Introduction

Year after year in the substance abuse counseling class I teach, when I ask students how many of them know someone close who struggles with a substance use problem, at least 75 percent raise their hands. As a follow-up question, I ask how many have family members or close friends who have suffered serious negative consequences as a result of substance use—again, the majority raises their hands. As a professional counselor and counselor educator, I continue to be astonished at the pervasiveness of substance use problems in our society. Statistics on the prevalence and scope of substance use and its associated consequences in the United States provide students with hard quantitative data, but that simple survey conducted at the beginning of class tells it all. Simply looking around the classroom, one is hard-pressed not to run into someone who either struggles with substance problems themselves or is close to someone who does.

The pervasiveness of substance abuse and addiction begs the question of what or how is the best way to address these problems clinically—that is, what is effective substance abuse treatment? What does effective treatment look like? Scores of scientific research has shown that a variety of approaches are effective in treating substance abuse and addiction, many of which are covered in this text. Some approaches have amassed an impressive amount of outcome research support, whereas others are more conceptual in nature. A survey of the substance addiction literature suggests that
much more information is related to the first question (What is effective substance abuse treatment?) and less information is related to the second (What does effective treatment look like?). In this text, which is constructed with the practitioner in mind, I attempt to address both questions, with a strong emphasis on the gap related to the latter question—the how to—with theory as the foundation.

In this introductory chapter, I set the stage for the rest of the chapters by discussing the importance of counseling theory and how to incorporate it with greater intentionality into substance abuse treatment. This is followed by a brief overview of each theory presented in the text. A roadmap as to when certain theories are most useful in substance abuse treatment is provided, followed by clarification of what is meant by evidence-based approaches and associated research. The running case study for the text is provided, in full, in this chapter. The chapter concludes with some general comments regarding multicultural issues and substance abuse counseling.

THE IMPORTANCE OF THEORY

The concept of theory has traditionally held an important place in the psychological sciences. Theories of Counseling and Psychotherapy is one of the first courses students take in mental health training programs and is most certainly required before students begin their internship experiences and see bona fide clients with real-life problems for the first time. On a practical level, theories offer an organizing philosophy for how problems develop. They also provide grounding from which to develop and implement techniques within a counseling session. Theories contain assumptions about people and have in common the desire to help others live more effective lives (Sharf, 2004).

Traditional substance abuse and addiction treatment has generally consisted of loosely defined and organized approaches based on mental health techniques but without a central, organized set of principles (Rawson, Obert, McCann, & Marinelli-Casey, 1993). This has led to a somewhat random application of therapy techniques to address substance abuse problems (Rawson et al., 1993). Some clinical settings bear more of a resemblance to case management or crisis intervention (Rawson et al., 1993) rather than facilities designed to assess, treat, and monitor those on substances. The intentional application of psychological theory and associated techniques can provide this structure. The field of substance abuse counseling and addiction treatment has moved too far astray from psychological theories, which can offer clinicians a comprehensive way to conceptualize clients struggling with addiction as well as provide a system of techniques and strategies to help clients on the road to recovery. Put differently, the theories presented in this text can provide the clinician with a set of organizing principles from which to operate when counseling those struggling with substance abuse and addiction issues.

It is no longer adequate to treat addictions in isolation of other problems. Indeed, many, if not most, clients who present with substance abuse and addiction issues also have other problems in their lives. Theoretically grounded approaches can be helpful guides when addressing clients with co-occurring disorders (discussed in greater depth in Chapter 4). Psychological theories were created to address problems in living, whether these problems stem from depression, anxiety, substance abuse and addiction, thought disturbances, or a combination of some or all of these. The sheer richness of theories makes them ideal for complex issues that characterize co-occurring
problems. As we will see in Chapter 4, the literature on effective treatment of co-occurring disorders calls for an integrative approach, one that draws from many different schools of thought, theories, and traditional substance abuse and addiction treatment ideas. Theories give us ideas, ways to think about a problem or problems, and strategies for how to intervene.

