treatment plan? • Was 12-step recovery reflected in the progress notes? • Review your findings and discuss whether 12-step programming should be reflected in the treatment record with your Preceptor.

Self-Study Questions

Match Definitions to A.A. Terminology

ANSWER	Definition	Term
	A phrase that reminds alcoholics that when one tries to do things perfectly, one is attempting to do the impossible.	a. Half Measures
	An untrue belief held by some alcoholics that trying the same methods over and over again will result in a different outcome.	b. H.A.L.T
	An acronym that reminds individuals to avoid certain states to protect their recovery.	c. Higher Power
	A condition of returning to one's old alcoholic thinking and behavior without actually having taken a drink.	d. Hitting Bottom
	The complete lack of intent to deceive oneself or anyone else.	e. H.O.W.
	The key to recovery. Making the decision to turn my drinking over to a Power greater than myself.	f. People, Places, and Things
	The act of giving up feelings of resentment or anger as a result of a perceived offense.	g. Progress Not Perfection
	An alcoholic's insistence on having his own way.	h. Balance
	Being willing to do whatever is necessary to maintain sobriety.	i. Alcoholic Grandiosity
	Reaching such a state of hopelessness that one becomes willing to admit complete defeat in dealing with alcoholism.	j. Alcoholic Insanity
	Acronym that stands for three keys to recovery.	k. Any Length
	Feelings of ill will that an individual holds for others usually as a result of some perceived harm others have done them.	l. Dry Drunk

	A thinking pattern that may indicate an alcoholic is not working the A.A. program and is getting close to drinking.	m. Resentment
	An emotional, mental, and spiritual state that is achieved as a result of working the 12 steps.	n. Stinking Thinking
	A phrase that reminds alcoholics not to take short cuts.	o. Rigorous Honesty
	A phrase that reminds alcoholics they must take responsibility for sobriety on themselves and not blame external factors.	p. Forgiveness
	A self-defined Power greater than ourselves that one ultimately turns to for assistance and guidance in leading a sober life.	q. Surrender

*Definitions taken from 2014 NDACS Student Guide Lesson on the 12 Steps of Alcoholics Anonymous

Self-Study Answers

Match Definitions to A.A. Terminology

ANSWER	Definition	Term
g.	A phrase that reminds alcoholics that when one tries to do things perfectly, one is attempting to do the impossible.	a. Half Measures
j.	An untrue belief held by some alcoholics that trying the same methods over and over again will result in a different outcome.	b. H.A.L.T
b	An acronym that reminds individuals to avoid certain states to protect their recovery.	c. Higher Power
l.	A condition of returning to one's old alcoholic thinking and behavior without actually having taken a drink.	d. Hitting Bottom
o.	The complete lack of intent to deceive oneself or anyone else.	e. H.O.W.
q.	The key to recovery. Making the decision to turn my drinking over to a Power greater than myself.	f. People, Places and Things
p.	The act of giving up feelings of resentment or anger as a result of a perceived offense.	g. Progress Not Perfection
i.	An alcoholic's insistence on having his own way.	h. Balance
k.	Being willing to do whatever is necessary to maintain sobriety.	i. Alcoholic Grandiosity
d.	Reaching such a state of hopelessness that one becomes willing to admit complete defeat in dealing with alcoholism.	j. Alcoholic Insanity
e	Acronym that stands for three keys to recovery.	k. Any Length
m.	Feelings of ill will that an individual holds for others usually as a result of some perceived harm others have done them.	l. Dry Drunk
n.	A thinking pattern that may indicate an alcoholic is not working the A.A. program and is getting close to drinking.	m. Resentment
h.	An emotional, mental, and spiritual state that is achieved as a result of working the 12 steps.	n. Stinking Thinking
a.	A phrase that reminds alcoholics not to take short cuts.	o. Rigorous Honesty
f.	A phrase that reminds alcoholics they must take responsibility for sobriety on themselves and not blame external factors.	p. Forgiveness
c.	A self-defined Power greater than ourselves that one ultimately turns to for assistance and guidance in leading a sober life.	q. Surrender

Supplemental Chapter 5: Psychopharmacology and Medication-assisted Therapy

Purpose of This Chapter

This chapter provides a review of medication-assisted treatment (MAT) for addiction and co-occurring disorders (CODs).

Learning Objectives

- Provide understanding of the role of recovery in MAT.
- Understand the screening and assessment process for MAT.
- Review psychopharmacological options for MAT.

Introduction

Addiction to substances can be compared to other disorders such as diabetes, asthma, and hypertension. These three disorders are universally considered medical and are sometimes relapsing and chronic. However, addiction historically has been treated as an acute illness and not chronic when, in fact, patients respond best to treatments combining behavioral and pharmacological interventions just like patients with other chronic disorders. MAT is the use of medication in the treatment of substance use disorders (SUDs).

MAT is used in combination with counseling and behavioral therapies to reduce the cravings and other symptoms associated with withdrawal from various substances. MAT is used for the treatment of opioid use disorder but also is used for alcohol use disorder, tobacco use disorder, and CODs. When treating individuals with MAT, always note potential contraindications of MAT drugs and any other medications that the patient might take.

There have been ongoing discussions about what recovery looks like for patients on MAT due to the difference between using medication as an aid to recovery, and the view that the use of any medication compromises recovery. Medication-assisted recovery combines holistic recovery principles with the traditional behavioral and psychopharmacological interventions.

This chapter discusses the role of MAT and recovery in the treatment of opioid, alcohol, tobacco, and CODs. Key medications used in MAT are included in **Table S-5.1**.

Table S-5.1

MAT Types	U.S. Food and Drug Administration (FDA)-approved Medications
MAT for Alcohol	Disulfiram Acamprosate Naltrexone
MAT for Opioids	Methadone Buprenorphine Naltrexone
MAT for Tobacco Use Disorders	Varenicline Bupropion Nicotine

Integrated Treatment: Medication and Counseling

Recovery in the past decades emerged as the new paradigm within the problem arena of drugs and alcohol. In the 1990s, long-tenured addiction professionals voiced that addiction treatment, through its over-commercialization/commodification had become detached from the more enduring and larger process of family and personal recovery. These concerns set the stage for this shift. As the disillusionment with palliative and acute care models of addiction treatment grew, addiction was reconceptualized as a chronic disorder. As a consequence, assertive approaches to long-term recovery management (RM) were developed, and RM was nested within larger recovery-oriented systems of care (ROSC).

Recovery

The Substance Abuse and Mental Health Services Administration (SAMHSA) has defined recovery as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Recovery Management

Recovery management provides a guiding philosophy that organizes treatment and recovery support services to enhance pre-recovery engagement, recovery initiation, long-term recovery maintenance, and the quality of personal/family life in long-term recovery. The following are key performance indicators linked to long-term recovery outcomes:

- Attraction, access, and early engagement
- Screening, assessment, and placement

- Composition of the service team
- Service relationship
- Service dose, scope, and quality
- Locus of service delivery
- Assertive linkage to communities of recovery
- Post-treatment monitoring, support, and early re-intervention

Recovery-oriented Systems of Care

ROSCs are coordinated networks of community-based services and supports that are person-centered and build on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.

The early pioneering efforts at facilitating recovery-oriented system transformation at the federal and state levels garnered considerable national and international acclaim. These larger transformations within the culture of recovery in the United States unfolded and influenced the rise and increased vibrancy of a new movement in recovery advocacy. New institutions on recovery support include recovery community centers, recovery schools, recovery homes, recovery ministries, recovery cafes, and recovery industries. Recovery communities developed cultures of recovery with their heroes, language, history, literature, folkways, and values.

Recovery Resources

Assessing the resources a person has in their life that support recovery can help to focus treatment objectives and help a patient plot a course for recovery. Recovery capital, as defined by Granfield and Cloud (1999), is the amount of internal and external assets that can be harnessed to begin and sustain recovery from SUDs. Recovery capital will vary by individual and be influenced by the severity of the SUD. The amount of recovery capital will influence the level of initial treatment required and the supports that will need to be established or enhanced to establish recovery. The Multidimensional Inventory of Recovery Capital (MIRC) is a tool developed by a multidisciplinary team at the University at Buffalo School of Social Work. It can be useful in helping patients assess the support they have for recovery - positive capital - and the challenges they may face - negative capital. More information on the MIRC can be found at

https://socialwork.buffalo.edu/resources/multidimensional-inventory-recovery-capital.html

Recovery-oriented Methadone Maintenance (ROMM)

ROMM is a framework for opioid addiction treatment. It combines pharmacotherapy and a menu of services that is sustained by professional and peer-based recovery support services that can assist the patients and their families in initiating and maintaining a long-term addiction recovery.

Screening and Assessment

There are various ways to screen and assess patients to determine their eligibility and readiness for MAT and admission to treatment. Initial screening should be used for the family's or individual's first point of engagement with the program, and ongoing assessments should be utilized as soon as the patient is admitted into treatment. Patient assessment should be an ongoing process as it provides the necessary information to develop and maintain individualized treatment plans. Screening determines whether there is the potential for a particular problem. Assessments are more comprehensive than screenings, as they define the nature of the identified problem and are used to develop specific treatment recommendations for addressing them.

Opioids

Initial screening and intake procedures determine the eligibility and readiness of an applicant for MAT and also their admission to an opioid treatment program (OTP). The comprehensive assessment will offer the basis for individualized treatment plan development. There is no single tool that incorporates all of the essential elements for assessing patients in MAT. Tools should include elements from the following.

Initial Screening

- Crisis intervention
    - Is the patient exhibiting behaviors that could jeopardize themselves or others?
    - Is the patient at risk of suicidal behaviors?
    - Is the patient threatening violent or homicidal behavior?
    - If yes, then refer the patient for immediate medical or psychiatric services.
- Eligibility verification
    - Does the applicant satisfy federal and state regulations and program criteria for admission to the program?
- Clarification of the treatment alliance
    - Explain patient and program responsibilities.
- Education
    - Communicate operational information such as dosing schedules, program hours, and treatment requirements.
    - Discuss the benefits and drawbacks of MAT to help applicants make informed decisions about treatment.
- Identification of treatment barriers
    - Ask patients about potential factors that might hinder their ability to meet treatment requirements (for example, lack of childcare or transportation).

Comprehensive assessments should include:

- Recovery environment
- Suicide and other agency risks
- Patient history, including substance use

- Prescription drug and over-the-counter medication use
- Method and level of drug use
- Pattern of daily preoccupation with drugs
- Compulsive behaviors
- Patient motivation and reason for seeking treatment
- Patient personal recovery resources
- Medical assessment
- Physical examination
- Laboratory testing: tuberculosis, hepatitis, HIV, sexually transmitted diseases

Alcohol

Screening for alcohol use disorders can be included in other routine comprehensive screening activities during routine examinations. Routine screening provides consistent data on the risk and use status of the patient population. Screening is especially important for the following populations:

- Pregnant or trying to conceive
- Having health problems that could be exacerbated or induced by alcohol
- At risk for heavy or binge drinking
- Having one or more chronic health problems, including other SUDs, which are not responding to the treatment
- Having social or legal problems that might be worsened or caused by the use of alcohol

Tobacco

Screening for tobacco use disorders can be included in other routine comprehensive screening activities during routine examinations. Routine screening provides consistent data on the risk and dependence status of the patient population. **Table S-5.2** Lists screening questions (Fiore, et.al., 2008)

Table S-5.2

The "5 As"	
Ask about tobacco use.	Identify and document tobacco use status for every patient at every visit.
Advise to quit.	In a clear, strong, and personalized manner, urge every tobacco user to quit.
Assess willingness to make a quit attempt.	Is the tobacco user willing to make a quit attempt at this time?
Assist in quit attempt.	For the patient willing to make a quit attempt, offer medication and provide or refer for counseling or additional treatment to help the patient quit.
Arrange follow-up.	For the patient willing to make a quit attempt, arrange for follow up contacts, beginning within the first week after the quit date.

