



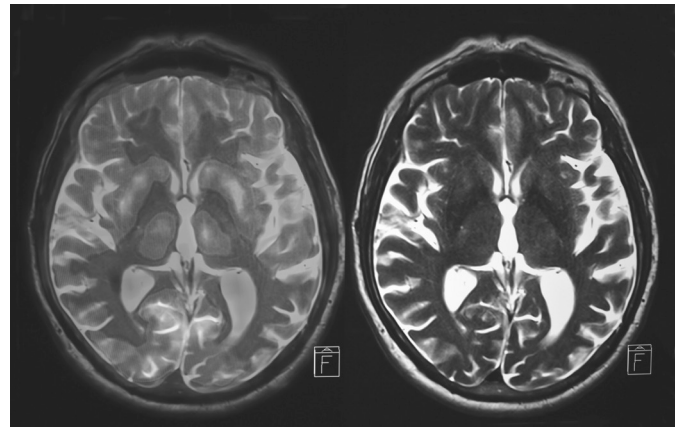
■ Source: iStock/FatCamera.



Someone you know and love is dying of addiction. No one, not even the addict, knows the extent of the disease that is poisoning this person's body. More than half of Americans drink alcohol, and many of them innocently fall victim to this silent killer. Addicts are good people with a bad disease. One hundred years ago, doctors couldn't see anything wrong with alcoholics, so they turned them over to the criminal justice system. In the last 20 years, with the advent of imaging techniques, we have learned to recognize addiction as a genetic brain disease. An addicted brain is hijacked by the addiction. Craving gets worse throughout the history of a person's addiction, but because of a genetic feedback loop, the pleasure caused by the addiction lessens. So, in time, the addict can't get high and can't get clean. The brain needs to make sense of what makes no sense, so the addict needs many unconscious distortions of reality to make life livable. These defense mechanisms are many, but the main ones are minimization (making the problem seem smaller than it is), rationalization (a good excuse for the problem), and denial (an angry refusal to see the truth). Addicts live their lives deeply alone and immersed in these self-told lies. They do not know what the truth is. They are living in a world of carefully constructed self-betrayal: "I am fine. I can stop anytime I want. I do not drink or use any more than my friends drink." "Everybody loves to gamble. It is so much fun, and I win." "I was born to use speed." At times, the addicts want to cut down or stop and they try, but they always fail—repeatedly, they fail. Addicts live in world full of self-hatred and shame. They do not want anyone to know the terrible truth. They put on a false front of being fine. You might suspect something is wrong, and you would be right, but there seems to be little you can do to help an addict see the truth. Most addicts die of their addiction. Ninety-five percent of untreated alcoholics die of alcoholism an average of 26 years too early. The death certificate might read heart disease, cancer, or something else to protect the family, but the real reason is addiction.

Addiction is more than a behavior problem. Repeated drug use causes long-lasting changes in the brain, so the addict loses voluntary control. The prefrontal lobe of the brain where we make decisions, plan, organize, reason, and resist primitive impulses goes offline. Clients are obsessed with doing what they hate doing. They try to stop many times, but they can't. The addiction is the only way they know how to feel more normal. Their brain is cut off from the truth. Not to use causes withdrawal, which causes craving that is too painful to endure. Craving is not like wanting. You might like chocolate a lot, but craving is pacing the floor at 3 in the morning while saying to yourself, "Just one more time." The addicted brain adapts to the point that the addict cannot get high *or* get sober. This is when addicts feel hopeless, helpless, and powerless, and their lives are unmanageable. This is when many of them commit suicide or come in for treatment.

In the United States, 51.1% of the population drinks alcohol, and a little less than a third of these individuals will have a substance use disorder in their



Source: iStock/semnic.

lifetime (Substance Abuse and Mental Health Services Administration [SAMHSA], 2019; see www.samhsa.gov/data/report/2019-nsduh-annual-national-report).

Almost 1 million Americans die of substance use disorder annually. This does not count the people who die of diabetes, coronary artery disease, and cancer caused by drinking, smoking, poor eating, and lack of exercise. Heavy drinking or drug use contributes to illnesses in each of the top three causes of death: heart disease, cancer, and stroke. At least 13.8 million Americans develop problems associated with drinking. Over many years of following alcohol and drug problems, studies have found that 78% of high school seniors have tried alcohol. Fifty-three percent have tried illegal drugs. Fifty-seven percent have tried cigarettes, and 14% are current smokers. Addiction is one of the most horrible plagues to attack the human race. According to the Centers for Disease Control and Prevention (CDC), 25% of Americans die as a direct result of substance abuse (Heron et al., 2009).

Millions of Americans are dying annually of preventable conditions.