**Overview of Theories**  The selection of theories for this text was based on a combination of empirical support, conceptual literature, and my own clinical experience. The theories presented in Part II of the text generally have more empirical support compared to the theories presented in Part III. However, all theories have a substantial literature base from which much of the information in this text was drawn. In selecting theories to include, I also relied on the successes and struggles of my own clinical experiences. I have implemented evidence-based practices, such as relapse prevention strategies, as well as less evidence-based approaches, such as Gestalt therapy. When positive experiences are not forthcoming, I have learned (and continue to learn) that it is okay to switch approaches and try something new if a theoretical application is not a good fit for a client. Let's now turn to a brief overview of the theoretical approaches to substance abuse and addiction counseling presented in this text.

**Motivational Interviewing (MI)**  Any textbook on substance abuse and addiction counseling strategies *must* have a chapter on motivational interviewing (MI). Not only was MI born out of the addictions field, but it has also amassed an impressive array of empirical evidence. MI is an excellent strategy to use at the beginning of counseling, which is one of the reasons it is presented first. (MI is not technically considered a theory; however, its concepts are derived from many theoretical approaches and can be used as a stand-alone strategy with clients.) In a survey of the frequency with which substance abuse treatment facilities used certain clinical approaches, 55 percent reported using MI “always or often” (Office of Applied Studies [Division of SAMSHA], 2009).

**Cognitive Behavioral Therapy (CBT)**  Most counseling theories textbooks have separate chapters on cognitive therapy and behavioral therapy, with some mention of how the two have been combined as cognitive behavioral therapy. In doing the research for this text, it became clear that in the application of substance abuse and addiction counseling, cognitive and behavioral methods were *almost always together and in conjunction with one another in the empirical literature*. As such, attention is given to cognitive and behavioral theories separately, followed by a focus on their use in combination (CBT). Current approaches that heavily rely on CBT principles, such as dialectical behavior therapy, also are presented as examples. CBT and its variations are well-known, evidence-based models used in substance abuse and addiction counseling. The amount of literature and empirical evidence to support their inclusion is impressive. In a survey of the frequency with which substance abuse and addiction treatment facilities used certain clinical approaches, 66 percent of those surveyed reported using CBT “always or often” (Office of Applied Studies [OAS; Division of SAMSHA], 2009).

**Relapse Prevention**  Much of substance abuse and addiction counseling is relapse prevention. Although this is not a traditional counseling theory, it leans heavily on cognitive behavioral, person-centered, and motivational interviewing principles.
Its inclusion is supported because of the strong empirical research base showing its effectiveness as an intervention to manage and prevent a return to substance use. In the OAS (2009) survey, 87 percent of substance abuse treatment facilities reported using relapse prevention “always or often.”

**Group Therapy** Group therapy and practice have a theoretical and empirical base of literature supporting this modality as a best practice in substance abuse and addiction treatment. In this chapter, I discuss general considerations in the formation and functioning of a substance abuse counseling group, keeping consistent with general group theory. Mutual help groups (i.e., AA) are also discussed. Twelve-step group facilitation was used by 56 percent of facilities that treat substance abuse and addiction issues (OAS, 2009).

**Family Therapy** The problem of substance addiction often impacts the entire family, making family therapy an important part of any text on substance abuse counseling. In this chapter, I focus on family systems theory as well as other approaches and techniques clinicians can implement in their work with addicted families. The material from this chapter comes from many different sources: clinically generated concepts, the experiences of family therapists, the writings of family systems experts, and empirical studies on family-based models.

**Solution-focused Therapy (SFT)** Solution-focused counseling is a brief, behaviorally based intervention that is quite applicable to substance abuse and addiction issues. SFT complements MI (the two share similar philosophies) and can even serve as an extension of MI. In addition, there is a growing, impressive base of empirical support for counseling addicted clients through this approach.