Pharmacology

Alcohol

Disulfiram disrupts the metabolism of alcohol in the body, leaving individuals consuming alcohol while on the medication with a severe and unpleasant reaction. Symptoms include flushing, nausea, and heart palpitations. Compliance can be a problem; therefore, disulfiram may be better suited to patients with stronger recovery supports and who are highly motivated.

Acamprosate reduces symptoms of long extended withdrawal symptoms such as insomnia, anxiety, restlessness, and dysphoria. It functions by normalizing brain systems negatively affected by chronic alcohol consumption in adults. It appears to be more effective in patients with severe alcohol use.

Naltrexone blocks the brain's reward receptors affected by drinking and reduces the craving for alcohol. It reduces relapse in heavy drinking behavior and is highly effective in some patients where varied outcomes could be due to genetic factors. The medication is available in both oral tablet and long-acting injectable forms.

Opioids

Methadone prevents opioid withdrawal symptoms and reduces craving by activating opioid receptors in the brain. It has been used extensively in the treatment of opioid dependence in adults and is available in specialty methadone treatment programs.

Buprenorphine is designed to reduce or eliminate opioid withdrawal symptoms, including cravings, without producing the high or dangerous side effects of heroin and other opioids. It both activates and blocks opioid receptors in the brain. It is available as a stand-alone or in combination with another agent called naloxone. The combined product with naloxone deters diversion or abuse of the medication by causing a withdrawal reaction if it is intravenously injected by individuals physically dependent on opioids. Physicians with special certification may provide office-based buprenorphine treatment for detoxification and maintenance therapy.

Naltrexone prevents relapse in adult patients after complete detoxification from opioids. Naltrexone blocks the brain's opioid receptors, preventing drugs from acting on them, thereby blocking the high the user would normally feel. It also can cause withdrawal if recent opioid use has occurred. It can be taken orally in tablets or as a once-monthly injection given in a doctor's office.

MAT options for treatment include:

- Maintenance treatment—combines support services and pharmacotherapy with a full program of psychosocial intervention and assessment.
- Medical maintenance treatment—stabilizes the patients and can include provisions of buprenorphine, naltrexone, or methadone for a long period where clinic attendance and other services are reduced.
- Detoxification from short-acting opioids—stabilizes the patients through withdrawing them in a controlled manner from illicit opioids. It involves the use of medication. Counseling or other assistance is sometimes involved.

- Medically supervised withdrawal treatment—the controlled tapering of treatment medication for patients wishing to remain abstinent from opioids, without the assistance of medication.

Phases of Treatment for Opioid Treatment Program Patients

1. The **acute phase**, during which patients attempt to eliminate illicit-opioid use and lessen the intensity of other problems associated with their addiction.
2. The **rehabilitative phase**, during which patients continue to address addiction while gaining control of other major life domains.
3. The **supportive-care phase**, during which patients maintain their abstinence while receiving other interventions when needed.
4. The **medical-maintenance phase**, during which patients are committed to continuing pharmacotherapy for the foreseeable future but no longer rely on other OTP services.
5. The **tapering and readjustment phase**, an optional phase in which patients gradually reduce and eliminate opioid treatment medication.
6. The **continuing-care phase**, in which patients who have tapered from treatment medication continue regular contact with their treatment program.

SAMHSA TIP 43

Tobacco Use Disorders

Bupropion was the first non-nicotine medication proven effective for smoking cessation. It potentially blocks the neuronal reuptake of dopamine and norepinephrine and as well as of nicotinic acetylcholinergic receptors. It is contraindicated in patients with the following:

- A seizure disorder
- A current or prior diagnosis of bulimia or anorexia nervosa
- Use of a monoamine oxidase inhibitor within the previous 14 days
- In patients taking another medication that contains bupropion

Bupropion is available exclusively as a prescription medication and can be used in combination with nicotine replacement therapies.

Varenicline is another non-nicotine medication. It acts as a partial nicotine receptor agonist with antagonist effects. It is tolerated well in most patients; however there appears to be a need for additional research as to whether there is a negative impact on existing mental health illnesses.

The FDA has noted that depressed mood, agitation, changes in behavior, suicidal ideation, and suicide have been reported in patients attempting to quit smoking while using varenicline. The FDA recommends that: patients tell their healthcare provider about any history of psychiatric illness prior

to starting this medication; and clinicians monitor patients for changes in mood and behavior when prescribing this medication. It should be used with caution in patients with severe renal dysfunction and is not recommended for use in combination with nicotine replacement therapy because of its nicotine antagonist properties.

Nicotine replacement therapy medications deliver nicotine as at least a partial replacement to the nicotine obtained from cigarettes. It also is effective as a means of reducing the severity of nicotine withdrawal symptoms. Nicotine replacement products are FDA-approved in the following forms:

- Nicotine gum
- Nicotine inhaler
- Nicotine lozenge
- Nicotine nasal spray
- Nicotine patch

Summary

In conjunction with traditional behavioral health and recovery-oriented interventions, MAT is a proven best practice in facilitating recovery for many patients suffering from addiction.

Learning Activities

The next time you have a patient on medication, whether to assist with their substance use or a mental health problem, utilize these questions in your sessions. Review with your Preceptor.

Take 5–10 minutes every few sessions to go over these topics with your patients:

- Remind them that taking care of their mental health will help prevent relapse.
- Ask how their psychiatric medication is helpful.
- Acknowledge that taking a pill every day is a hassle.
- Acknowledge that everybody on medication misses taking it sometimes.
- Do not ask if they have missed any doses; instead, ask, “How many doses have you missed?”
- Ask if they felt or acted differently on days when they missed their medication.
- Was missing the medication related to any substance use relapse?
- Without judgment, ask “Why did you miss the medication? Did you forget, or did you choose not to take it at that time?”

Supplemental Chapter 6: Chronic Pain, Addiction, and the Military: Understanding, Challenges, and Treatment

Purpose of This Chapter

To become familiar with the challenges of patients with chronic pain and how to address these challenges in treatment.

Learning Objectives

At the end of this course, participants will be able to identify the following:

- How pain occurs in the body
- Explore the complex relationship between chronic pain, addiction, and the military, and to provide insights into the challenges faced by service members in managing these issues
- Highlight effective treatment approaches and strategies that can be employed to address the unique needs of military personnel dealing with chronic pain and addiction

The Problem

Chronic pain and addiction are two intertwined issues that have a significant impact on the lives of military personnel. Service members often face physically demanding tasks, rigorous training, and combat situations, which can lead to various injuries and conditions causing chronic pain. Furthermore, the culture of the military, characterized by stoicism and the need to "push through" pain, can contribute to the underreporting and inadequate management of chronic pain.

The confluence of chronic pain and military service can create a perfect storm for the development of addiction. Prescription opioids, frequently used to manage pain, have a high potential for misuse and addiction. The need for quick relief from pain, combined with stressors unique to military life, can push individuals towards self-medication, exacerbating the risk of addiction. This cycle of pain, prescription drug use, and potential addiction poses a substantial challenge to the well-being of military personnel.

How Pain Functions in the Body

Pain is a complex and intricate process that involves a combination of sensory, emotional, and cognitive factors. It serves as a vital warning mechanism to alert the body to potential harm or injury. The process of how pain works in the body can be broken down into several stages:

1. **Detection (Transduction):** Pain begins with the activation of specialized nerve endings called nociceptors. These sensory receptors are located throughout the body, particularly in the skin, muscles, joints, and internal organs. When tissue is damaged or injured, nociceptors detect various types of stimuli, such as heat, pressure, chemicals released from injured cells, or mechanical forces.

2. **Transmission:** Once nociceptors are activated, they generate electrical signals (action potentials) that travel along nerve fibers, called neurons, towards the spinal cord and then on to the brain. These signals are transmitted through different types of nerve fibers: A-delta fibers for fast, sharp pain (e.g., a cut), and C fibers for slower, duller pain (e.g., a burn).
3. **Processing (Perception and Modulation):** The brain receives the signals from the nociceptors and processes them in various regions, including the thalamus and the somatosensory cortex. This processing stage involves the perception of the pain sensation, as well as modulation of the pain signal. The brain can amplify or dampen the pain perception based on factors like attention, emotional state, and past experiences.
4. **Interpretation (Integration and Evaluation):** The brain interprets the pain signals in the context of the individual's experiences, emotions, and beliefs. This interpretation helps determine the overall experience of pain. For example, the same level of tissue damage can be perceived differently based on an individual's mindset or emotional state.
5. **Response:** In response to the pain signal, the brain initiates motor and behavioral responses. These responses can include reflexive actions, such as pulling away from a hot object, as well as more complex behaviors like seeking medical attention or taking pain-relieving measures.

It is important to note that pain is not solely a physical sensation but also has emotional and cognitive components. Factors such as anxiety, fear, depression, and even cultural influences can amplify or modulate the perception of pain. Additionally, chronic pain, which persists beyond the expected healing time, can involve changes in the nervous system that contribute to prolonged pain sensations even after the initial injury has healed.

Understanding the complex interplay between sensory, emotional, and cognitive factors in the pain process is crucial for developing effective pain management strategies. Treatments that address both the physical and psychological aspects of pain can lead to better outcomes for individuals experiencing acute or chronic pain.

Treatment Approaches

Addressing chronic pain and addiction in the military requires a comprehensive and multidisciplinary approach that considers the physical, psychological, and social aspects of these issues. Several treatment approaches can be effective in helping service members overcome these challenges:

1. **Integrated Pain Management:** Implementing a holistic approach to pain management that combines physical therapy, alternative therapies (such as acupuncture and mindfulness), and non-opioid pain medications. Emphasizing function and quality of life can help service members manage pain without relying solely on opioids.
2. **Behavioral Interventions:** Cognitive-behavioral therapies (CBT) and pain-specific interventions can help individuals develop coping strategies for managing pain and reduce the risk of addiction. Additionally, addressing any coexisting mental health conditions is crucial.

3. **Medication-Assisted Treatment (MAT):** For individuals already struggling with opioid addiction, MAT can provide relief while minimizing withdrawal symptoms and cravings. Methadone, buprenorphine, and naltrexone are examples of medications that can be used as part of a comprehensive treatment plan.
4. **Peer Support and Counseling:** Creating support networks and peer-led counseling programs within the military community can foster a sense of belonging and understanding. Veterans who have successfully navigated chronic pain and addiction can provide valuable insights and encouragement.
5. **Education and Training:** Promoting awareness and education about the risks of opioids, the signs of addiction, and available resources can empower service members to make informed decisions about pain management.
6. **Collaboration:** Encouraging collaboration between medical professionals, mental health experts, addiction specialists, and military leadership is essential for creating a cohesive and effective treatment strategy.