- 480,000 die of abuse of tobacco products.
- 365,000 die of improper diet and exercise habits.
- 34,000 die of alcohol abuse.
- 93,000 die of drug overdose.
- 75,000 die of exposure to microbial agents.
- 55,000 of exposure to toxic agents.
- 32,000 die of adverse reactions to prescription drugs.
- 40,000 die of injury from automobile accidents.
- 29,000 die of violence by firearms.
- 19,000 die of homicide.
- 44,000 die of suicide.
- 20,000 die of infections caused by sexual behavior.
- 17,000 die of abuse of illegal drugs. (Drug Policy Facts, 2021)

Treatment Works

Some addicts will quit on their own by making a highly motivated personal choice, then working hard at recovery, usually with multiple attempts at quitting and periods of relapse and reevaluation. Most of the people who quit on their own have learned about treatment and recovery through someone who is in recovery, a health care professional, or a friend. These people decide that the negative consequences of continued use outweigh the rewards. They go through the same motivational steps that a client needs to make in treatment (DiClemente, 2006b). Other addicts cannot seem to quit on their own, and they need treatment. We know from many years of scientific experiments that addiction treatment works. For every dollar spent on treatment, the economy saves \$7 in health care and costs to society. Most clients who work a program of recovery stay clean and sober. To get clean, clients have to come out of hiding and use their journey to help others. By sharing our experience, strength, and hope, addicts in recovery give other people reasons to get clean. Working the program means getting honest, going to

recovery group meetings, and making conscious contact with a higher power of their own understanding (Johnston et al., 2008; McLellan, 2006).

Your first meeting with a client might be accidental, or it might be by appointment. During the interview—if you look and listen carefully—you will sense something is wrong with this person, but you do not know what it is. You have a clinical thermometer inside of you that you will over time learn to trust. This is more than intuition; it is a gift. The skill is to watch the client so carefully and listen so intensely that you pick up cues that others miss. Clients like this might look depressed and anxious. Their faces may be red and swollen, their eyes watery and red, or they may be markedly thin with scabs caused by “meth bugs.” They might have a fine hand tremor or have difficulty sitting still. Sometimes a client’s head hangs in depression that looks like shame. Something is wrong, and it will nag at you. That clinical thermometer inside of you feels uncomfortable, and you do not like it.

If you are reading this manual, you have probably been a natural-born healer all of your life. When you were a little kid, you cared more about puppies and kittens than others did. People in school talked to you and told you secrets when they would not talk to anyone else. People recognize a healer when they see one.

There is another side of you that is very different. It has been in trouble with clients like this before. Sometimes being a healer is not good. Sometimes you have to tell people the truth when they do not want to hear it. They can rebel against you and fight. You have learned that sometimes it is best to let the truth go—or worse, lie to yourself and your clients and let them go. You hate that part of yourself, but you have learned how to live with it. After all, you live in a world full of litigation and managed care. Fear has overcome your best judgment many times.

And there is that client sitting in your office, crying out for the healer in you. Clients desperately need someone to tell them the truth. This time, if you let the problem go, if you take the easy way out, the client may die. Addiction is like brain cancer. To let this client out of your office without confronting the truth is to be responsible for the client’s death.

Yet you have confronted drug addicts before. Addicts seem to have two sides. One knows they are in trouble while the other knows they can continue the addiction safely. You and your client are in a life-or-death battle with the truth. The trick is to help the client win. You are up against a great enemy. Alcoholics Anonymous (AA, 2001) says this illness is “cunning, baffling and powerful” (pp. 58–59).

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

The enemy does not know that you are a healer. You will not lie, and you will not let the addict go home to die. You are going to fight. This is who you are, and it is who you will always be. To be anything else leaves you in shame.

The Motivational Interview

So you decide to take action. Either you do this yourself, or you call in an addiction professional to do it for you. You suspect your client is addicted. Your client does not even want to know the reason because to know the truth confronts the addict with change. Your job is to go with the client toward the truth. It does no good to go against such clients’ idea of themselves. Arguing with them will not work because addicts are expert at giving every excuse in the world for abnormal behavior. If you argue, they will win because they will leave your office convinced you are a bad person. Walk *with* the client toward the truth.



Source: ©iStockphoto.com/
AlexRaths.

Listen and seek out ambivalence about the negative consequences of continuing the addictive behavior. This is client-centered counseling, not self-centered counseling. You must listen so you can step into your clients' world and connect with that gentle voice of reason inside of them. That healthy voice is there, and your job is to connect with it, empathize with it, and pull for more. The other voice in clients' heads says something else is to blame. They might have another problem, but it has nothing to do with addiction.

As a professional, you are used to your clients being honest with you, but this one is going to lie. The client is not a bad person; the client is a good person with a bad disease. The disease of addiction lives in and grows

in the self-told lie. Clients like this must lie to themselves and believe the lie, or the illness cannot continue. These clients will have a long list of excuses for their behavior:

- My spouse has a problem.
- The police have a problem.
- The school has a problem.
- My boyfriend has a problem.
- I have a physical problem.
- I am depressed.
- I am anxious.
- I have a stomachache.
- I cannot sleep.

The excuses go on and on, and they might confuse you if you are caught up in them. They are all part of a tangled web of deceit. Remember, your job is to walk *with* the client toward the truth, not *against* the client toward the truth. You are going to spend most of your time agreeing with the client. When the client is honest, you are going to agree. When the client is dishonest, you are going to probe for the truth. Look at it this way: If the client is listening to you, you can work. If the client is not listening to you, anything you say is useless.