**Adlerian Therapy** The inclusion of Adlerian theory is based more on clinical wisdom and experience than empirical evidence, although some empirical support exits. Adlerian theory is comprehensive in that it is analytic, cognitive, behavioral, and systemic. As such, comprehensive theory has much to offer substance abuse treatment. Adlerian theory assumes substance abuse is secondary to general psychological problems and provides an appropriate contrast to the “addiction as disease” concept.

**Gestalt Therapy** Gestalt therapy can be an effective and powerful approach to those struggling with addiction. A growing theoretical base of literature supports this notion, although the empirical work is scant. However, the lack of empirical support is not because this approach is ineffective but because the concepts and philosophy underlying Gestalt theory are not as amendable to empirical investigation. A Gestalt approach can help an addicted person live with greater awareness, integration, and authenticity on their recovery journey.

**Existential Therapy** Existential theory, like Gestalt, is difficult to study empirically; however, a foundation of literature and clinical experience suggests that substance use often manifests as crises in meaning and other “givens” of existence. The role that lack of meaning, existential isolation, and anxiety plays in substance abuse has been well established. However, relatively little has been written about what an existential exploration of substance abuse would look like with clients. As you will see in this chapter, I have found that clients, even younger, adolescent clients, often respond well to discussions of existential topics and themes.
Each theory presented in this text, no matter the level of empirical support, can be effective if the “how to” is demonstrated. Of course, not all theories will be a fit for every client; some clients might respond better with an explorative existential approach compared to a structured CBT approach. In addition, clinicians may be more comfortable with some approaches versus others. In all chapters, I cite empirical research (if available) and note that more research may be desirable for some theoretical approaches. However, no approach is discussed willy-nilly; that is, each approach has empirical support, conceptual support, clinical support, or all of them. It is my hope that this text will provide students, clinicians, and researchers a template or model to apply in their practice or research. From a research perspective, understanding the “how to” can help one design treatment protocols for future research studies. In essence, that is the way much outcome research is generated; theory is presented first, followed by empirical investigation to test effectiveness.

The 2009 Office of Applied Studies report demonstrated that many substance abuse treatment facilities use approaches that are well established in the substance abuse field—MI, CBT, Rational Emotive Behavioral Therapy (REBT), relapse prevention, and 12-Step facilitation. However, the report also cited that 96 percent of facilities engage in *substance abuse and addiction counseling* “always or often.” Substance abuse counseling was defined as generally short-term treatment that included supportive techniques, expressive techniques, approaches to enhance interpersonal relationships, and strategies to increase self-understanding. All the theories presented in this text promote one or more of these general counseling strategies, offer a conceptual framework, and provide techniques to assist in accomplishing therapeutic goals. Furthermore, the National Institute on Drug Abuse (NIDA), based on decades of research, included “counseling and other behavioral therapies” as part of their *13 Principles of Drug Addiction Treatment* (NIDA, 1999) and specifically noted that counseling and behavioral therapies are “critical components of effective treatment for substance addiction.” Activities such as building motivation, building drug resistance and refusal skills, improving problem solving, improving interpersonal relationships, and replacing drug-using activities with rewarding non-drug activities were mentioned as key benefits of addictions counseling.1

### A Possible Roadmap to Theory Utilization

It is fair at this point to wonder where in the recovery process should each theory be utilized (active use, transition [abstinence], early recovery, or ongoing recovery; Brown, 1995, 1997) or which theory best matches inpatient versus outpatient settings. Unfortunately, there are no firm guidelines in terms of specific theoretical application for specific recovery stages or settings, although some suggestions can be inferred from the literature.

