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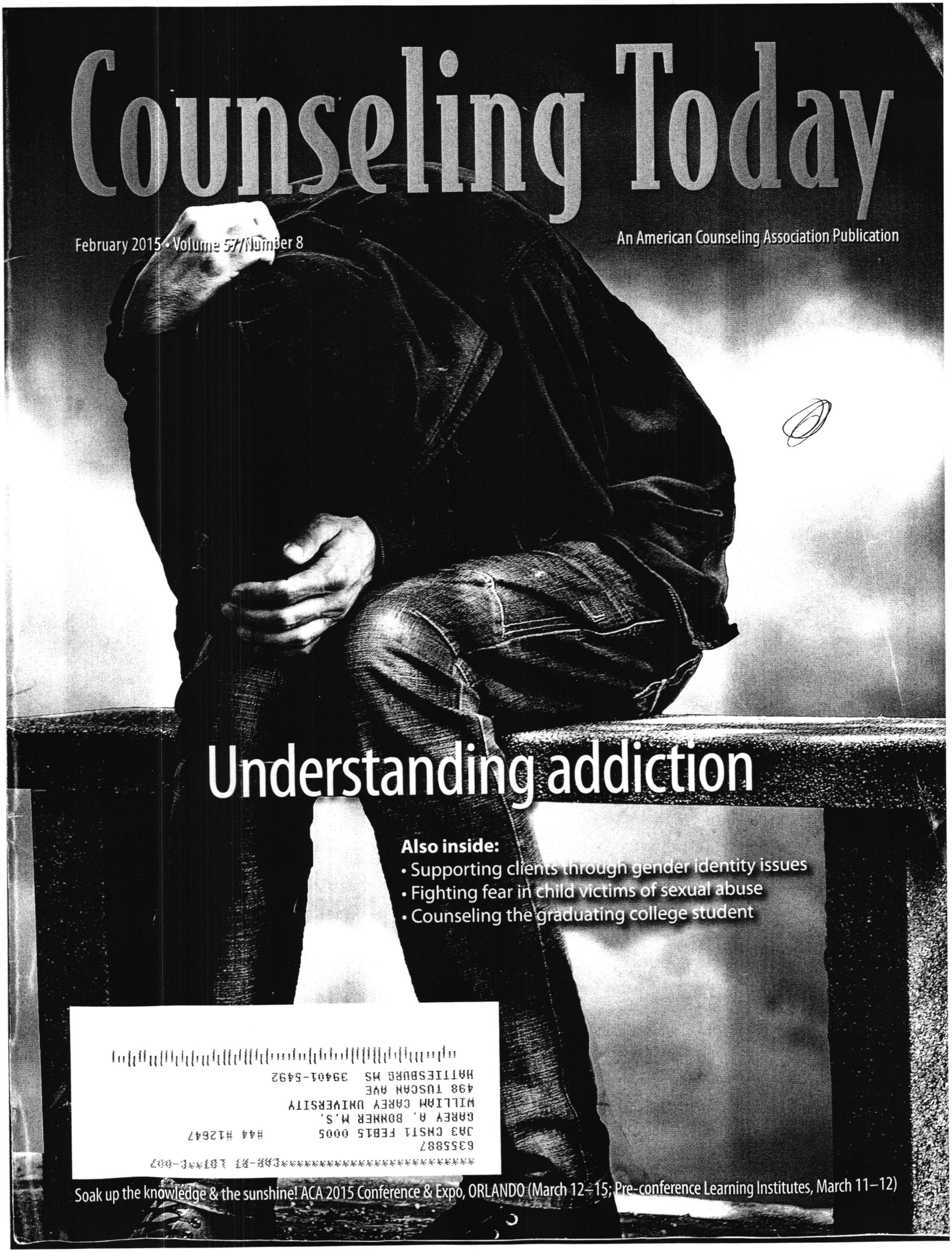

Understanding addiction

Also inside:

- Supporting clients through gender identity issues
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- Counseling the graduating college student

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Hidden in plain sight

By Laurie Meyers

Counselors may not intentionally set out to work with issues surrounding substance use and addiction, but with a little digging, they may discover that these issues are often connected to even their most 'typical' clients

Drunk. Junkie. Loser. These are just some of the ugly labels that get thrown around when people talk about addiction. Labels that reinforce the belief that addiction happens to "other" people — or other counselors' clients.