Watch the client's nonverbal behavior very carefully. You are a healer, and you have the gift of supersensitivity. Your intuition will tell you whether the client is going with you or resisting. When the client goes with you, you feel peace. When the client goes against you, you feel uncomfortable. When the client is ready, you will educate the client about the disease. This is a gentle process, and it takes time. If you are in a hurry, this is not going to work.

The client has been using the addiction for a long time to relieve pain. All addictions tell the brain, "Good choice!" All organisms have a way of finding their way in a complicated environment. They learn which foods are good and which are bad. They find the best way through the jungle. They learn what is safe and what is dangerous. We learn these things deep in the reptilian brain. What is good is remembered as if it is very good, after one experience. The addiction has been good to this client for many years, but now it is destructive. The very thing that gave the client joy now gives pain. This process fools the client. Remember, the addiction has always said, "Good choice!" So how can it be a bad choice? You are fighting with the client's basic understanding of the world, and the client will be convinced

that you are wrong. You must help the client see that the addiction is no longer a good choice—it is a deadly choice. The addict cannot see this alone, but AA has an old saying: “What we cannot do alone, we can do together.” The client cannot discover the truth without your help. You must guide clients like this toward a decision they find impossible. You need to help these clients see that they need to stop the addictive behavior.

What you are looking for is the truth. The client will rarely tell you accurate symptoms. You have to look for signs of the disease. Symptoms are what the client reports. Signs are what you see. You will continue to investigate—testing; smelling the air; ordering laboratory studies; and, if you get a release, talking to family, friends, court workers, school personnel, and anyone else who can help you uncover the truth.

Your client cannot tell you the truth because the client does not know the truth. Addiction hijacks a client’s thinking, a web of self-deception. Remember, you are the healer. You care for your clients even if they hate themselves. You are going to love them even though they are being deceptive. You are going to help them even though they do not understand what you are doing.

How to Develop the Therapeutic Alliance

From the first contact, your client is learning some important things about you. You are friendly. You are on the client’s side. You are not going to beat up, shame, or blame your client. You answer any questions. You are honest, and you hold nothing back. You discuss every option in detail. You are committed to do what is best for the client. You provide the information, and the client makes the decisions. The client sees you as a concerned professional. You are asking questions no one else has asked. This leads the client to believe you are a skilled professional. In time, the client begins to hope that you can help. The therapeutic alliance is built from an initial foundation of love, trust, and commitment.

You show these clients that they do not have to feel alone. Neither of you can recover alone. Both of you are needed in cooperation with each other to solve the problem. These clients know things that you do not know. They know themselves better than anyone else does, and they need to learn how to share their life with you. Likewise, you have knowledge that the clients do not have. You know the tools of recovery.

Your clients must trust you. To establish this trust, you must be honest and consistent. You must prove to your clients, repeatedly, that you are going to be actively involved in their individual growth. You are not going to argue or shame your clients; you are going to try to understand them. When you say you are going to do something, you do it. When you make a promise, you keep it. You never try to get something from a client without using the truth. You never manipulate, even to get something good. The first time a client catches you in a lie, even a small one, your alliance is weakened.

If you work in a treatment facility or group practice, your clients must learn that your staff works as a team. You can share with the whole team what a client tells you—even in confidence. Some clients will occasionally test this. They will tell you that they have something to share, but that it can only be shared with you. They want you to keep it secret. Many early professionals fall into this trap. The truth is that all facts are friendly and all information is vital to recovery. You must explain to your clients that if they feel too uncomfortable sharing certain information with the group, they should keep it secret for the time being. Maybe they can share this information later when they feel more comfortable.

Your clients must understand that you are committed to their recovery, but you cannot recover for them. You cannot do the work by yourself. You must work together, cooperatively. You can only teach the tools of recovery. The clients must use the tools to stay sober.

How to Do a Motivational Interview

In the first interview, you begin to motivate clients to see the truth about their problem. Questions about alcohol and other drug use are most appropriately asked as a part of the history of personal habits, such as use of tobacco products and caffeine. Questions should be asked candidly and in a nonjudgmental manner to avoid defensiveness. Remember that this is client-centered interviewing, not professional-centered, and the interview should incorporate the following elements (with the client being free of alcohol at the time of the screening) (DiClemente, 2006a; Prochaska, 2003, 2019):

- Offer empathic, objective feedback of data.
- Work with ambivalence.
- Meet the client's expectations.
- Assess the client's readiness for change.
- Assess barriers and strengths significant to recovery efforts.
- Reinterpret the client's experiences in light of the current problem.
- Negotiate a follow-up plan.
- Provide hope.

Example of a Motivational Interview

Professional: Hello, Frank, I am _____ [your name]. Why did you come in to see me today?

Client: My wife wanted me to talk to you.

Professional: Why did she want that?

Client: I don't know.

Professional: I talked to your wife on the phone yesterday, and she said she was concerned about your drinking.

Client: She is always concerned about something. Her father was an alcoholic, so she thinks everyone drinks too much. [*The client looks irritated.*]

Professional: Sounds like things are not going well at home? [*The professional mirrors the client's feelings and facial expression. When you mirror people's expression, you validate their worldview.*]

Client: I don't know. It is just that she gets all worked up about everything.