Brown (1995, 1997) outlined four stages in the recovery process (Brown’s Developmental Model of Alcoholism and Recovery was intended to focus on alcoholism but can reasonably be applied to other substance addictions). The first stage is active *drinking or use*, where denial is the main defensive structure because clients

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1For a complete listing of the 13 Principles of Drug Addiction Treatment, visit www.nida.gov.
believe they have control over their use (when they clearly do not) and thus minimize subsequent problems. The second stage is transition, where clients develop little interest outside substance use, and drugs have become the central organizing principle of their lives. Negative consequences begin to pile up. When clients come to see that (a) they are an “alcoholic” or “addict” and (b) they have lost control, they transition into the end of using and the beginning of abstinence. This is a critical and vulnerable spot for clients because depression, anxiety, eating problems, and other addictions rise to the surface to fill the void (Brown, 1997). According to Brown (1995, 1997), fundamental building blocks of recovery need to be in place for clients to move on toward recovery. Relapse is a constant possibility. The third stage is early recovery, where the client begins to gain some momentum in the recovery process, experiences a decline in impulses, and is committed to attending a 12-Step mutual support group in addition to regular counseling. Those in early recovery begin the shift from external support to internal support. Their world begins to open as they catch their impulses and make alternative choices to using. The fourth stage is ongoing recovery where the client is firmly in recovery and has expanded his life interests and pursuits. Clients generally engage in deeper levels of self-exploration in this stage (Brown, 1995, 1997). Twelve-Step attendance is still an important component but is at a maintenance level. It may take several years for a client to reach ongoing recovery (Brown, 1997). Notice how abstinence is in the middle of the model as the client transitions away from using or drinking. According to Brown (1997), many have wrongly assumed that once a client is abstinent from substances, then treatment stops. As one can see, abstinence is really the start of treatment, rather than the end.

Brown's model is helpful in understanding the recovery process and provides insights into where certain theoretical approaches might be most useful. In general, the earlier in the model the client is (active use, transition, beginning of early recovery), the more one should rely on the theoretical approaches discussed in Part II of this text: Motivational Interviewing, CBT, relapse prevention, group therapy, and family therapy, in addition to assessment and evaluation procedures. As a client progresses from early recovery to ongoing recovery, approaches such as Gestalt therapy, existential explorations, and Adlerian interventions become more appropriate. These latter approaches may invoke greater emotion and generally involve deeper, more philosophical explorations that the client may not be ready to experience during active use or early recovery.

Indeed, Brown (1997) noted that for much of active use, transition, and even early recovery, clients are not ready to deal with deep psychological explorations or therapies that may have the potential to dig up old emotional wounds. Motivational interviewing can be quite effective when a client is actively using or has reached abstinence but may be less effective and even unproductive when the client is solidly in recovery and is motivated to stay there. In the early stages of Brown's model, clients benefit more from practical considerations related to motivation (motivational interviewing), negative thinking processes that maintain substance use (CBT), relapse concerns (relapse prevention), staying in therapy (both group and individual), and 12-Step mutual help group attendance. As clients build their recovery and are ready to delve into topics such as personal choice, emotional processing and exploration, meaning, and awareness, Gestalt, existential, and Adlerian therapies become more relevant and useful to strengthen one's life free from substance use.
The preceding guidelines can generally be applied to inpatient versus outpatient treatment. For clients in inpatient treatment (who are most likely actively using), in transition, or in very early recovery, the theories in Part II of the text are a good fit. For outpatient treatment, where clients may be more firmly established in recovery, additional theoretical approaches would be appropriate. There is risk, however, in oversimplifying the matching of theory to stage of recovery or location of treatment. For example, I work primarily in an outpatient facility and have used Motivational Interviewing, relapse prevention, and CBT with my clients. In addition, I also have used Adlerian, solution-focused therapy, and Gestalt in relatively early stages of the recovery process. When determining which theories to use, perhaps the more critical aspects to consider are what would be the best fit for the client, good clinical judgment and intuition, familiarity with the theory, client motivation, input, resources, and the cultivation of the therapeutic relationship. Buchbinder (1986) added that one’s choice of a theoretical approach depends on many variables, including individual personality, professional training, peer and academic influence, and supervisory consultation. By and large, no firm “this is the only way to work” mandates exist in substance abuse and addiction treatment. Table 1.1 outlines one possible set of guidelines for which theoretical approaches fit best with the stage of recovery the client is experiencing.