Addressing Surgeries in Recovery from Addiction: Comprehensive Care and Considerations

It is common for military personnel to go under anesthesia at one point or another during their service career. For many, recovery from surgery involves managing pain. For someone in recovery, this can pose a risk to their recovery if they are prescribed pain management medications, particularly opioid analgesics.

Surgery presents a unique challenge for individuals in recovery from addiction, as it requires careful planning and management to ensure both successful medical outcomes and the preservation of sobriety. Balancing pain management, potential relapse triggers, and the risk of opioid dependence demands a comprehensive and multidisciplinary approach. Counselors do not directly manage pain medications, however, do participate as part of the interdisciplinary team and can be a strong advocate for the patient. Here are key considerations and strategies for addressing surgery in the context of addiction recovery:

1. **Preoperative Assessment and Planning:**
    a. Open Communication: Inform the surgical and anesthesia teams about the individual's history of addiction and current recovery status. This allows for tailored pain management strategies and the avoidance of addictive medications.
    b. Multidisciplinary Team: Create a team that includes addiction specialists, pain management experts, surgeons, anesthesiologists, and mental health professionals. Collaboration ensures a holistic approach to care.
    c. Pain Management Plan: Develop a personalized pain management plan that considers non-opioid alternatives, such as nerve blocks, nonsteroidal anti-inflammatory drugs (NSAIDs), and local anesthetics.
2. **Intraoperative Care:**

   a. Minimize Opioid Use: Use opioids sparingly, if at all, during and immediately after surgery. Employ opioid-sparing techniques and monitor pain levels closely.
   b. Anesthetic Considerations: Work with the anesthesia team to select agents that minimize potential drug interactions and support the patient's recovery goals.
3. **Postoperative Recovery:**
   a. Non-Opioid Pain Management: Prioritize non-opioid pain relief methods, such as regional anesthesia, physical therapy, acupuncture, and cognitive-behavioral interventions.
   b. Monitoring and Support: Provide continuous monitoring and support by addiction-trained professionals to manage any pain flare-ups and address emotional distress.
   c. Relapse Prevention: Implement relapse prevention strategies, including counseling, therapy, and support groups, to help the individual cope with the stressors of surgery and recovery.
4. **Medication Management:**
   a. Opioid Use Disorder (OUD): If the individual has a history of OUD, consult addiction specialists to determine if medication-assisted treatment (MAT) should be continued or adjusted during the perioperative period.
   b. Avoid Triggers: Minimize the use of benzodiazepines and other addictive medications that could trigger relapse.
5. **Emotional and Psychological Support:**
   a. Counseling and Therapy: Incorporate counseling and therapy into the recovery plan to address the emotional challenges and potential triggers associated with surgery and the recovery process.
   b. Peer Support: Connect the individual with peer support networks or recovery communities to provide encouragement and shared experiences.
6. **Long-Term Recovery:**
   a. Continued Care: Ensure that the individual's long-term recovery plan is adjusted to account for the surgical experience and any pain management interventions.
   b. Addressing Challenges: Regularly assess for signs of postoperative pain, emotional distress, or relapse, and adjust the recovery plan accordingly.

Addressing surgery in the context of addiction recovery requires a comprehensive and individualized approach that considers physical, psychological, and emotional well-being. By involving a multidisciplinary team, focusing on non-opioid pain management strategies, and providing continuous support throughout the perioperative period, individuals can successfully navigate surgery while safeguarding their recovery journey. The integration of addiction expertise into surgical care ultimately enhances patient outcomes and contributes to the overall well-being of those in recovery.

Summary

Chronic pain and addiction among military personnel represent a complex and pressing challenge. The unique circumstances of military life, combined with the physical demands and psychological

stressors, necessitate tailored approaches to treatment and prevention. By implementing a comprehensive strategy that integrates various therapeutic modalities and emphasizes support, education, and collaboration, it is possible to mitigate the impact of chronic pain and addiction on service members, enabling them to lead healthier, more fulfilling lives both during and after their military service.

Supplemental Chapter 7: Cultural Competency

The U.S. Department of Health and Human Services (HHS) defines cultural competence as "the ability to honor and respect the beliefs, languages, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff members who are providing services. Cultural competence is a dynamic, ongoing developmental process that requires a long-term commitment and is achieved over time" (HHS 2003a, p.12) The TAP 21 reflects the importance of cultural competence as vital to counselor development in its list of counselor competencies. A review of the *TAP 21* competencies shows that the word "culture" is directly used in eleven of the competency statements. An additional fourteen competencies have a cultural component to the defined knowledge, skills, and attitudes needed to meet the competency (CSAT, 2006). The diversity of the population of the United States and global nature of the 21st century society requires helping professionals to be open to exploring more about communities, people, and cultures that differ from their own.

It is impossible for you to have advanced knowledge about every culture that may be represented by the patients that cross your doorstep. Cultural competency, therefore, requires an attitude of openness and a willingness to address individual and organizational barriers to serving diverse populations. In addition, culturally competent counselors make every effort to gain knowledge about the cultural groups most frequently represented in the treatment population. This appendix offers resources that will help to expand your knowledge of other cultures, examine your own thoughts and attitudes about working with people different than yourself, and a list of cultural competencies offered by the Association for Multicultural Counseling and Development (AMCD), a division of the American Counseling Association.

Resources

Substance Abuse and Mental Health Administration (SAMHSA): www.SAMHSA.gov
SAMHSA offers several resources on specific cultural groups. Many of SAMHSAs *Treatment Improvement Protocols (TIPs)* and *Technical Assistance Publications (TAPs)* include guidelines for meeting the needs of diverse communities in approaches to specific treatment populations. The internal search engine of the website is a useful place to start. *TIP 59: Improving Cultural Competence* is an excellent resource for learning more on this subject (SAMHSA, 2014).

Office of Minority Health (OMH): http://minorityhealth.hhs.gov
OMH, a division of the U.S. Department of Health and Human Services, offers several publications and research information on providing health care to ethnic minorities. Resources include a list of national standards on Culturally and Linguistically Appropriate Services (CLAS).

Health Resources and Services Administration (HRSA): www.hrsa.gov
HRSA, a division of the U.S. Department of Health and Human Services, offers resources to help health care provide services to diverse communities.

Multicultural and Social Justice Counseling Competencies

The Multicultural and Social Justice Counseling Competencies (MSJCC), which revises the Multicultural Counseling Competencies (MCC) developed by Sue, Arredondo, and McDavis (1992) offers counselors a framework to implement multicultural and social justice competencies into counseling theories, practices, and research. A conceptual framework (See Figure 1) of the MSJCC is provided to illustrate a visual map of the relationship between the constructs and competencies being articulated within the MSJCC. Moreover, quadrants are used to highlight the intersection of identities and the dynamics of power, privilege, and oppression that influence the counseling relationship. Developmental domains reflect the different layers that lead to multicultural and social justice competence:

1. counselor self-awareness,
2. client worldview,
3. counseling relationship
4. counseling and advocacy interventions.

Embedded within the first three developmental domains of the MSJCC are the following aspirational competencies: attitudes and beliefs, knowledge, skills, and action (AKSA). The socioecological model is incorporated within the counseling and advocacy interventions domain to provide counselors with a multilevel framework for individual counseling and social justice advocacy.

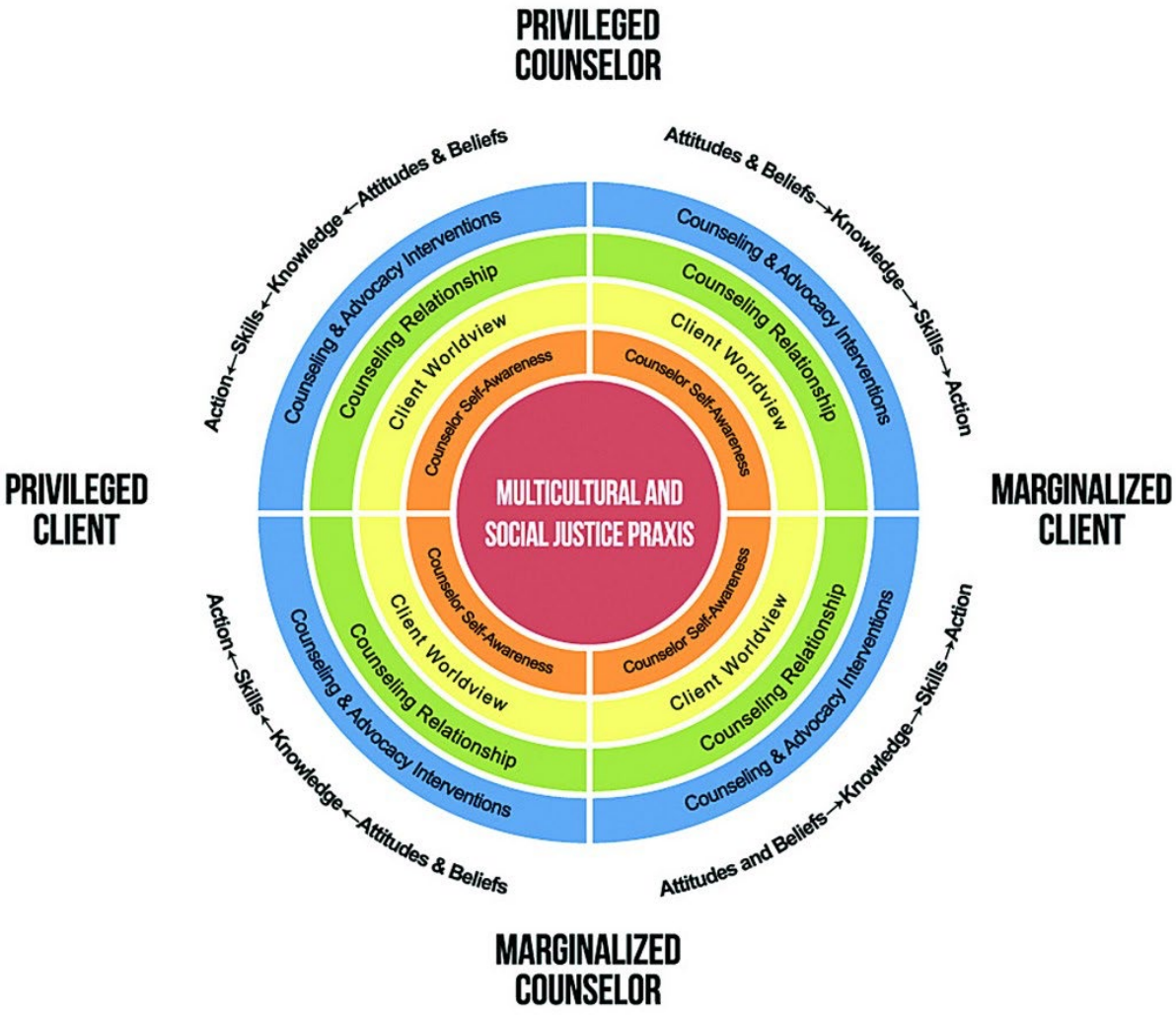

Figure S-7.1: *Multicultural and Social Justice Counseling Competencies* Retrieved from http://www.counseling.org/knowledge-center/competencies. Copyright 2015 by M.J. Ratts, A.A. Singh, S. Nassar-McMillan, S.K. Butler, & J.R. McCullough. Reprinted with permission.