Professional: Your wife said you have been drinking heavily every day. She is afraid for you.

Client: I work hard, and I like to come home and relax with a few beers. Is anything wrong with that? [*The client is obviously irritated with coming to the interview. So far, the client is saying, "My wife has a lot of problems."*]

Professional: There's nothing wrong with relaxing. How do you relax? [*The professional goes with the client's point of view.*]

Client: I have a couple of beers. So what?

Professional: Your wife says you have been drinking a 12-pack a day.

Client: It's not that much.

Professional: Are you drinking more than a couple of beers a day? [*The professional is gently pulling for the truth.*]

Client: Maybe a little more.

Professional: Is it around 12?

Client: I work hard, and I deserve to relax. [*The client is resisting, and the professional backs off a little. It is important to keep the client's ears open. Be empathic, tender, and understanding. Try to see the problem from the client's point of view. Once you enter the client's world and understand that point of view, you will get clues about what will motivate the client to change. This client is mad at his wife and needs some help with that, but what is his real problem?*]

Professional: I like to relax after a hard day, too. Your wife sounds afraid for you. What is frightening her?

Client: My wife just sits around all day and watches television while I am working my tail off.

Professional: So you really need to relax when you come home. Particularly if you feel like you are pulling the load all by yourself?

Client: Yeah, she sits around and thinks about things to argue with me about.

Professional: Do you think your wife loves you? [*This is pulling the client toward the truth. Why is his wife worried about him?*]

Client: Well, yeah, I think she does. [*The client visibly softens.*]

Professional: It is great to have a wife who loves you. Sounds like you are a lucky man. [*The professional reinterprets the client's experience in light of the alcohol problem.*]

Client: But I am not drinking too much. I am just drinking a few beers.

Professional: You said it was 12. [*The professional reminds the client what he said earlier to cement the fact.*] What is the most beer you have ever drunk in a full day?

Client: Oh, I do not know.

Professional: Give me a guess.

Client: Well, on the weekends I can drink up to a case if I am watching a ball game.

Professional: That is a lot of beer. [*The professional determines the client is an alcoholic but does not jump the gun; the client is not ready yet.*]

Client: Not if I am drinking all day.

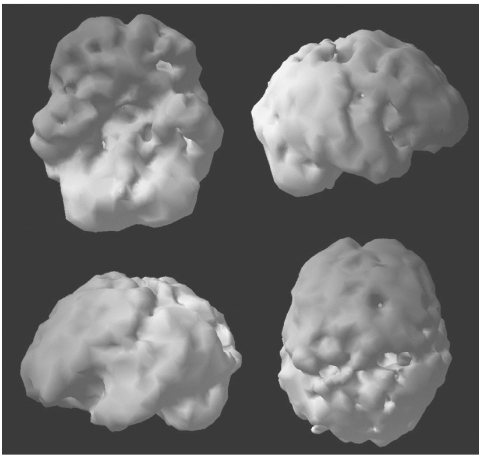
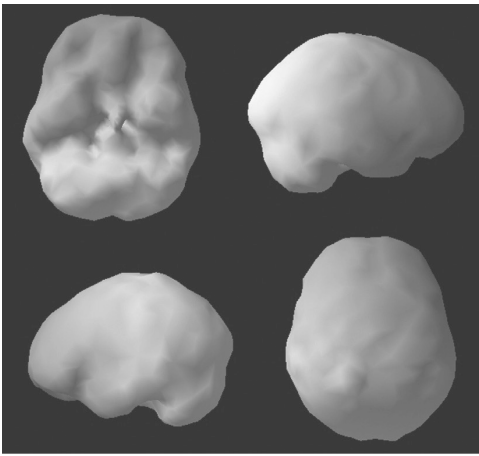


Photo 1.4 Amen Clinics alcohol abuse brain.

Professional: Did you know that if you drink more than three beers a day, more than three times a week, your organs are dying? Alcohol is a poison. It kills the brain, heart, kidneys—every cell in the body. If you are drinking more than three drinks per day, you are literally killing yourself. That might be why your wife is worried about you. [*The professional believes the client's ears are open, so it is time to try a little education.*]

I want to show you two single photon emission computed tomography, or SPECT, scans: pictures of a healthy brain and a brain of someone who abuses alcohol.

The client quickly looks away. He does not want to see a picture of his brain dying. However, he has seen it, and he cannot make that fact go away. He has to rapidly deny the professional's statements and the pictures or admit that he has a problem. A part of him knows he has a drinking problem, and now it is confirmed. It is not only his wife's opinion, but now a picture and a professional's opinion confirm the diagnosis. He has not admitted it yet, but he knows he has been drinking too much.

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

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

Client: No, honestly, I have not. [*This comes across as real. When clients' words and affect match, they are probably telling the truth. Most addicts think their addictive behavior is normal.*]

Professional: Maybe that is because you did not understand how much you could drink safely. If alcohol is killing you, don't you want to know?

Client: Well, sure.