Counselors know that addiction is a disease, of course. But it's a disease with a particularly bad reputation, and many counselors may associate it with resistant clients and low rates of successful treatment. For some counselors, it might even seem easier to avoid working with clients who are struggling with addiction. The problem is, that's not possible.

"I think I've heard more often than not [from counseling students], 'You know, I really don't want to work with alcoholics and addicts,'" says Ford Brooks, an addictions specialist and counselor educator at Shippensburg University in Pennsylvania. "And I'm thinking, 'Well, unless you work on the moon, most of your caseload is going to have some impact through [the client's substance use] or someone else's use.'"

Gerald Juhnke, an American Counseling Association member who has been involved with addictions counseling since 1995, confirms that thought. "I didn't really want to go into addictions counseling," he says. "I mean, who would talk to a counselor whose name is Juhnke? I wanted to go into marriage and family therapy, but what I found is that so many of the couples and families I saw came in with issues related to addiction."

According to the 2012 National Survey on Drug Use and Health conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), an estimated 20.7 million Americans have a substance use disorder. The survey data is based on face-to-face interviews with a representative portion of the population. However, because of the strong stigma attached to acknowledging addiction, many experts believe that estimate is low.

Many of these underreported and undiagnosed cases will end up in counselors' offices — though not necessarily with addiction as the presenting cause. Myriad issues that bring clients to counseling, such as marital and family discord, problems at work and especially mental health complaints such as depression and anxiety, are frequently connected to substance abuse and addiction.

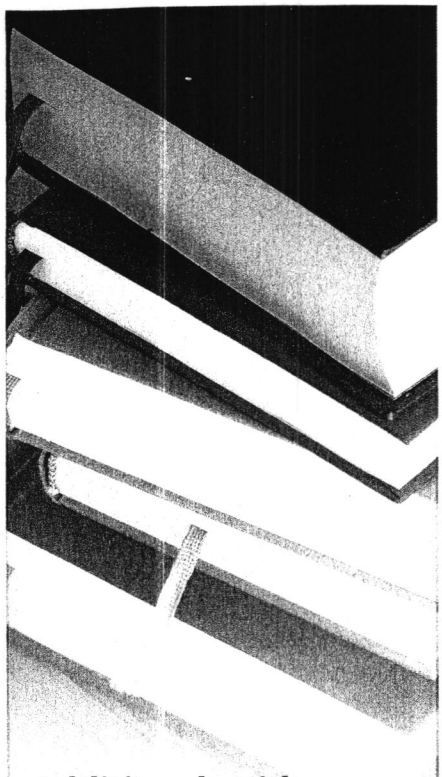
To genuinely help these clients — who may or may not recognize their substance use problems — counselors of all stripes and specialties need to educate themselves about addiction. This knowledge includes the various types of addiction, how to spot addiction, how to help treat it and when to refer clients for more intense or specialized help.

Counselors should begin by examining their own beliefs about addiction, says Brooks, who was a practicing addictions counselor for 14 years and is the co-author, with Bill McHenry, of *A Contemporary Approach to Substance Use Disorders and Addiction Counseling*, the second edition of which ACA published this month.

"I want people to be aware of their own biases and preconceived notions about people who use drugs and alcohol," Brooks explains. "For students, it may be, 'An alcoholic is my Uncle Joe' or 'Drug addicts are worthless and don't work.'"

Brooks makes a point of discussing with all of his counseling students their perceptions of what addiction is and looks like. "If you have the attitude of 'I'm better than you' or you think, 'Oh, you dope. You shot up drugs and got pregnant and are still using,' these biases are going to get in the way," he notes.

To help banish such stereotypes, Brooks has students go to Alcoholics Anonymous and Al-Anon meetings. He says they are almost always surprised by what they see,



Additional guidance

The International Association of Addictions and Offender Counselors, a division of the American Counseling Association, was chartered in 1972. Members of IAAOC advocate for the development of effective counseling and rehabilitation programs for people with substance abuse problems and other addictions, as well as for adult and juvenile public offenders. For more information, visit *iaaoc.org*.