Quadrants: Quadrants reflect the complex identities and the privileged and marginalized statuses that counselors and clients bring to the counseling relationship. Clients and counselors are both members of various racial, ethnic, gender, sexual orientation, economic, disability and religious groups, to list a few. These identities are categorized into privileged and marginalized statuses. A client or counselor may hold either status or both statuses simultaneously. These statuses are prevalent depending on how each individual is experiencing the current interaction.

Being attentive of these statuses highlights how issues of power, privilege and oppression play out between counselors and clients. The interactions are categorized into four quadrants:

- Quadrant I: Privileged Counselor–Marginalized Client
- Quadrant II: Privileged Counselor–Privileged Client
- Quadrant III: Marginalized Counselor–Privileged Client
- Quadrant IV: Marginalized Counselor–Marginalized Client

Conceptually, client and counselor interactions may fit into the quadrants in numerous ways. They reflect the fluidity of identities and how the dynamics of power, privilege and oppression impact the counseling relationship.

Multicultural and Social Justice Counseling Competencies

I. Counselor Self-Awareness

Privileged and marginalized counselors develop self-awareness, so that they may explore their attitudes and beliefs, develop knowledge, skills, and action relative to their self-awareness and worldview.

1. *Attitudes and beliefs*: Privileged and marginalized counselors are aware of their social identities, social group statuses, power, privilege, oppression, strengths, limitations, assumptions, attitudes, values, beliefs, and biases.

   Multicultural and social justice competent counselors:
   - Acknowledge their assumptions, worldviews, values, beliefs, and biases as members of privileged and marginalized groups.
   - Acknowledge their privileged and marginalized status in society.
   - Acknowledge their privileged and marginalized status influences their worldview.
   - Acknowledge their privileged and marginalized status provides advantages and disadvantages in society.
   - Acknowledge openness to learning about their cultural background as well as their privileged and marginalized status.

2. *Knowledge*: Privileged and marginalized counselors possess an understanding of their social identities, social group statuses, power, privilege, oppression, strengths, limitations, assumptions, attitudes, values, beliefs, and biases.

Multicultural and social justice competent counselors:

- Develop knowledge of resources to become aware of their assumptions, worldviews, values, beliefs, biases, and privileged and marginalized status.
- Develop knowledge about the history and events that shape their privileged and marginalized status.
- Develop knowledge of theories that explain how their privileged and marginalized status influences their experiences and worldview.
- Develop knowledge of how their privileged and marginalized status leads to advantages and disadvantages in society.

3. *Skills*: Privileged and marginalized counselors possess skills that enrich their understanding of their social identities, social group statuses, power, privilege, oppression, limitations, assumptions, attitudes, values, beliefs, and biases.

   Multicultural and social justice competent counselors:

   - Acquire reflective and critical thinking skills to gain insight into their assumptions, worldviews, values, beliefs, biases, and privileged and marginalized status.
   - Acquire communication skills to explain how their privileged and marginalized status influences their worldview and experiences.
   - Acquire application skills to interpret knowledge of their privileged and marginalized status in personal and professional settings.
   - Acquire analytical skills to compare and contrast their privileged and marginalized status and experiences to others.
   - Acquire evaluation skills to assess the degree to which their privileged and marginalized status influences their personal and professional experiences.

4. *Action*: Privileged and marginalized counselors take action to increase self- awareness of their social identities, social group statuses, power, privilege, oppression, strengths, limitations, assumptions, attitudes, values, beliefs, and biases.

   Multicultural and social justice competent counselors:

   - Take action to learn about their assumptions, worldviews, values, beliefs, biases, and culture as a member of a privileged and marginalized group.
   - Take action to seek out professional development opportunities to learn more about themselves as a member of a privileged or marginalized group.
   - Take action to immerse themselves in their community to learn about how power, privilege, and oppression influence their privileged and marginalized experiences.

- Take action to learn about how their communication style is influenced by their privileged and marginalized status.

II. Client Worldview

Privileged and marginalized counselors are aware, knowledgeable, skilled, and action-oriented in understanding clients' worldview.

1. *Attitudes and beliefs*: Privileged and marginalized counselors are aware of clients' worldview, assumptions, attitudes, values, beliefs, biases, social identities, social group statuses, and experiences with power, privilege, and oppression.

   Multicultural and social justice competent counselors:

   - Acknowledge a need to possess a curiosity for privileged and marginalized clients' history, worldview, cultural background, values, beliefs, biases, and experiences.
   - Acknowledge that identity development influences the worldviews and lived experiences of privileged and marginalized clients.
   - Acknowledge their strengths and limitations in working with clients from privileged and marginalized groups.
   - Acknowledge that learning about privileged and marginalized clients may sometimes be an uncomfortable or unfamiliar experience.
   - Acknowledge that learning about clients' privileged and marginalized status is a lifelong endeavor.
   - Acknowledge the importance of reflecting on the attitudes, beliefs, prejudices, and biases they hold about privileged and marginalized clients.
   - Acknowledge that there are within-group differences and between group similarities and differences among privileged and marginalized clients.
   - Acknowledge clients' communication style is influenced by their privileged and marginalized status.

2. *Knowledge*: Privileged and marginalized counselors possess knowledge of clients' worldview, assumptions, attitudes, values, beliefs, biases, social identities, social group statuses, and experiences with power, privilege, and oppression.

   Multicultural and social justice competent counselors:

   - Develop knowledge of historical events and current issues that shape the worldview, cultural background, values, beliefs, biases, and experiences of privileged and marginalized clients.
   - Develop knowledge of how stereotypes, discrimination, power, privilege, and oppression influence privileged and marginalized clients.

- Develop knowledge of multicultural and social justice theories, identity development models, and research pertaining to the worldview, culture, and life experiences of privileged and marginalized clients.
- Develop knowledge of their strengths and limitations in working with clients from privileged and marginalized groups.
- Develop knowledge of how to work through the discomfort that comes with learning about privileged and marginalized clients.
- Develop a lifelong plan to acquire knowledge of clients' privileged and marginalized status.
- Develop knowledge of the attitudes, beliefs, prejudices, and biases they hold about privileged and marginalized clients.
- Develop knowledge of the individual, group, and universal dimensions of human existence of their privileged and marginalized clients.
- Develop knowledge of the communication style of their privileged and marginalized client (e.g., high context vs. low context communication, eye contact, orientation to time and space, etc.).

3. *Skills*: Privileged and marginalized counselors possess skills that enrich their understanding of clients' worldview, assumptions, attitudes, values, beliefs, biases, social identities, social group statuses, and experiences with power, privilege, and oppression.

   Multicultural and social justice competent counselors:

   - Acquire culturally responsive evaluation skills to analyze how historical events and current issues shape the worldview, cultural background, values, beliefs, biases, and experiences of privileged and marginalized clients.
   - Acquire culturally responsive critical thinking skills to gain insight into how stereotypes, discrimination, power, privilege, and oppression influence privileged and marginalized clients.
   - Acquire culturally responsive application skills to apply knowledge of multicultural and social justice theories, identity development models, and research to one's work with privileged and marginalized clients.
   - Acquire culturally responsive assessment skills to identify limitations and strengths when working with privileged and marginalized clients.
   - Acquire culturally responsive reflection skills needed to work through the discomfort that comes with learning about privileged and marginalized clients.
   - Acquire culturally responsive conceptualization skills to explain how clients' privileged and marginalized status influence their culture, worldview, experiences, and presenting problem.

- Acquire culturally responsive analytical skills to interpret the attitudes, beliefs, prejudices, and biases they hold about privileged and marginalized clients.
- Acquire culturally responsive conceptualization skills to identify the individual, group, and universal dimensions of human existence of privileged and marginalized clients.
- Acquire culturally responsive cross-cultural communication skills to interact with privileged and marginalized clients.

4. *Action*: Privileged and marginalized counselors take action to increase self- awareness of clients' worldview, assumptions, attitudes, values, beliefs, biases, social identities, social group statuses, and experiences with power, privilege, and oppression.

   Multicultural and social justice competent counselors:

   - Take action by seeking out formal and informal opportunities to engage in discourse about historical events and current issues that shape the worldview, cultural background, values, beliefs, biases, and experiences of privileged and marginalized clients.
   - Take action by attending professional development trainings to learn how stereotypes, discrimination, power, privilege, and oppression influence privileged and marginalized clients.
   - Take action by applying multicultural and social justice theories, identity development models, and research to one's work with privileged and marginalized clients.
   - Take action by assessing one's limitations and strengths when working with privileged and marginalized clients on a consistent basis.
   - Take action by immersing oneself in the communities in which privileged and marginalized clients reside to work through the discomfort that comes with learning about privileged and marginalized clients.
   - Take action by using language to explain how clients' privileged and marginalized status influence their culture, worldview, experiences, and presenting problem.
   - Take action by pursuing culturally responsive counseling to explore the attitudes, beliefs, prejudices, and biases they hold about privileged and marginalized clients.
   - Take action by collaborating with clients to identify the individual, group, and universal dimensions of human existence that shape the identities of privileged and marginalized clients.
   - Take action by consistently demonstrating cross-cultural communication skills required to effectively interact with privileged and marginalized clients.

III. Counseling Relationship

Privileged and marginalized counselors are aware, knowledgeable, skilled, and action-oriented in understanding how client and counselor privileged and marginalized statuses influence the counseling relationship.

1. *Attitudes and beliefs*: Privileged and marginalized counselors are aware of how client and counselor worldviews, assumptions, attitudes, values, beliefs, biases, social identities, social group statuses, and experiences with power, privilege, and oppression influence the counseling relationship.

   Multicultural and social justice competent counselors:
   - Acknowledge that the worldviews, values, beliefs, and biases held by privileged and marginalized counselors and clients will positively or negatively influence the counseling relationship.
   - Acknowledge that counselor and client identity development shapes the counseling relationship to varying degrees for privileged and marginalized clients.
   - Acknowledge that the privileged and marginalized status of counselors and clients will influence the counseling relationship to varying degrees.
   - Acknowledge that culture, stereotypes, discrimination, power, privilege, and oppression influence the counseling relationship with privileged and marginalized group clients.
   - Acknowledge that the counseling relationship may extend beyond the traditional office setting and into the community.
   - Acknowledge that cross-cultural communication is key to connecting with privileged and marginalized clients.

2. *Knowledge*: Privileged and marginalized counselors possess knowledge of how client and counselor worldviews, assumptions, attitudes, values, beliefs, biases, social identities, social group statuses, and experiences with power, privilege, and oppression influence the counseling relationship.

   Multicultural and social justice competent counselors:

   - Develop knowledge of the worldviews, values, beliefs, and biases held by privileged and marginalized counselors and clients and its influence on the counseling relationship.
   - Develop knowledge of identity development theories and how they influence the counseling relationship with privileged and marginalized clients.

- Develop knowledge of theories explaining how counselor and clients' privileged and marginalized statuses influence the counseling relationship.
- Develop knowledge of how culture, stereotypes, discrimination, power, privilege, and oppression strengthen and hinder the counseling relationship with privileged and marginalized clients.
- Develop knowledge of when to use individual counseling and when to use systems advocacy with privileged and marginalized clients.
- Develop knowledge of cross-cultural communication theories when working with privileged and marginalized clients.

3. *Skills*: Privileged and marginalized counselors possess skills to engage in discussions with clients about how client and counselor worldviews, assumptions, attitudes, values, beliefs, biases, social identities, social group statuses, power, privilege, and oppression influence the counseling relationship.