Professional: Looking at these pictures, and thinking about how much you have been drinking, do you think you have been drinking too much? [*The professional is taking the biggest chance of all.*]

Client: Maybe? [*A maybe is very close to a yes. The client has admitted that he drinks too much. That moves him from the precontemplation phase to the contemplation phase. For the first time, he is considering the negative consequences of his drinking. This is a huge step toward recovery.*]

Professional: Did you know that 95% of untreated alcoholics die of their alcoholism? And they die 26 years earlier than they would otherwise?

The client says nothing.

Professional: Knowing what you know now, would you like to learn how to drink less or even stop drinking entirely? [*The professional is negotiating how far the client is willing to go to get better.*]

- Client:* I didn't know it was that bad. [Now the client is contemplating change. We are on the road to recovery. With a gentle approach, the professional can negotiate and listen to the client's life from his perspective, allowing the client to move toward the truth.]
- Professional:* Why don't we meet again with your wife and talk about what we can do to help you two feel better? Would that be all right with you?
- Client:* If you think it will help.
- Professional:* Most people who try to get better get better.
- Client:* Okay, let's do it. [A commitment to change has occurred. Now the client realizes he has a problem and is making plans to take action. These are the first giant steps toward recovery.]

Questions to Ask the Adult Client

The National Institute on Alcohol Abuse and Alcoholism (NIAAA, 2020) has developed the following low-risk drinking guidelines:

Men should drink no more than two drinks a day and no more than four drinks on a single occasion.

Women and clients over 65 years of age should drink no more than one drink a day and no more than three drinks on a single occasion.

Pregnant clients and those with medical problems complicated by alcohol use should abstain completely ("U.S. Surgeon General Releases Advisory on Alcohol Use in Pregnancy," 2005).

We could also add that no person should ingest an illegal substance. If people cannot stop something they want to stop, they might have an addiction.

At some time during the first interview, certain questions need to be asked to assess addiction problems. They have to be answered honestly to give you a clear picture of the extent of the problem. Most clients who have addiction problems will be evasive or deny their addiction, so the questions should be asked of the client, as well as a reliable family member.

The following questions and flags are taken from the American Society of Addiction Medicine (ASAM; see www.asam.org):

1. Have you ever tried to cut down on your drinking?
2. Have you ever felt annoyed when someone talked to you about your drinking?
3. Have you ever felt bad or guilty about your drinking?
4. Have you ever had a drink in the morning to settle yourself down?
5. Has your use of alcohol or drugs ever caused you family problems?
6. Has a physician ever told you to cut down on or quit use of alcohol?
7. When drinking/using drugs, have you ever had memory loss or a blackout?

Similar questions could be asked about gambling or any other addictive behavior. If clients answer yes to any one of these questions, it is a red flag for addiction. If they answer yes to two questions, it is probably addiction. Make sure you do not just ask the client. Ask family members, friends, and anyone else who can give you collateral information. (See Figures 1.1 through 1.5.)

Figure 1.1 Client History/Behavioral Observation Red Flags for Addiction

Tremor/perspiring/tachycardia
Evidence of current intoxication
Prescription drug-seeking behavior
Frequent falls; unexplained bruises
Diabetes-elevated blood pressure; ulcers nonresponsive to treatment
Frequent hospitalizations
Gunshot/knife wound
Suicide talk/attempt; depression
Pregnancy (screen all)

Figure 1.2 Laboratory Red Flags for Adult Alcohol/Drug Abuse

Mean corpuscular volume (MCV)—Over 95
Mean corpuscular hemoglobin (MCH)—High
Gamma-glutamyl transferase (GGT)—High
Serum glutamic-oxaloacetic transaminase (SGOT)—High
Bilirubin—High
Triglycerides—High
Anemia
Positive urinalysis for alcohol

Figure 1.3 Client History/Behavioral Observation Red Flags for Adolescent Alcohol Abuse

Physical injuries: motor vehicle accident (MVA), gunshot/knife wound, unexplained or repeated injuries
Evidence of current use (e.g., dilated/pinpoint pupils, tremors, perspiring, tachycardia, slurred/rapid speech)
Persistent cough (cigarette smoking is a risk factor)
Engages in risky behavior (e.g., unprotected sex)
Marked fall in academic/extracurricular performance
Suicide talk/attempt; depression
Sexually transmitted diseases
Staphylococcus infection on face, arms, legs
Unexplained weight loss
Pregnancy (screen all)

Figure 1.4 Laboratory Red Flags for Adolescent Alcohol/Drug Abuse

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

Figure 1.5 Interview Questions for Suspected Addiction Among Adolescents

Questions to Ask the Adolescent Client

1. When did you first use alcohol on your own, away from family/caregivers?
2. How often do you use alcohol or drugs? When was your last use?
3. How often have you been drunk or high?
4. Has your alcohol or drug use caused you problems with your friendships, family, school, community, etc.? Have your grades slipped?
5. Have you had problems with the law?
6. Have you ever tried to quit/cut down? What happened?
7. Are you concerned about your alcohol or drug use?