In addition, ACA is publishing three new or updated books this year on treatment of addictions:

- *A Contemporary Approach to Substance Use Disorders and Addiction Counseling*, second edition, by Ford Brooks and Bill McHenry (available in February)
- *Treatment Strategies for Substance and Process Addictions* by Robert L. Smith (available in March)
- *Addiction in the Family: What Every Counselor Needs to Know* by Virginia A. Kelly (available in May)

For more information or to order these books, visit *counseling.org/bookstore* or call 800.422.2648 ext. 222.

including that the individuals struggling with alcoholism and addiction seem so "normal." More than that, the students are often able to recognize reflections of themselves or their families in members of the recovery groups.

Julie Bates, an ACA member and former addictions counselor, would like to see all counselors-in-training given opportunities early on to interact with people who have substance abuse problems. She notes that education and exposure have been shown to reduce stigma.

Even when counselors haven't been exposed to issues surrounding addiction in training or early in their careers, they can strive to understand the person struggling with these issues, just as they would with any other client.

"We need to train our counselors to be curious — curious about the complexity of addiction," says Bates, who is now a counselor educator at the University of Wisconsin-Stout, where she teaches classes on addiction. "The 'why' questions, such as 'Why do you use?' and 'Why don't you just stop?' are not inherently bad questions. In fact, if asked in curiosity and not judgment, [they] are actually exceptionally valuable. We should be very interested and invested in the answers to those questions."

In fact, asking "why," along with other questions, has become an essential part of addiction therapy. Counselors and other helping professionals have largely abandoned the confrontational addiction therapy model previously used for decades and exchanged it for more collaborative and client-centered techniques.

New perspectives on addiction

These newer techniques and perspectives on addiction and substance abuse are driven in part by research that has upheld what counselors and other helping professionals have long contended: Addiction is a disease, not a moral failing.

In 2011, after years of research, including an extensive focus on the chemistry and wiring of the brain, the American Society of Addiction Medicine officially defined addiction as a disease of the brain — specifically, a "primary, chronic disease of brain reward, motivation, memory and related circuitry." Brooks believes this definition, with its emphasis on physical changes that cause behavioral impairment, helps ease some of the stigma attached to addiction and substance abuse disorders.

Of course, in addiction, as with any other mental health disorder, the brain does not hold the full story — not physically, at least. Although addiction has a strong genetic component, psychological, environmental and social factors also play essential roles. Probing these elements is a critical part of addiction therapy and recovery.

When Brooks began working with clients struggling with addiction in the mid-1980s, the recovery field was dominated by helpers who had been formerly addicted themselves. These individuals didn't necessarily have training in mental health disorders or counseling but instead drew upon their personal experiences in recovery.

This was a seemingly practical approach, based in both the 12-step process and directly confronting clients with their problems by saying things such as, "This is your sixth DUI. Time to make a change!" Brooks says. This approach came from a place of compassion, he notes, but tended to increase defensiveness in a client base that was already on guard and often in denial.

By the late 1980s, treatment was no longer routinely dispensed by formerly addicted helpers in recovery. Instead, it became the realm of counselors and other trained professionals. However, until the past decade or so, the confrontational model still dominated treatment, notes Juhnke, a former president of the International Association of Addictions and Offender Counselors, a division of ACA, and a counselor educator at the University of Texas at San Antonio. Now, in addition to the 12-step process, which many professionals still consider an essential part of recovery, Juhnke, Brooks and other counselors have increasingly been turning to more collaborative, person-centered methods such as motivational interviewing. Brooks and McHenry note in their book that motivational interviewing can be particularly helpful for evaluating the existence and extent of a client's addiction.

"MI [motivational interviewing] … has the counselor or group work side by side with the client," Brooks explains. "I'm helping you side by side, versus me sitting

across from you telling you all that your disease has done."