   Multicultural and social justice competent counselors:
   - Acquire assessment skills to determine how the worldviews, values, beliefs and biases held by privileged and marginalized counselors and clients influence the counseling relationship.
   - Acquire analytical skills to identify how the identity development of counselors and clients influence the counseling relationship.
   - Acquire application skills to apply knowledge of theories explaining how counselor and clients' privileged and marginalized statuses influence the counseling relationship.
   - Acquire assessment skills regarding how culture, stereotypes, prejudice, discrimination, power, privilege, and oppression influence the counseling relationship with privileged and marginalized clients.
   - Acquire evaluation skills to determine when individual counseling or systems advocacy is needed with privileged and marginalized clients.
   - Acquire cross-cultural communication skills to connect with privileged and marginalized clients.

4. *Action*: Privileged and marginalized counselors take action to increase their understanding of how client and counselor worldviews, assumptions, attitudes, values, beliefs, biases, social identities, social group statuses, and experiences with power, privilege, and oppression influence the counseling relationship.

   Multicultural and social justice competent counselors:

- Take action by initiating conversations to determine how the worldviews, values, beliefs and biases held by privileged and marginalized counselors and clients influence the counseling relationship.
- Take action by collaborating with clients to identify the ways that privileged and marginalized counselor and client identity development influence the counseling relationship.
- Take action by exploring how counselor and clients' privileged and marginalized statuses influence the counseling relationship.
- Take action by inviting conversations about how culture, stereotypes, prejudice, discrimination, power, privilege, and oppression influence the counseling relationship with privileged and marginalized clients.
- Take action by collaborating with clients to determine whether individual counseling or systems advocacy is needed with privileged and marginalized clients.
- Take action by using cross-communication skills to connect with privileged and marginalized clients.

IV. Counseling and Advocacy Interventions

Privileged and marginalized counselors intervene with, and on behalf, of clients at the intrapersonal, interpersonal, institutional, community, public policy, and international/global levels.

A. Intrapersonal: The individual characteristics of a person such as knowledge, attitudes, behavior, self-concept, skills, and developmental history.

   Intrapersonal Interventions: Privileged and marginalized counselors address the intrapersonal processes that impact privileged and marginalized clients.

   Multicultural and social justice competent counselors:

   - Employ empowerment-based theories to address internalized privilege experienced by privileged clients and internalized oppression experienced by marginalized clients.
   - Assist privileged and marginalized clients develop critical consciousness by understanding their situation in context of living in an oppressive society.
   - Assist privileged and marginalized clients in unlearning their privilege and oppression.
   - Assess the degree to which historical events, current issues, and power, privilege and oppression contribute to the presenting problems expressed by privileged and marginalized clients.
   - Work in communities to better understand the attitudes, beliefs, prejudices, and biases held by privileged and marginalized clients.

- Assist privileged and marginalized clients with developing self-advocacy skills that promote multiculturalism and social justice.
- Employ quantitative and qualitative research to highlight inequities present in current counseling literature and practices in order to advocate for systemic changes to the profession.

B. Interpersonal: The interpersonal processes and/or groups that provide individuals with identity and support (i.e., family, friends, and peers).

Interpersonal Interventions: Privileged and marginalized counselors address the interpersonal processes that affect privileged and marginalized clients.

Multicultural and social justice competent counselors:

- Employs advocacy to address the historical events and persons that shape and influence privileged and marginalized client's developmental history.
- Examines the relationships privileged and marginalized clients have with family, friends, and peers that may be sources of support or non-support.
- Assist privileged and marginalized clients understand that the relationships they have with others may be influenced by their privileged and marginalized status.
- Assist privileged and marginalized clients with fostering relationships with family, friends, and peers from the same privileged and marginalized group.
- Reach out to collaborate with family, friends, and peers who will be a source of support for privileged and marginalized clients.
- Assist privileged and marginalized clients in developing communication skills to discuss issues of power, privilege, and oppression with family, friends, peers, and colleagues.
- Employ evidenced-based interventions that align with the cultural background and worldview of privileged and marginalized clients.

C. Institutional: Represents the social institutions in society such as schools, churches, community organizations.

Institutional Interventions: Privileged and marginalized counselors address inequities at the institutional level.

Multicultural and social justice competent counselors:

- Explore with privileged and marginalized clients the extent to which social institutions are supportive.

- Connect privileged and marginalized clients with supportive individuals within social institutions (e.g., schools, businesses, church, etc.) who are able to help alter inequities influencing marginalized clients.
- Collaborate with social institutions to address issues of power, privilege, and oppression impacting privilege and marginalized clients.
- Employ social advocacy to remove systemic barriers experienced by marginalized clients within social institutions.
- Employ social advocacy to remove systemic barriers that promote privilege that benefit privileged clients.
- Balance individual counseling with systems level social advocacy to address inequities that social institutions create that impede human growth and development.
- Conduct multicultural and social justice based research to highlight the inequities that social institutions have on marginalized clients and that benefit privileged clients.
- Community: The community as a whole represents the spoken and unspoken norms, value, and regulations that are embedded in society. The norms, values, and regulations of a community may either be empowering or oppressive to human growth and development.

D. Community Interventions: Privileged and marginalized address community norms, values, and regulations that impede on the development of individuals, groups, and communities.

   Multicultural and social justice competent counselors:

   - Take initiative to explore with privileged and marginalized clients regarding how community norms, values, and regulations embedded in society that hinder and contribute to their growth and development.
   - Conduct qualitative and quantitative research to evaluate the degree to which community norms, values, and regulations influence privileged and marginalized clients.
   - Employ social advocacy to address community norms, values, and regulations embedded in society that hinder the growth and development of privileged and marginalized clients.
   - Utilize the norms, values, and regulations of the marginalized client to shape the community norms, values, and regulations of the privileged client.

E. Public Policy: Public policy reflects the local, state, and federal laws and policies that regulate or influence client human growth and development.

Public Policy Interventions: Privileged and marginalized counselors address public policy issues that impede on client development with, and on behalf of clients.

Multicultural and social justice competent counselors:

- Initiate discussions with privileged and marginalized clients regarding how they shape and are shaped by local, state, and federal laws and policies.
- Conduct research to examine how local, state, and federal laws and policies contribute to or hinder the growth and development of privileged and marginalized clients.
- Engage in social action to alter the local, state, and federal laws and policies that benefit privileged clients at the expense of marginalized clients.
- Employ social advocacy to ensure that local, state, and federal laws and policies are equitable toward privileged and marginalized clients.
- Employ social advocacy outside the office setting to address local, state, and federal laws and policies that hinder equitable access to employment, healthcare, and education for privileged and marginalized clients.
- Assist with creating local, state, and federal laws and policies that promote multiculturalism and social justice.
- Seek opportunities to collaborate with privileged and marginalized clients to shape local, state, and federal laws and policies.

F. International and Global Affairs: International and global concerns reflect the events, affairs, and policies that influence psychological health and well-being.

International and Global Affairs Interventions: Privileged and marginalized counselors address international and global events, affairs and polices that impede client development with, and on behalf of, clients.

Multicultural and social justice competent counselors:

- Stay current on international and world politics and events.
- Seek out professional development to learn about how privileged and marginalized clients influence, and are influenced by, international and global affairs.
- Acquire knowledgeable of historical and current international and global affairs that are supportive and unsupportive of privileged and marginalized clients.
- Learn about the global politics, policies, laws, and theories that influence privileged and marginalized clients.
- Utilize technology to interact and collaborate with international and global leaders on issues influencing privileged and marginalized clients.

- Take initiative to address international and global affairs to promote multicultural and social justice issues.
- Utilize research to examine how international and global affairs impact privileged and marginalized clients. (Ratts, et.al., 2016)

Counseling the LGBTQ+ Population

Providing counseling to the LGBTQ+ population requires a culturally sensitive and affirming approach. LGBTQ+ individuals often face unique challenges related to their sexual orientation, gender identity, and societal biases. Here are some guidelines for effectively counseling LGBTQ+ individuals:

1. **Cultural Competence:** Educate yourself about LGBTQ+ issues, terminology, and identities. Understand the challenges and discrimination they may face. This will help you create a safe and supportive environment.
2. **Create a Safe Space:** Ensure that your counseling environment is welcoming and free from judgment. Use inclusive language, display LGBTQ+ affirming symbols, and provide resources that are relevant to this population.
3. **Respect Pronouns and Identities:** Always use the individual's chosen name and pronouns. If you are unsure, respectfully ask for their preferences.
4. **Avoid Assumptions:** Do not make assumptions about a person's sexual orientation or gender identity. Allow them to share their identity with you on their terms.
5. **Active Listening:** Listen carefully and empathetically to their experiences. Allow them to share their stories and feelings without interruption.
6. **Normalize Experiences:** Assure them that their experiences, thoughts, and feelings are valid. Help them understand that they are not alone and that many others have similar experiences.
7. **Address Mental Health:** Be prepared to address mental health concerns that may arise from the stressors and discrimination LGBTQ+ individuals often face. Offer appropriate coping strategies and referrals to mental health professionals if needed.
8. **Family Support:** Recognize the importance of family support. Some LGBTQ+ individuals may face challenges within their families. Offer guidance on how to communicate with unsupportive family members or facilitate family counseling if appropriate.
9. **Affirmation and Validation:** Offer affirming and validating statements about their identity. Show them that you respect and acknowledge who they are.
10. **Trauma-Informed Care:** Be sensitive to the potential for trauma related to societal stigma, discrimination, or past experiences. Use trauma-informed approaches when necessary.
11. **Social and Legal Support:** Be knowledgeable about local LGBTQ+ resources, support groups, and legal protections. Provide information about LGBTQ+-friendly organizations and services.
12. **Boundaries and Self-Care:** As a counselor, it is important to set boundaries and practice self-care to avoid burnout. Dealing with sensitive issues can be emotionally demanding.

13. **Ongoing Education:** Stay up-to-date with current LGBTQ+ issues, research, and best practices in counseling. Attend workshops, conferences, and training sessions to continually enhance your skills.

The LGBTQ+ community encompasses a diverse range of identities and expressions. Here are some key terms and references:

- **LGBTQ+:** An acronym that stands for Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning, with the "+" indicating the inclusion of other identities.
- **Lesbian:** A woman who is emotionally, romantically, or sexually attracted to other women.
- **Gay:** A term often used to describe a man who is emotionally, romantically, or sexually attracted to other men. It is also used more broadly to refer to anyone who identifies as homosexual.
- **Bisexual:** A person who is emotionally, romantically, or sexually attracted to both men and women.
- **Transgender:** A term for people whose gender identity differs from the sex they were assigned at birth. For example, a person assigned male at birth but identifies as female is a transgender woman.
- **Queer:** An umbrella term used to describe a variety of sexual orientations and gender identities that do not conform to heterosexual or cisgender norms. Some people identify specifically as queer, while others use it as an inclusive term.
- **Questioning:** Refers to individuals who are exploring or questioning their own sexual orientation or gender identity.
- **Cisgender:** A term for individuals whose gender identity matches the sex they were assigned at birth.
- **Gender Identity:** A person's deeply-felt internal sense of their own gender, which may be different from the sex assigned at birth.
- **Gender Expression:** The way a person presents their gender to others through behavior, clothing, hairstyles, and other means.
- **Non-binary:** A gender identity that does not fit within the traditional binary of male and female. Non-binary individuals may identify as a mix of both genders, neither gender, or a different gender altogether.
- **Genderqueer:** A term used by individuals whose gender identity is outside the norms of their assigned gender.
- **Genderfluid:** Refers to individuals whose gender identity shifts or changes over time.
- **Pansexual:** A person who is attracted to individuals regardless of their gender identity or expression.
- **Asexual:** A person who experiences little or no sexual attraction to others.
- **Aromantic:** A person who experiences little or no romantic attraction to others.
- **Pronouns:** The words used to refer to a person in the third person. For example, "she/her," "he/him," "they/them."