Questions to Ask the Parent/Caregiver

1. Do you know/suspect your child is using alcohol/other drugs?
2. Has your child's behavior changed significantly in the past 6 months (e.g., sneaky, secretive, isolated, assaultive, aggressive, hostile)?
3. Has the school, community, or legal system talked to you about your child?
4. Has there been a marked fall in academic/extracurricular performance?
5. Do you believe an alcohol/other drug assessment might be helpful?

What to Do If There Are One or More Red Flags

Once you have one or more red flags, you have several important actions to take:

1. Advise the client of the risk.
2. Advise abstinence or moderation. Men should be advised to drink no more than three drinks a day no more than three days a week. Women should be advised to drink no more than two drinks a day no more than three days a week. More drinking than this will result in disease. This is a harm reduction approach where you teach a client how to drink responsibly. This would not be appropriate for someone who has a serious drinking problem.
3. Advise against any illegal drug use.
4. Schedule a follow-up visit to monitor progress.

Natural History of Addiction

Addiction can begin at any age, and it often occurs in individuals with no history of psychological problems. When the addictive substance is readily available, inexpensive, and rapid acting, the incidence of use increases. Whenever the individual is ignorant of healthy alcohol or drug use, is susceptible to heavily using peers, or has a high genetic predisposition to abuse or to antisocial personality disorder, abuse may increase. This is also true if the client is poorly socialized into the culture or in pain, or if the culture makes a substance the recreational drug of choice.

Risk Factors

Risk factor 1: Substance or behavior is readily available.

Risk factor 2: Substance use or addictive behavior is cheap.

- Risk factor 3: The addictive chemicals reach the brain quickly.
- Risk factor 4: Addiction is a pain reliever.
- Risk factor 5: Addiction is more common in certain occupations (e.g., bartending).
- Risk factor 6: Addiction is prevalent in the peer group.
- Risk factor 7: Addiction is preferred in deviant subcultures.
- Risk factor 8: Social instability is found.
- Risk factor 9: There is a genetic predisposition.
- Risk factor 10: The family is dysfunctional.
- Risk factor 11: Comorbid psychiatric disorders are present. (Vaillant, 2003)

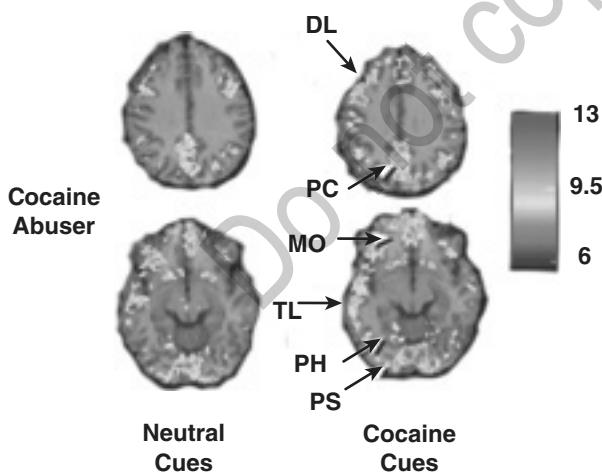
How to Diagnose an Addiction Problem

In the assessment, you must determine if the client fits into your range of experience and care. Do you have the ability to deal with this client's problem, or do you need to refer the client to someone else? Does the client have a problem with chemicals or an addictive behavior? Is the client motivated to get better? Does the client have the resources necessary for treatment? Is the individual well enough to see you? For the most part, you will start by asking yourself certain basic questions: Does this person have signs and symptoms of addiction? Does the client need treatment? Is the client motivated for treatment? What kind of treatment does the client need? For the benefit of third-party payers, it is important to use assessment instruments to document (1) diagnosis, (2) severity of addiction, and (3) motivation and rehabilitation potential. Third-party reviewers will often have more faith in a test battery than your clinical opinion.

A number of companies sell inexpensive, disposable Breathalyzers and drug screening instruments. There are also hair screens gamma-glutamyl transferase (GGT) alcohol screen that will test for alcohol ingestion for 80 hours after use; and ankle bracelets that measure alcohol in the sweat of probationers 24 hours a day, 7 days a week. Order a number of these tests, and have them readily available for assessment, treatment, and continued care monitoring. Positive tests are only suggestive of drug and alcohol use, so before any legal or workplace action is taken, the test should be confirmed by both an approved immunoassay and gas chromatography/mass spectrometry, which can be administered and analyzed by a health care provider.

Two quick screening tests for alcoholism have been developed: the Short Michigan Alcoholism Screening Test (SMAST), provided in Appendix 1 (Selzer et al., 1975), and the CAGE questionnaire (Ewing, 1984; Selzer et al., 1975). The SMAST, as well as the more extensive Michigan Alcoholism Screening Test (MAST), has greater than 90% sensitivity to detect alcoholism. It can be administered to either the client or the spouse. The World Health Organization collaborative project developed the alcohol use disorders identification test (AUDIT) (Appendix 2) as a tool to detect persons with harmful alcohol consumption around the world. The screen is in the public domain and comes in most languages (Saunders et al, 1993).