When the counselor and the client collaborate, it allows them not only to identify the problem but also to more clearly understand the triggers, behaviors and negative consequences associated with the addictive behavior, Juhnke notes.

"MI allows me to ask simple questions to help them figure out what might be causing their problems," he says. For instance, Juhnke might ask the client a question or make a statement such as, "Help me understand what you are doing when you have trouble getting into work in the morning."

With this process, Juhnke is probing for — and simultaneously opening the client's eyes to — the addictive behavior that caused a particular negative outcome. This line of questioning might reveal that the client drank several beers before work, allowing Juhnke to call attention to the damage that the client's overconsumption of alcohol is doing.

In Juhnke's experience, clients don't usually come to counseling looking for help with addiction but rather for assistance with work problems, family troubles or some other issue. But if substance abuse is a contributing or precipitating factor to the client's problems, careful probing through the technique of motivational interviewing can reveal a pattern, he says.

"You might say, 'Are you using any substances?'" Juhnke explains. "And they might say, 'Yeah, I'm drinking a little bit.' And then you ask, 'How's that going?' 'Well, it's going pretty good — I have no problems.' But then, as you begin to talk with them, you find out that it is a problem — that they're losing money because they drink so much, and they just got terminated from their job because of their drinking on the job or before going into work."

Even after this revelation, Juhnke doesn't confront the client. Instead he might say, "Hey, I'm a little confused. You say you're not having problems with your alcohol consumption, yet you tell me you got terminated from your job [and] that you're abusive toward your spouse or partner when you drink. Help me understand that."

Juhnke explains that if he were using the "old school" approach to treatment, he would be in the client's face, determined to show the person that he or she has an addiction.

"But with MI, if they don't admit it, no problem," he says. "I just keep asking questions, and my goal is to help them gain insight by their answers. And hopefully they'll begin to realize, 'Hey, I do have a problem here.'"

Once a client recognizes that he or she has a problem, Juhnke will continue to use motivational interviewing in conjunction with family or couples therapy, if possible, and have the client attend 12-step meetings.

ACA member W. Bryce Hagedorn, an addictions counselor in Orlando, Florida, and an associate professor and coordinator of the Department of Child, Family and Community Sciences at the University of Central Florida, frames his addiction counseling around the Stages of Change Model.

"Research has shown that no matter what kind of change they are seeking," Hagedorn says, "clients go through six

stages: precontemplation, contemplation, planning, action, maintenance and termination."

Hagedorn tailors his approach according to what stage the client is in. He notes that motivational interviewing is particularly helpful in tackling the denial that is entrenched in the precontemplation and contemplation stages. He also likes to use "heart-centered" therapies such as Gestalt or art therapy in the contemplation stage. He thinks this provides a way for clients to bypass the mental blocks of denial and resistance by connecting directly with their emotions. Once a client reaches the stages of planning, action, maintenance and termination, Hagedorn advises using a behavioral method such as cognitive behavior therapy, dialectical behavior therapy or acceptance and commitment therapy.

Juhnke says motivational interviewing is also particularly effective in helping clients identify circumstances that might trigger an episode of substance abuse or, for those in recovery, a relapse.

"The hard part with addiction is that everyone always thinks that they have their addiction beat," he says. "I just had a client recently who thought he had his addiction beat. He had been sober for seven years and, suddenly, at the department Christmas party, he has a drink. And then he thinks, 'Well, I've already had one drink and it didn't hurt me. I bet I could have two.' And then by the end of the night, he's got a fifth of vodka down and he's saying inappropriate things to his boss and subordinates."

Afterward, the client was embarrassed and ashamed, but Juhnke helped him work through the issue by examining what had happened. He asked the client why he suddenly took a drink after so long in recovery. What specifically was happening when he made that decision? What were the triggers? And how could he learn from that?

"Because in recovery, it's all about learning from your relapses," Juhnke emphasizes. "Anyone in recovery is going to have relapses, but it's learning from each time you relapse, learning what happened. How did that happen? What kind of things can I do to insulate myself from that same situation or having those feelings again?"