- **Coming Out:** The process of revealing one's LGBTQ+ identity to others, often involving friends, family, or peers.
- **Drag:** A form of performance art where individuals dress and act in a way that exaggerates gender roles, often for entertainment purposes.
- **Pride:** Refers to LGBTQ+ pride, a movement that celebrates and advocates for the rights and acceptance of LGBTQ+ individuals.

These terms represent just a portion of the rich and evolving vocabulary within the LGBTQ+ community. Remember that language is important and can vary from person to person, so it is always respectful to use the terms and pronouns that individuals use to describe themselves. Remember that every individual is unique, and their needs may vary. The key is to approach counseling with empathy, respect, and a willingness to learn and adapt to each person's specific circumstances

Surveys

In the next section of this chapter are three tools that were developed by Peter Bell, a well-known trainer on cultural competency. His specific area of expertise is in service of African American populations. These tools can be used to help start a dialogue with your preceptor or peers regarding cultural competency and your preparedness to provide services to diverse populations.

- Racial Identity Questionnaire
- Cultural Adjustment Questionnaire
- Working with Diversity: Your Personal Assessment Tool

Racial Identity Questionnaire

Please indicate each of your answers by filling in the adjacent box or boxes.

What is your mother's race? (Mark all that apply.)

- ☐ African American or Black
- ☐ American Indian or Native American
- ☐ Asian American or Pacific Islander
- ☐ Hispanic or Latino
- ☐ White
- ☐ I'm not sure

What is your father's race? (Mark all that apply.)

- ☐ African American or Black
- ☐ American Indian or Native American
- ☐ Asian American or Pacific Islander
- ☐ Hispanic or Latino
- ☐ White
- ☐ I'm not sure

Who had the greatest influence on your racial identity?

- ☐ Mother
- ☐ Father
- ☐ Grandparent
- ☐ Aunt or uncle
- ☐ Other relative
- ☐ Other person (specify): _____
- ☐ I'm not sure

When you were growing up, did you live in a neighborhood or community where most residents were the same race/ethnicity as you?

- ☐ Yes, all the time
- ☐ Yes, some of the time
- ☐ No

When you were growing up, did you go to schools where most students were the same race/ethnicity as you?

- ☐ Yes, all the time
- ☐ Yes, some of the time
- ☐ No

When you were growing up, how did your family talk about people of different racial/ethnic groups?

- ☐ All groups in positive ways
- ☐ All groups in negative ways
- ☐ Some groups in positive ways, others negative
- ☐ There was little or no talk about racial/ethnic groups

When you were growing up, did your family teach you about the history and traditions of your racial/ethnic group?

- ☐ Yes, a lot
- ☐ Yes, a little
- ☐ No

Do you try to learn more about the history and traditions of your racial/ethnic group?

- ☐ Yes, often
- ☐ Yes, sometimes
- ☐ No

How or when? _____
_____

Do you take pride in your racial/ethnic background?

- ☐ Yes, often
- ☐ Yes, sometimes
- ☐ No

How or when? _____
_____

Do you participate in organizations in which most members are the same race/ethnicity as you?

- ☐ Yes, often
- ☐ Yes, sometimes
- ☐ No

How or when? _____
_____

Do you ever fear that you are seen as not committed to your racial/ethnic group?

☐ Yes, often
☐ Yes, sometimes
☐ No

How or when? _____
_____

Do you seek out close friendships with persons who are members of another race/ethnicity?

☐ Yes, often
☐ Yes, sometimes
☐ No

How or when? _____
_____

How do you feel about members of your race/ethnicity dating or marrying persons of a different race/ethnicity?

☐ I approve
☐ I'm neutral
☐ I disapprove

Would you take a white friend or acquaintance to a religious or social event attended mostly by people of your race/ethnicity?

☐ Yes
☐ No

Do you think whites have good intentions toward people of your racial/ethnic group?

☐ Yes, most of the time
☐ Yes, some of the time
☐ No

Do you consider your race/ethnicity an important part of your life today?

☐ Yes, often
☐ Yes, sometimes
☐ No

How or when? _____
_____

When you are around people of another race/ethnicity, do you change the way you talk, act, or dress?

☐ Yes, often
☐ Yes, sometimes
☐ No

How or when? _____
_____

When your parents are around people of another race/ethnicity, do they change the way they talk, act, or dress?

☐ Yes ☐ I don't know
☐ No ☐ My parents are deceased

When your children are around people of another race/ethnicity, do they change the way they talk, act, or dress?

☐ Yes ☐ I don't know
☐ No ☐ I don't have children

Do you think that in order to be successful in this country, minorities must shed much of their racial/ethnic identity?

☐ Yes
☐ No

Do you think that your life has been affected by your racial/ethnic background?

☐ Yes, mostly in positive ways
☐ Yes, mostly in negative ways
☐ Yes, in both positive and negative ways
☐ No

Overall, do you think white people make too much of racial/ethnic issues?

☐ Yes
☐ No

Overall, do you think your racial/ethnic group makes too much of racial/ethnic issues?

- ☐ Yes
- ☐ No

Would race/ethnicity affect your decision as to where to send your children to school?

- ☐ Yes
- ☐ No

Would race/ethnicity affect your decision where to attend church?

- ☐ Yes
- ☐ No

Do you think there is a white standard of beauty in this county?

- ☐ Yes
- ☐ No

Do you think most whites view issues such as crime, unemployment, welfare, education, and poverty differently than most members of your racial/ethnic group?

- ☐ Yes
- ☐ No

Do you think that your race/ethnicity plays a role in any difficulties you are now having?

- ☐ Yes, a big part
- ☐ Yes, a small part
- ☐ No

How or when? _____
_____

Does a person's race/ethnicity affect any of your relationships with the following? (Check all that apply.)

- ☐ Spouse
- ☐ In-laws
- ☐ Boyfriend or girlfriend
- ☐ Close friend
- ☐ Casual friend
- ☐ Neighbor
- ☐ Boss or supervisor
- ☐ Co-worker
- ☐ Business partner
- ☐ Classmate
- ☐ Social club member
- ☐ Sports team member
- ☐ Member of your religious congregation
- ☐ Your doctor
- ☐ AA sponsor
- ☐ Member of a support group
- ☐ Counselor or therapist

For which, if any, of the following relationships does the other person's race/ethnicity influence your decision whether to have a relationship with that person?

- ☐ Spouse
- ☐ In-laws
- ☐ Boyfriend or girlfriend
- ☐ Close friend
- ☐ Casual friend
- ☐ Neighbor
- ☐ Boss or supervisor
- ☐ Co-worker
- ☐ Business partner
- ☐ Classmate
- ☐ Social club member
- ☐ Sports team member
- ☐ Member of your religious congregation
- ☐ Your doctor
- ☐ AA sponsor
- ☐ Member of a support group
- ☐ Counselor or therapist

Please add any comments regarding how you feel about your racial identity, any experiences that may be important to talk about, or any conflicts you may be experiencing.

_____

_____

_____

_____

_____

_____

Cultural Adjustment Questionnaire

	Seldom▼				Always
1. I can function in most racial/ethnic groups, but don't feel totally accepted in any.	1	2	3	4	5
2. I don't have a community to call my own.	1	2	3	4	5
3. When I was growing up, I would get embarrassed or frustrated by my parents' attitudes or behaviors that were associated with race or culture.	1	2	3	4	5
4. I feel strong resentments toward other racial or cultural groups.	1	2	3	4	5
5. I reject cross-racial/ethnic marriages as being disloyal or a "slap in the face."	1	2	3	4	5
6. I feel members of other racial/ethnic groups view me as the "good one."	1	2	3	4	5
7. I feel stereotypes regarding my racial/ethnic groups are true.	1	2	3	4	5
8. I think a lot about issues of race/ethnicity.	1	2	3	4	5
9. I feel the majority community will never fully accept my racial/cultural group.	1	2	3	4	5
10. I wish the issue of race/ethnicity should simply go away. After all, "people are people."	1	2	3	4	5
11. My family had/have numerous arguments regarding the issues of race/ethnicity.	1	2	3	4	5
12. I get tense when race/ethnicity comes up in a mixed group.	1	2	3	4	5
13. I get tense when race/ethnicity comes up in my racial/ethnic group.	1	2	3	4	5
14. I feel members of my racial/ethnic group have to "sell out" to be successful in this country.	1	2	3	4	5
15. I have clear racial/ethnic boundaries (friendship, humor, music) in my personal and professional life.	1	2	3	4	5
16. I feel accepted by my racial/ethnic group.	1	2	3	4	5
17. I feel anger when race/cultural issues are discussed.	1	2	3	4	5
18. I feel misunderstood when talking about racial/cultural issues.	1	2	3	4	5
19. I feel frustrated when talking about racial/cultural issues.	1	2	3	4	5
20. I think I am viewed as uncommitted or disloyal to my racial or ethnic group.	1	2	3	4	5
21. I think I am viewed as outspoken on most racial/cultural issues.	1	2	3	4	5

When a patient answers these questions, it is useful for a counselor to review the questions with commonly applied follow-up discussion items, such as:

- What specific situations make you feel that way?
- How do those feelings get in your way at work, or in your personal life?
- How can you cope better with the feelings that develop in those situations?
- Who in your life have you seen handle the (feelings or situations) better? What can you learn from that?
- Create a scenario in your mind on ideally what you would say or do in a similar situation.
- Who is a role model for you on handling racial/cultural issues?
- What do you want to teach your children (nieces, nephews, cousins) about handling racial/cultural issues?
- What are two or three principles you believe are important in handling racial/cultural issues?
- What single thing gets in your way the most in addressing racial/cultural issues (anger, hurt, frustration, etc.)?
- If you could paint a perfect picture of race/cultural relations in your life, what would it look like?