The Substance Abuse Subtle Screening Inventory, or SASSI (www.sassi.com), was developed to screen clients when defensive and in denial. The SASSI measures defensiveness and



Source: From "Activation of Memory Circuits During Cue-Elicited Cocaine Craving," by S. Grant et al., 1996, *Proceedings of the National Academy of Sciences, USA*, 93, pp. 12040-12045.

the subtle attributes that are common in chemically dependent persons. It is a difficult test to fake, unlike the SMAST or the CAGE. Clients can complete the SASSI in 10 to 15 minutes, and it takes 1 or 2 minutes to score. It identifies accurately 98% of clients who need residential treatment, 90% of nonusers, and 87% of early-stage abusers. This is a good test for those clients whose diagnosis you are still unsure about after your first few interviews—clients who continue to be evasive (Miller, 1985).

The Addiction Severity Index (ASI) and the Teen Addiction Severity Index (T-ASI) are widely used, structured interviews for adults and teens and are designed to provide important information about the severity of the client's substance abuse problem. These instruments assess seven dimensions typically of concern in addiction, including medical status, employment/support status, drug/alcohol use, legal status, family history, family/social relationships, and psychiatric status. The tests are administered by a trained technician. The ASI is an excellent tool for delineating the client's case management needs (Kaminer et al., 1991; McLellan et al., 1980).

The Adolescent Alcohol Involvement Scale (AAIS) is a 14-item, self-report questionnaire that takes about 15 minutes to administer. It evaluates the type and frequency of drinking, the last drinking episode, reasons for the onset of drinking behavior, drinking context, short- and long-term effects of drinking, perceptions about drinking, and how others perceive one's drinking (Mayer & Filstead, 1979; Mee-Lee, 1988; Mee-Lee et al., 1992). The Recovery Attitude and Treatment Evaluator—Clinical Evaluation (RAATE-CE) is a 35-item scale that assesses treatment readiness and examines client awareness of problems; behavioral intent to change; capacity to anticipate future treatment needs; and medical, psychiatric, or environmental complications. The RAATE-CE determines the client's level of acceptance and readiness to engage in treatment and targets impediments to change. Adolescents prefer the CRAFFT (Brooks et al., 2019; see Appendix 3), which was developed to screen adolescents for alcohol and other drug use. Compared to being interviewed by a professional, adolescents say they are more likely to answer correctly in a self-report (Knight et al., 2019).

How to Intervene

- No problem usage: If the client is at low risk for addiction, you should provide positive prevention messages that support the client's continued positive lifestyle. Clients with a positive family history of addiction should be warned about their increased vulnerability to addiction and the need for vigilance.
- Problem with addiction: The client who has had recurrent problems due to addiction should be encouraged to abstain from, or at least reduce, the addictive behavior. A client such as this should be strongly encouraged to abstain from using all illegal drugs and addictive behaviors. You should discuss the biopsychosocial complications of addiction (see Appendix 4). Clients who are encouraged to cut down on their addictive behavior should be provided with the brochure from NIAAA (see Appendix 5). It is essential that these clients be reassessed frequently to monitor their ability to comply with your recommended limits.
- Addiction: Addicts need to have their diagnoses carefully discussed with them and a treatment plan negotiated. You need to be empathic and address the problems that seem to be caused by or made worse by the client's continued addictive behavior. These clients need to hear that this illness is not their fault and that there is excellent treatment available that will help them to stay clean and sober. These clients need to hear that only 4% of addicts can quit on their own over the course of a year, but 50% can quit over the course of a year if they go through treatment. Seventy percent can quit over the course of a year if they also attend recovery group meetings regularly, and 90% can stay sober if they go through treatment, attend

Figure 1.6 Positive and Negative Prognostic Factors

Positive Prognostic Factors

- Lack of physical dependence
- Intact family
- Stable job
- Presence of prior treatment (prognosis improves for clients who have been through one to three treatments)
- Absence of psychiatric disease
- Presence of long-term monitoring arrangement, such as a Physician Effectiveness Program or Employee Assistance Program

Negative Prognostic Factors

- More severe, advanced dependency
- Presence of intoxication at office visits
- Loss of job
- Loss of home
- Loss of family
- Multiple, unsuccessful attempts at treatment
- Severe physiological dependence
- Coexisting psychiatric disorders
- Absence of long-term monitoring (Conigliaro, Reyes, Parran, & Schultz, 2003)

meetings, and go to continuing care once a week for a year (Hoffmann, 1991, 1994; Hoffman & Harrison, 1987). These clients should also be told about the potential benefits of naltrexone, acamprosate, methadone, and butyrophenone maintenance and disulfiram when used along with formal treatment programs. Carefully discuss the ASAM client placement criteria to help you and your clients negotiate the best treatment plan possible to bring the addiction under control. (See Figure 1.6.) The following questions may be helpful in negotiating a treatment plan:

1. Is the client a danger to self or others (suicidal and homicidal ideation, impaired judgment while intoxicated, history of delirium tremens)?
2. Has the client ever been able to stay clean for 3 or more days?
3. What happened when the client stopped the addictive behavior in the past? How serious were the withdrawal symptoms?
4. Has the client ever been able to stay completely abstinent for long periods?
5. Why did previous attempts at staying clean fail?
6. How does the family understand alcoholism and its treatment?