Juhnke finds it is helpful to teach all of his clients — but particularly those battling addiction — the acronym H.A.L.T.: *hungry, angry, lonesome, tired.* He says these feelings often represent precipitating events for substance abuse, and if clients can learn to recognize those feelings as they're happening, they can address the situation without reaching for a substance.

Intervening on campus

Addiction treatment isn't the only thing that has changed in the field; the diagnosis of substance abuse has changed as well. The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) has combined the *DSM-IV* categories of substance abuse and substance dependence into a single disorder measured on a continuum from mild to severe. As a fact sheet published by the American Psychiatric Association notes, "In *DSM-IV*, the distinction between abuse and dependence was based on the concept of abuse as a mild or early phase and dependence as the more severe manifestation. In practice, the abuse criteria were sometimes quite severe. The revised substance use disorder, a single diagnosis, will better match the symptoms that patients experience."

This new diagnosis range fits nicely with what ACA member Rick Gressard is trying to do at the College of William & Mary with the New Leaf Clinic. Gressard and his colleague Sara Scott created the student substance abuse clinic to provide counseling services to students and a place for counselors-in-training to get hands-on experience with addiction treatment. Gressard, Scott and the college view the clinic as playing a crucial role in the prevention of future, more serious substance abuse problems.

New Leaf Clinic operates in conjunction with the Office of Student Affairs and is part of the disciplinary system at the college. The clinic is open to any student who wants to come in voluntarily for counseling, but all students at the college who incur an alcohol or substance use infraction, such as being drunk in public, destroying property, or possessing marijuana or another illicit substance, are required to visit the clinic. Depending on the infraction, the student faces three different levels of intervention, all of which are nonconfrontational, nonjudgmental and focused on harm reduction, Gressard says.

The first level consists of required attendance at a single psychoeducational session. "We take the approach that people are seeking a high from alcohol, and they think more is better," Gressard says. "But we try to help them see that high levels really bring problems, and you actually don't feel better but worse."

The session covers topics such as binge drinking and the increased likelihood that students will experience negative consequences such as being arrested, passing out, getting injured, getting into fights, having a sexual experience they regret, being sexually assaulted or otherwise harmed, or ending up in the hospital because of an overdose the more frequently they engage in the behavior. "It's become a cliché — college students falling off balconies — but we see a lot of those kinds of accidents," Gressard says. "These are the kinds of problems we are hoping to help them avoid."

The second level of intervention consists of two sessions. In the first,

students fill out a survey on their patterns of drinking and substance use, receive additional psychoeducation and are asked to track their use over the course of the next week. During the second session, students receive an assessment of their drinking or substance use habits based on the survey they completed in session one. The survey was designed specifically for William & Mary and uses data provided by the school's students so that respondents can compare their drinking and substance use habits against the habits of peers. The student and the counselor-in-training then discuss the assessment, the student's feelings about the assessment and any concerns or questions.

The third level of intervention involves a minimum of six individual sessions. Students at this level also take an initial assessment during the first session. The remaining sessions are dedicated to individual counseling using motivational interviewing.

According to Gressard, the intervention program has been surprisingly successful in reducing harm to students and helping those who are grappling with more serious forms of substance abuse.

Intertwining issues

One of the most substantial complicating factors in addiction treatment is the prevalence of comorbid or co-occurring disorders. According to the SAMHSA survey estimates, out of the more than 20 million Americans with a substance abuse problem and the nearly 44 million Americans who have some form of mental illness, 8.4 million people have both. Many professionals who treat addiction believe the incidence of comorbidity is actually much higher. Brooks thinks the comorbidity rate continues to rise with the field's increasing awareness of co-occurring disorders. In other words, addiction and other mental health issues have always been intertwined; professionals in the field are just getting better at recognizing it.

In Gressard's experience, where there is substance abuse, there are often other mental health problems. He notes that the epidemiology has shown that those with substance abuse disorders are twice as likely to have other mental health problems and vice versa.

Hagedorn might peg the rate of comorbidity even higher. He says he rarely sees a client who presents solely with a substance abuse problem such as alcoholism or solely with a mental health disorder such as depression.