Working with Diversity: Your Personal Assessment Tool

	Seldom ▼			Always
1. Do you feel society tries to force everyone to accept mainstream values and behavior?	1	2	3	4
2. Do you feel society emphasizes differences too much?	1	2	3	4
3. Do you feel any internal pressure to convey to people different than yourself that you have no racial or cultural biases?	1	2	3	4
4. Do you feel competent when you think of yourself working with people who are different from you (ethnically, linguistically, racially)?	1	2	3	4
5. Are you judgmental of the value and lifestyles in some communities?	1	2	3	4
6. Are you comfortable with interracial dating and marriage for members of your family?	1	2	3	4
7. Do you take the initiatives in dispelling misconceptions, stereotypes, and prejudices with other ethnic/racial groups?	1	2	3	4
8. Are you ever afraid of being perceived as a racist?	1	2	3	4
9. Should parenting and discipline styles used in different cultures be given equal legitimacy?	1	2	3	4
10. Do you “walk on eggshells” when interacting with people who are a different age, race, or sex?	1	2	3	4
11. Do you ever feel uneasy or protective of people of color who are in an all-white setting?	1	2	3	4
12. Do you believe that productivity would improve if everyone had similar work styles?	1	2	3	4
13. Do you feel there are certain American traditions and practices that all cultural groups living in this country should adhere to?	1	2	3	4
14. Do you ever let the realities of racism (lack of opportunity, oppression) be an excuse for unacceptable actions by people of color?	1	2	3	4
15. Do you feel a sense of relief when a person of color says he/she has no racial/cultural issues?	1	2	3	4
16. Do you feel anger or disbelief when a person of color says he/she has no racial/cultural issues?	1	2	3	4
17. Would you be comfortable with native or traditional dress worn by your ethnic or cultural group in a work setting?	1	2	3	4
18. Do you ever fear you are seen as uncommitted to your ethnic or cultural group?	1	2	3	4
19. Do you allow “cultural differences” to be used as a rationale for behavior or action?	1	2	3	4
20. Do you seek out close personal relationships with racially or culturally diverse persons?	1	2	3	4
21. Do you feel other racial or ethnic groups make too much of differences?	1	2	3	4
22. Do you feel adhering to middle class values (persistence, hard work, delayed gratification, education, honesty) is a prerequisite for a middle class life?	1	2	3	4

23. On average, do you feel whites have good intentions towards minorities?	1	2	3	4
24. Do you feel assimilation in the "public square" should be the goal of racial minorities?	1	2	3	4
25. Do you feel there is some truth to the notion of reverse discrimination?	1	2	3	4
26. Does an employer have the right to demand that an employee adhere to "mainstream cultural stands" in dress, speech, humor, etc.?	1	2	3	4
27. Is your race/ethnicity a relatively unimportant part of your life?	1	2	3	4
28. Do you feel pressure to act or talk differently when you are in the minority?	1	2	3	4
29. Do you ever try to establish your credibility with people who are different from you by saying, "I was in the service with…," "One of my best friends is…," "I used to date somebody named…," etc.?	1	2	3	4
30. Do you feel we should honor and respect the treatment and role other cultures have for women?	1	2	3	4
31. Do you feel it is possible for people of color to be racist?	1	2	3	4
32. Are whites that oppose affirmative action exhibiting a form of racism?	1	2	3	4
33. Do you feel communities of color must solve more of their own problems?	1	2	3	4
34. Is white privilege a reality in this country?	1	2	3	4
35. Should race be a significant factor in cross-racial adoptions?	1	2	3	4
36. Are we becoming a nation of victims?	1	2	3	4
37. Is it important for persons of color to have a racial identity?	1	2	3	4
38. Is it important for whites to have a racial identity?	1	2	3	4
39. Do you believe there is a degree of truth to stereotypes of men/women and different racial/ethnic groups?	1	2	3	4
40. Should the behavior pattern and lifestyles of all cultures be given the same degree of legitimacy and respect?	1	2	3	4
41. Do you feel that racial/ethnic minorities are allowed by society to exhibit "racial loyalty" and solidarity more than whites?	1	2	3	4
42. Based on negative past experience, an Asian Grocer watches young black male customers closer. Is this a rational and legitimate form of stereotyping?	1	2	3	4

List the two questions that were personally most difficult for you to respond to and the reasons for that difficulty:

Question # ____

Reason:

_____

_____

_____

_____

Question # ____

Reason:

_____

_____

_____

_____

How might the above two issues affect your working with a culturally diverse group?

_____

_____

_____

_____

Supplemental Chapter 8: Co-Occurring Disorders, Addiction, and the Military: Understanding, Challenges, and Treatment

Purpose of This Chapter

To become familiar with the challenges of patients with co-occurring disorders and how to address these challenges in treatment.

Learning Objectives

At the end of this course, participants will be able to identify the following:

- Common co-occurring disorders with addiction
- Explore the complex relationship between co-occurring disorders, addiction, and the military, and to provide insights into the challenges faced by service members in managing these issues.
- Highlight effective treatment approaches and strategies that can be employed to address the unique needs of military personnel dealing with co-occurring disorders and addiction.

The Problem

Co-occurring disorders, also known as dual diagnosis, refer to the presence of both a mental health disorder and a substance use disorder in an individual. This combination can complicate diagnosis, treatment, and recovery, as the two conditions can interact in ways that exacerbate both. Co-occurring disorders and addiction within the military context present unique challenges and considerations. The prevalence of mental health disorders and substance use disorders among military personnel is a significant concern, often complicated by the unique stressors and experiences associated with military service.

Unique Stressors in the Military

1. Combat Exposure: Exposure to combat and other traumatic events during military service can increase the risk of developing mental health disorders, such as PTSD (Post-Traumatic Stress Disorder), which can, in turn, lead to substance use as a coping mechanism.

2. Physical Injuries: Injuries sustained during service, including traumatic brain injuries (TBIs), can contribute to the development of mental health issues and the misuse of prescription medications, particularly opioids.

3. Reintegration Challenges: The transition from active duty to civilian life can be difficult, leading to feelings of isolation, identity loss, and difficulty adjusting, which can exacerbate or lead to mental health and substance use disorders.

4. Military Culture: The culture within the military, which often values strength and resilience, may deter individuals from seeking help for mental health issues and substance use, for fear of stigma or negative impacts on their career.

Studies indicate that the rates of co-occurring disorders, including PTSD and substance use disorders, are higher among military personnel compared to the civilian population. This is attributed to the high-stress environment and the experiences encountered during service. Substance use, particularly alcohol abuse, is prevalent in the military, partly due to its use as a coping mechanism for stress and trauma.

Key Studies and Findings

1. **Hoge, C.W., et al. (2004)**: In a landmark study published in the *New England Journal of Medicine*, Hoge and colleagues examined the mental health of U.S. soldiers returning from Iraq and Afghanistan. They found significantly higher rates of PTSD, depression, and other mental health disorders among veterans compared to civilian populations, with a notable portion also reporting alcohol misuse and risky drinking behaviors.
2. **Seal, K.H., et al. (2011)**: This study, published in the *Archives of Internal Medicine*, analyzed data from nearly 600,000 veterans returning from Iraq and Afghanistan who were newly diagnosed with PTSD. The findings indicated a strong association between PTSD and the development of SUDs, suggesting that veterans with PTSD were more likely to have co-occurring SUDs than those without PTSD.
3. **Jacobson, I.G., et al. (2008)**: In research featured in the *Journal of the American Medical Association*, the Millennium Cohort Study provided evidence of increased rates of new-onset heavy drinking, binge drinking, and other health-related behaviors indicative of SUDs among U.S. military personnel following deployment.
4. **Institute of Medicine (IOM) Report (2013)**: The IOM released a comprehensive report titled "Substance Use Disorders in the U.S. Armed Forces," which detailed the challenges of SUDs within military ranks. It confirmed that the rates of prescription drug abuse and heavy alcohol use were higher among military personnel than civilians and called for improved prevention and treatment strategies within the Department of Defense.
5. **Dworkin, E et al. (2018)**: A review published in the *Alcohol Research* examined the prevalence and treatment of co-occurring SUDs and PTSD among veterans. It highlighted the complexity of treating these conditions in tandem, noting the higher prevalence of both disorders among military populations compared to civilians and advocating for integrated treatment approaches.

Common Co-occurring disorders with addiction in the military

In the military context, certain co-occurring disorders are particularly common alongside addiction, reflecting both the unique stressors of military life and the broader vulnerabilities associated with mental health. These co-occurring disorders can be exacerbated by, or even contribute to, substance

use and addiction, creating a cycle that requires specialized treatment and support. Here are some of the most common co-occurring disorders with addiction in military personnel:

1. **Post-Traumatic Stress Disorder (PTSD)**: Perhaps the most widely recognized co-occurring disorder, PTSD results from exposure to traumatic events, such as combat or sexual assault. Individuals with PTSD may use alcohol or drugs as a way to self-medicate, attempting to alleviate symptoms such as anxiety, flashbacks, and insomnia.

2. **Depression**: This mood disorder is characterized by persistent feelings of sadness, hopelessness, and a lack of interest or pleasure in activities. Depression can lead to substance use as individuals attempt to cope with their symptoms.

3. **Anxiety Disorders**: Anxiety disorders, including generalized anxiety disorder (GAD), panic disorder, and social anxiety disorder, are prevalent among military personnel. The use of substances can be a maladaptive coping mechanism to manage anxiety symptoms.

4. **Traumatic Brain Injury (TBI)**: TBIs are common in military populations due to combat-related injuries and training accidents. Individuals with TBIs may experience a range of cognitive, emotional, and behavioral changes, which can increase the risk of developing substance use disorders and other mental health conditions.

5. **Chronic Pain**: Chronic pain is a significant issue for many military members and veterans, often resulting from injuries sustained during service. The long-term use of prescription pain medications can lead to dependency and addiction. Additionally, the psychological impact of living with chronic pain can contribute to the development of mental health disorders.

6. **Personality Disorders**: Personality disorders, such as borderline personality disorder (BPD) and antisocial personality disorder (ASPD), can be more common in populations under significant stress, including military personnel. These disorders can complicate the relationship between mental health and substance use.

7. **Sleep Disorders**: Sleep disorders, including insomnia and sleep apnea, are prevalent among veterans and active-duty military personnel. Poor sleep can exacerbate mental health disorders and increase the likelihood of substance use as individuals seek to improve their sleep or cope with tiredness.

Screening for Co-occurring Disorders in the Military

The screening process is used to determine whether a potential patient shows signs of mental health or SUDs. It determines whether a potential patient needs further assessment to determine the severity of the identified issue. Any potential patient who screens positive should receive a comprehensive assessment.

The 12 steps to the Co-Occurring Disorders assessment process are:

1. Engage the patient.
2. Identify and contact collaterals (family, friends, or other providers) to gather additional information.
3. Screen for and detect COD.
4. Determine quadrant and locus of responsibility.
5. Determine level of care.
6. Determine diagnosis.
7. Determine disability and functional impairment.
8. Identify strengths and supports.
9. Identify cultural and linguistic needs and supports.
10. Identify problem domains.
11. Determine stage of change.
12. Plan for treatment.

SAMHSA's TIP 42 (2020) offers some dos and don'ts of screening and assessing co-occurring disorders:

- **Do** keep in mind that assessment is about getting to know a person with complex and individual needs. Tools alone cannot produce a comprehensive assessment.
- **Do** always make every effort to contact all involved parties if possible, including family members, people who have treated the patient previously, and DAPAs, as quickly as possible in the assessment process. (These other sources of information will henceforth be referred to as collaterals.)
- **Don't** allow preconceptions about addiction to interfere with learning about what the patient really needs. CODs are as likely to be underrecognized as over recognized. Assume initially that an established diagnosis and treatment regimen for mental illness is correct and advise patients to continue with those recommendations until careful reevaluation has taken place.
- **Do** become familiar with the diagnostic criteria for common mental disorders, including serious mental illness (SMI) (e.g., bipolar disorder, schizophrenia, other psychotic disorders). Also become familiar with the names and indications of common psychiatric medications and with the criteria in your clinic for determining who is a mental disorder priority patient. Know the process for referring patient for mental illness case management services or for collaborating with mental health services providers.
- **Don't** assume there is one correct treatment approach or program for any type of COD. The purpose of assessment is to collect information on multiple variables, enabling individualized treatment matching. Assess stage of change for each problem and patients' level of ability to follow treatment recommendations.
- **Do** get familiar with the specific role your program plays in delivering services related to CODs in the wider context of the system of care. This allows you to have a clearer idea of what

patients your program will best serve and helps you to facilitate access to other settings for patients who might be better served elsewhere.