How to Assess Motivation

Constantly ask yourself about the client's stage of motivation and introduce appropriate motivating strategies to move the client up a motivational level. This book will give you many ways of doing this. No client is alike, so you must be creative in helping all clients to see the inaccuracies in their thinking and move away from the lies toward the truth.

The Stages of Motivation

Precontemplation

The individual is not intending to take action in regard to the substance abuse problem in the near future.

Tasks: Try to increase awareness of the need to change; increase concern about the current pattern of behavior.

Goal: Make a serious consideration of change.

Contemplation

The individual examines the current positive and negative effects of drinking behavior and the potential for change in a risk–reward analysis.

Tasks: Analyze the pros and cons of the current behavior and of the costs and benefits of change.

Goal: Write a list of the positive and negative consequences of continued use.

Preparation

The individual makes a commitment to take action to change and develops a plan for change.

Tasks: Increase commitment and create a change plan.

Goal: Create an action plan to be implemented in the near future.

Action

The individual implements the plan and takes steps to change and begins new behavior patterns.

Tasks: Implement change and revise the plan as needed while sustaining commitment in the face of difficulty.

Goal: Develop a successful action for changing behavior and establish a new pattern of behavior for a significant period of time (3–6 months).

Maintenance

The new behavior is sustained for an extended period of time and is consolidated into the lifestyle of the individual.

Tasks: Sustain change over time and integrate the behavior into everyday life.

Goal: Sustain long-term change of the old behavior and establish a new pattern of behavior. (DiClemente, 2006a; Prochaska, 2019; Prochaska & DiClemente, 1983; Prochaska et al., 1992; Prochaska et al., 1994)

Motivating Strategies

Clients at different stages of motivation will need different motivating strategies to keep them moving toward recovery, and these stages are not static. Clients can shift back and forth through the stages for various reasons or spontaneously. Clients in the precontemplation stage underestimate the benefits of change and overestimate its cost. They are not aware that they are making mistakes in judgment, and they believe they are right. Environmental events can trigger a person to move up to the contemplation stage. An arrest, a spouse threatening

to leave, or a formal intervention can all increase motivation to change. Persons in the precontemplation stage cannot be treated as if they are in the action stage. If they are pressured to take action, they will terminate treatment (Prochaska, 2003, 2019).

Client in the preparation stage have a plan of action to cut down on or quit their addictive behavior in the near future. Such a client is ready for input from professionals, counselors, or self-help books. The client should be recruited and motivated for action. Action is the client changing behavior to cut down or quit the addiction. This is the client who has entered early recovery and is involved in treatment (DiClemente, 2006a).

In the maintenance stage, clients are still changing their behavior to be better and are working to prevent relapse. A client who relapses is not well prepared for the prolonged effort it takes to stay clean and sober. All clients need to be followed in long-term containing care because addiction is fraught with relapse and clients need encouragement and support for years to stay in recovery. Addicts typically do not have the skills to work a program in early recovery. This takes time, commitment, and discipline, constantly trying to raise the client's consciousness about the causes, consequences, and possible treatments for a particular problem. Defense mechanisms, minimization, rationalization, and denial are unconscious and automatic. You must help the client raise the material from unconscious to conscious. Clients can make a better decision consciously than they can without automatically thinking about the consequences of their addictive behavior. Interventions that increase awareness include observation, confrontation, interpretation, feedback, and education, pointing out the need to reevaluate the environment and change behavior. Encourage your clients to reevaluate their self-image and explain how this is negatively affected by the addictive behavior. Encourage them to learn the new skills of being honest, helping others, and seeking a relationship with a higher power (DiClemente, 2006a).

In order to help motivate clients to progress from one stage to the next, it is necessary to know the principles and processes of change (DiClemente, 2006a; Prochaska, 2003, 2019; Prochaska & DiClemente, 1983; Prochaska et al., 1992; Prochaska et al., 1994).

The following process should be applied to clients in the precontemplation stage (see Figure 1.7) (DiClemente, 2006a; Prochaska, 2003; Prochaska & DiClemente, 1983; Prochaska et al., 1994).

Helping relationships combine caring, openness, trust, and acceptance, as well as family and community support for change.

Figure 1.7 Processes of Change for the Client in the Precontemplation Stage

1. Consciousness raising involves increasing the client's awareness of the causes, consequences, and responses to the alcohol problem.
2. Dramatic relief involves increasing the client's emotional arousal about one's current behavior and the relief that can come from changing.
3. Environmental reevaluation has the client assess the effects the alcohol problem has on one's social environment and how changing would affect that environment.
4. Self-reevaluation has the client assess his or her image of one's self free from alcohol problems.
5. Self-liberation involves the belief that one can change and the commitment and recommitment to act on that belief.
6. Counter-conditioning requires the learning of healthier behaviors that can substitute for drinking alcohol.
7. Contingency management involves the systematic use of reinforcers and punishments for taking steps in a particular direction.
8. Stimulus control involves modifying the environment to increase cues that promote healthy responses and decrease cues that lead to relapse.

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