"I subscribe to a self-medicating hypothesis, which is something of a chicken-and-egg situation," says Hagedorn, president of the Association for Spiritual, Ethical and Religious Values in Counseling, a division of ACA. "Are they using substances to medicate mental health concerns? Or is the psychological pain or wounding that is contributing to the mental health disorder also contributing to the substance disorder?"

In the past, substance abuse counseling and mental health counseling were often separated, which meant that clients frequently missed receiving all the treatment they needed. "I think we are doing a real disservice to clients by only treating just what makes the most noise. We tend to listen to what clients say hurts the most and not look for what is underlying the pain," Hagedorn says.

However, he believes that counselors should not try to address both co-occurring disorders simultaneously. "You don't start digging into why the client [with addiction] struggles in the first six months," he asserts. "Don't dig until you know how the client will cope with this understanding. A lot of clients want to understand why, and some counselors take them there way too early. I have seen the bad results of understanding why too soon."

Hagedorn explains his line of thinking with a hypothetical situation. "Say someone comes in and says, 'I just don't understand why I keep drinking. I want to know why,'" he says. As the counselor digs, he or she discovers that the client had a neglectful father and feelings of inadequacy. The client suddenly realizes this is why he or she drinks, Hagedorn says, but what then?

"How does the client deal with this without drinking again?" he asks. "You keep clients locked in pain without having [another method] to deal with the pain."

Hagedorn believes the addiction should be treated first so that when the client experiences the pain of understanding the underlying cause, he or she will have learned not to automatically turn to the addictive substance to cope.

Juhnke takes a different perspective. He thinks that once disorders co-occur, they're all but inextricable. "It's kind of like Jell-O," he says. "You have the granules, and then water is added, and then they're all just fused together."

In addition, Juhnke asserts that clients with comorbidity are often experiencing such severe problems that there's little time to separate disorders and treat them independently.

Brooks agrees that co-occurring disorders must be treated simultaneously. He points out that people with co-occurring disorders sometimes start their substance abuse as a way to self-medicate, so if counselors treat the addiction but not the mental health problem, the cycle will start all over again. Comorbidity greatly increases the chances that a client in recovery will relapse, he asserts. To guard against that, a counselor must consider both disorders at the same time. If the client is on medication, a counselor

should be working with a psychiatrist who specializes in both substance abuse and mental health disorders, Brooks notes. Similarly, any treatment program (whether inpatient or outpatient) should specialize in both substance abuse and mental illness, he says.

Juhnke thinks it's best to double or even triple down on treatments and interventions when it comes to comorbidity. "It's kind of like a big spider web. The more sticky substance we can put down, the better off the client will be," he says. "Twelve-step programs once a month, that's not going to be very helpful. But if we have them doing family counseling, if we have them attending 12-step meetings several times a week and if we've got them doing homework related to their panic disorder, putting that all together can be really helpful."

A different kind of addiction

To complicate the picture even further, addictions don't always involve substances such as drugs or alcohol. Certain behaviors can become addictive, and equally as problematic, as well. Known as process addictions, these behaviors are most commonly connected to sex, gambling, shopping, exercise, eating, Internet use and, some even speculate, work. Process addictions can cause just as much damage as substances, but the behaviors involve common activities, making them more difficult to recognize. But both substance and process addictions follow similar patterns.

"When people are in pain, they find something to ease it," says Summer Reiner, an ACA member who researches addiction and serves as an associate professor and school counseling program coordinator at the State University of New York at Brockport. That "something" might be alcohol or a substance, but it could also be a behavior such as sex, gambling or shopping, she explains.

As described in the upcoming book *Treatment Strategies for Substance and Process Addictions* (published by ACA and available in March), process addictions occur when a person experiences a high from a continued activity or behavior. The person's pleasure causes a rush that he or she is unable to get from other everyday activities. The *DSM-5* has a new section on behavioral addiction, but the only diagnosis included is for gambling. However, Internet gaming is listed in a separate section of the manual that includes diagnoses that need more research. Many addiction researchers and professionals believe that other processes or behaviors such as sex, exercise, shopping, eating and even work also qualify as behavioral or process addictions, despite their omission from the *DSM-5*.