- **Don't** be afraid to admit when you don't know, either to the patient or yourself. If you do not understand what is going on with a patient, acknowledge that to the patient, indicate that you will work with the patient to find the answers, and then ask for help. Use your LIP and preceptor, who are both knowledgeable about CODs, as resources for asking questions.
- Most important, **do** remember that empathy and hope are the most valuable components of your work with a patient. When in doubt about how to manage a patient with COD, stay connected, be empathic and hopeful, and work with the patient and the treatment team to try to figure out the best approach over time.

Treating Co-Occurring Disorders in the Military

The treatment of co-occurring disorders in military populations requires an integrated approach to behavioral health that addresses both the substance use disorder and the mental health condition simultaneously. This can involve a combination of medication, psychotherapy (such as cognitive-behavioral therapy or dialectical behavior therapy), peer support, and comprehensive case management.

Efforts to reduce stigma, encourage help-seeking, and increase awareness of the signs of co-occurring disorders are also vital components of supporting military members struggling with these challenges.

SAMHSA (2020) offers six (6) guiding principles for treating patients with co-occurring disorders:

1. Use a recovery perspective.
2. Adopt a multiproblem viewpoint.
3. Develop a phased approach to treatment.
4. Address specific real-life problems early in treatment.
5. Plan for the patient's cognitive and functional impairments.
6. Use support systems to maintain and extend treatment effectiveness.

A recovery perspective "acknowledges that recovery is a long-term process of internal change, and it recognizes that these internal changes proceed through various stages" (SAMHSA, 2020, pg. 14). It encourages the counselor to develop a treatment plan that is long-term and in phases. For example, a patient may start in a residential detoxification/withdrawal management program in order to get them stabilized and manage withdrawal symptoms as their initial treatment goal, however, they would likely not be ready to work on repairing broken relationships until a later phase of treatment.

Adopting a multiproblem viewpoint encourages the counselor to view the patient holistically and to develop a comprehensive treatment plan that is inclusive of all problem areas in a patient's life, even if the problem will be treated by a different provider. For example, a patient has medical issues that are currently untreated and is drinking more alcohol to cope with physical pain of their injuries. The

counselor would include obtaining medical treatment in the patients' treatment plan; however, the treating provider would be someone in the medical department.

Developing a phased approach to treatment recognizes that there are 3-5 treatment phases in a patient's recovery, including engagement, stabilization and/or persuasion, active treatment, and continuing care and/or relapse prevention. Not all patients engage in each phase, however, this approach to treatment encourages the counselor to develop stage-appropriate interventions based on what phase the patient is in at the present time.

Addressing specific real-life problems early in treatment focuses on assisting the patient with concrete problems such as financial, housing, occupational, and any other problems of everyday living that may be present. Connecting patients to available resources to assist them in these areas can go a long way towards engaging the patient successfully in treatment.

Planning for the patient's cognitive and functional impairments encourages the counselor to assess for and accommodate any impairments that may be present in a patient's life throughout treatment. Many patients display cognitive and other functional impairments that affect their ability to comprehend information or complete tasks thus complicating treatment. Such impairments frequently call for relatively short, highly structured treatment sessions that are focused on practical life problems. Slowing the pace of sessions is often necessary to allow patients to comprehend and process information given. Providing visual aids, written handouts, and repetition of skills can be very helpful for patients.

Using existing support systems and developing additional support systems are important for a patient with co-occurring disorders to maintain long-term recovery. Referring patients to available support groups or other resources to develop support systems can be vital to maintaining recovery.

Specialized Evidence-Based Treatment Approaches for PTSD

Since PTSD is a common co-occurring disorder in the military, there are often specialized treatment services for PTSD that a counselor can refer a patient to within the behavioral health clinic or Fleet and Family services.

- **Eye Movement Desensitization and Reprocessing (EMDR)** EMDR therapy involves eight phases, focusing on past memories of trauma, present disturbances, and future actions. The most distinctive element of EMDR is its use of bilateral sensory input, such as side-to-side eye movements, to stimulate the brain. This process is believed to facilitate the accessing and processing of traumatic memories, helping to reduce their lingering effects.
- **Prolonged Exposure Therapy** is a specific type of CBT that has been proven effective for PTSD. It involves gradually exposing individuals to trauma-related memories and stimuli in a safe and controlled environment to reduce the power of trauma-related fears. This approach can be critical for military personnel and veterans whose substance use is linked to traumatic experiences.

- **Medication-Assisted Treatment (MAT)** can be used to manage withdrawal symptoms, reduce cravings, and treat underlying mental health conditions. Medications such as buprenorphine, methadone, and naltrexone are commonly used for substance use disorders, while antidepressants, anti-anxiety medications, and mood stabilizers may be prescribed for mental health conditions.

Counseling Treatment Approaches for Co-occurring disorders and addiction

The relationship that a counselor builds with a patient is paramount and foundational to the patient's treatment efficacy. A foundation of trust is necessary for a patient's engagement with any treatment interventions. SAMHSA TIP 42 (2020) offers 10 guidelines to assist counselors in developing a successful therapeutic relationship with patients who have co-occurring disorders.

1. Develop and use a therapeutic alliance to engage patients in treatment.
2. Maintain a recovery perspective.
3. Ensure continuity of care.
4. Address common clinical challenges (e.g., countertransference, confidentiality).
5. Monitor psychiatric symptoms (including symptoms of self-harm).
6. Use supportive and empathic counseling; adopt a multiproblem viewpoint.
7. Use culturally responsive methods.
8. Use motivational enhancement.
9. Teach relapse prevention techniques.
10. Use repetition and skill building to address deficits in functioning.

The same treatment interventions used for SUDs can be utilized for co-occurring disorders as well, however, the focus shifts to the assist the patient with both disorders at the same time. For example, a counselor can use a CBT technique of assisting a patient with alcohol use and depression to identify triggers and coping strategies for both disorders at the same time. The substance use counselor will need to be mindful of scope of practice and maintain focus on the substance use as the issue that is primarily being treated, however, coordinating care with a behavioral health provider is paramount to effectively treating both disorders simultaneously.

The following therapeutic interventions can be individually tailored for each patient struggling with co-occurring disorders (same as interventions used for chronic pain).

Cognitive Behavioral Therapy (CBT)

- **CBT** is a widely used evidence-based approach that helps individuals identify and challenge negative thought patterns and behaviors that contribute to their mental health and substance use disorders. In the context of the military, CBT can be tailored to address trauma-related thoughts and behaviors, helping individuals develop coping strategies for managing stress and avoiding substance use.

Dialectical Behavior Therapy (DBT)

- **DBT** focuses on teaching coping skills to manage emotional distress, improve interpersonal relationships, and enhance self-regulation. It is particularly useful for individuals with borderline personality disorder, a condition that may co-occur with substance use disorders. DBT's emphasis on mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness can be beneficial for veterans dealing with emotional dysregulation and substance use.

Motivational Interviewing (MI)

- **MI** is a client-centered counseling approach that helps individuals resolve ambivalence about change and make positive decisions regarding their treatment. It is particularly effective in treating substance use disorders by enhancing motivation to change and supporting individuals in their recovery journey. MI can be adapted to the military context by acknowledging the unique values and strengths of service members and veterans.

Trauma-Informed Care

- **Trauma-Informed Care** is an overarching framework that recognizes the widespread impact of trauma and understands paths for recovery. It involves recognizing the signs and symptoms of trauma in clients and integrating this knowledge into treatment practices. Given the high incidence of PTSD and other trauma-related conditions among military populations, adopting a trauma-informed approach is essential in counseling for co-occurring disorders and addiction.

Group Therapy

- **Group Therapy** provides a supportive environment where individuals can share experiences and learn from each other under the guidance of a therapist. Groups specifically designed for military personnel and veterans can address common experiences, such as combat stress, reintegration challenges, and the stigma associated with seeking help, while fostering a sense of community and mutual support.

Family Therapy

- **Family Therapy** can play a crucial role in the treatment of co-occurring disorders and addiction, especially for service members and veterans. It helps family members understand the dynamics of addiction and mental health disorders, improve communication, and develop strategies to support their loved one's recovery.

Considerations for Counseling in the Military

1. **Cultural Competency**: Counselors should have an understanding of military culture, including the values, stressors, and experiences common to service members and veterans. This understanding can enhance the therapeutic alliance and ensure that treatment approaches are respectful and relevant.

2. **Confidentiality Concerns**: Addressing concerns about confidentiality is crucial in encouraging military personnel to seek counseling. Many may worry about the impact of their mental health on their career.

3. **Integrated Services**: Providing integrated treatment that addresses both mental health and substance use simultaneously is crucial for effective recovery. Counselors should work closely with other healthcare providers to coordinate care.

4. **Stigma Reduction**: Efforts to reduce stigma around mental health and substance use within the military community are essential. Counselors can play a key role in educating service members, veterans, and their families about the importance of seeking help and the effectiveness of treatment.

Commonly prescribed medications for Co-occurring disorders

Antipsychotics/neuroleptics: frequently used with persons experiencing psychotic symptoms as a result of having some form of schizophrenia, severe depression, or bipolar disorder.

Examples:

- Traditional antipsychotics: Thorazine and Haldol
- Atypical antipsychotics: Zyprexa and Seroquel

Mood stabilizer medications: used to control mood swings associated with bipolar disorder.

Examples:

- Lithium products
- Anticonvulsant products such as Depakote
- Atypical antipsychotics

Antidepressant medications: used for moderate to serious depressions, but they also can be very helpful for milder depressions such as dysthymia.

Examples:

- Selective Serotonin Reuptake Inhibitors such as Celexa, Zoloft, and Prozac
- Tricyclics such as Elavil
- Others: Wellbutrin, Serzone

Anti-anxiety medications: used to help calm and relax the anxious person as well as remove troubling symptoms associated with generalized anxiety disorder, posttraumatic stress disorder, panic, phobias, and obsessive-compulsive disorders.

Examples:

- Benzodiazepines such as Xanax and Klonopin

Stimulant medications: used to treat attention deficit/hyperactivity disorder, which is typically diagnosed in childhood but also occurs in adults.

Examples:

- Dexedrine and Adderall
- Non-stimulants such as Strattera

Narcotic and opioid analgesics: commonly used to control moderate to severe acute pain.

Examples:

- Natural opioids such as opium and morphine
- Pure, semi, or totally synthetic derivatives such as heroin and oxycodone

Antiparkinsonian medications: used to control the side effects associated with antipsychotic medications.

Examples:

- Cogentin
- Symmetrel

Hypnotics: used to help people with sleep disturbances get restful sleep.

Examples:

- Barbiturates such as Seconal
- Benzodiazepines such as Klonopin and Restoril
- Non-benzodiazepines such as Ambien

Summary

Counseling treatment approaches for co-occurring disorders and addiction in the military require a nuanced understanding of the unique challenges faced by this population. By employing a range of evidence-based therapies and considering the specific needs of military personnel, counselors can provide effective, compassionate care that supports recovery and resilience.

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