Juhnke says process addictions often co-occur with substance addictions and are actually a harder type of addiction to treat. The traditional addiction treatment model is based on abstinence. However, this approach will not work with people who have process addictions, Juhnke notes. After all, people naturally need to eat, work, exercise, buy things and have sex. So treatment for most process disorders needs to focus on finding a balance between use and abuse.

"With sex [addiction], it isn't about abstinence for life," Hagedorn says, citing an example. "It's how to have a healthy sexual relationship [and] have sex be a connecting experience, not sex being an endpoint."

But what happens when someone's process addiction is viewed by most others as a positive instead of a negative? That is the question Reiner asked herself when she started researching work addiction.

"[Work addiction] is something that is rewarded in society and is not seen as a problem," she says. "You make more money, are professionally rewarded, and when you work hard, your employer and co-workers benefit."

People with work addictions are often admired by their peers, so the behavior actually receives positive reinforcement, unlike most addictions, says Reiner, the author of a chapter on work addiction in *Treatment Strategies for Substance and Process Addictions*.

The family of someone with a work addiction is also more likely to make excuses, Reiner notes. "If you had an alcohol addiction and didn't come to a family party, that would be bad, but people see work as OK," she notes.

But like any other form of addiction, overwork will eventually result in negative consequences, Reiner says, so counselors should listen carefully for clues indicating that the client's approach to work is causing problems. For example, clients might mention that their spouse complains that they work too much or brag that they work 60 hours a week.

The client's co-workers may also start to notice negative consequences, Reiner says. For instance, people with work addictions are happy to do the extra work but often resent that others aren't putting in those 60 hours or working weekends. Over time, it becomes difficult to work with someone like that, she notes.

In addition, all of the work will eventually take its toll on the person with the addiction because it's often impossible to sustain that level of performance. Instead, the client is likely to develop health problems or experience total burnout, Reiner concludes.

Recovery from work addiction, as with other process addictions, is about moderation — learning to work, not overwork. "You need to be able to say, 'OK, I'm going to leave work at 8, and I'm not going to bring my laptop home,'" Reiner says.

Clients with process addictions also need to find other outlets, says Juhnke.

> "Counselors' ... perceptions [of addiction] may be one of the biggest impediments to providing successful treatment"

"It never works when you just try to remove something," he says. "If you take one [substance or behavior] away, they will move to another. You want to not just create a void by removal, but help people find out what brings them joy, makes them happy, and fill their lives with that."

Knowing your limits

"I think counselors should know that they will work with addiction," Bates says. "Counselors should know that their own perceptions of what addiction is and what it is not may be one of the biggest impediments to providing successful treatment." She urges counselors at all stages and in all practice settings to work through any biases with education, supervision, additional training and even personal counseling as needed.

Other experienced addictions counselors echo those comments, saying all practitioners should seek more education, training and supervision in this area because the limited courses on addiction in a typical graduate program aren't sufficient to teach counselors all they need to know. Equally important is that counselors who don't specialize in addictions treatment know when to ask for help because there inevitably will be times when they feel out of their depth or simply aren't qualified to provide what a client struggling with addiction needs.

After all, these experts point out, experienced addictions counselors don't go it alone either. They send clients to 12-step programs, collaborate with or refer to other professionals such as psychiatrists who specialize in substance abuse and mental health disorders and, in some cases, arrange for clients to enter an inpatient or outpatient clinic.

Brooks advises practitioners to make a habit of meeting regularly with peers and more experienced professionals. These meetings can be helpful not only for counselors in session, but also for their own state of mind, especially given the stressful and sometimes tragic circumstances that can accompany working with this client population.

"There is a higher incidence of mortality in this population," Brooks explains. "So you will have more clients pass away."

Clients dealing with addiction are also more likely to call in crisis, and that can take a toll, Brooks notes. Talking and sharing with other counselors who have navigated similar circumstances is an essential part of self-care.

But Bates doesn't want one truth to get lost in all the potential challenges of engaging in addiction work: "Counselors should know that clients with addiction are tremendously resilient people and that they deserve a lot of respect for their efforts to make such a major life change."

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