<table>
<thead>
<tr>
<th>Phase</th>
<th>Approach</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active drinking or use</td>
<td>Motivational Interviewing, CBT, Group Therapy, 12 step group attendance, Family Therapy (if family’s goal is to help member stop using)</td>
<td>Treatment is usually focused on stopping or seriously limiting use, rather than psychological explorations; client motivation and consciousness raising are important considerations</td>
</tr>
<tr>
<td>Transition (to abstinence)</td>
<td>Motivational Interviewing, CBT, Relapse Prevention, Group Therapy, Family Therapy, 12 step group attendance</td>
<td>Client is in emotionally vulnerable position; Assessing motivation, relapse potential, and providing support via group and family care become important</td>
</tr>
<tr>
<td>Early Recovery (1-3 years)</td>
<td>Relapse Prevention, Group Therapy, Family Therapy, 12 step group attendance</td>
<td>Treatment begins to move away from motivation issues (although these could still come back) and more toward preventing relapse and putting together a solid plan for recovery. Support continues to be important; slowly introduce other approaches with caution</td>
</tr>
<tr>
<td>Ongoing Recovery (3-5 years)</td>
<td>Existential, Gestalt, Adlerian</td>
<td>Client solidly in recovery and more amenable to deeper psychological explorations.</td>
</tr>
</tbody>
</table>

1 This chart is only one possible way to approach substance abuse counseling using theoretical approaches. For example, motivational interviewing may be important to come back to even in later stages of recovery. For some clients, Adlerian or Existential therapy might fit earlier in the process, depending on client motivation, pattern of use, emotional vulnerability, and so forth.
A WORD ABOUT EVIDENCE-BASED TREATMENTS

Evidence-based treatments (EBTs) or evidence-based practice seem like common buzzwords in today’s mental health practice. Many managed care and insurance companies mandate that clinicians use only “evidence-based” approaches lest they not get reimbursed for their services. Clinician training programs and agencies espouse the critical importance that treatment approaches be tied to the outcome literature. Traditionally, EBTs have referred to psychotherapeutic approaches, often grounded in theory, that have been supported as effective in clinical trials.

In the landmark book, The Heart and Soul of Change, Hubble, Duncan, Miller, and Wampold (2010) presented a cogent argument that scores of research has shown psychotherapy to be effective, yet little evidence suggests that one particular theory is superior to any other. Further, the authors argue, the clinician-client relationship, among other common factors, is one of the most important ingredients in successful client outcome, based on hundreds of empirical studies (Duncan & Miller, 2006). Hubble et al.’s (2010) analysis suggests an overemphasis on EBTs, to the exclusion of the common factors and other treatment variables that have a much greater contribution to successful client outcome. According to this research, clinicians who incorporate an exclusive focus on “manualized” treatment protocols or other EBT-style interventions are “missing the boat.” In addition, too much emphasis on EBTs has led clinicians to ignore other effective theoretical approaches that may not be as amenable to traditional scientific research. Lack of empirical evidence does not render an approach ineffective.

Does this mean that EBTs have no place in counseling and psychotherapy practice? Not at all. EBTs and theoretical approaches provide a bevy of options for the clinician to consider (Mee-Lee, McLellan, & Miller, 2010). EBTs and theoretical approaches also provide a comprehensive roadmap for how to conceptualize client problems and contain a plethora of interventions that may help a client on the road to recovery. The critical factor, however, is client feedback (Mee-Lee et al., 2010)—that is, does this EBT or theoretical approach appear to be a good fit for the client? Is the client improving? Emerging empirical evidence suggests that EBTs and theoretical approaches should be utilized based on direct client feedback to better inform practice (Mee-Lee et al., 2010). I couldn’t agree more.

The work of Hubble et al. (2010) has led, in part, to the reconsideration of what, exactly, “evidenced-based treatment” means. For example, the American Psychological Association created a task force to examine the meaning of evidence-based practice and settled on this definition: “Evidence-based practice in psychology is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (APA, 2006, p. 273). Clearly, this definition suggests that psychological treatment is a collaborative process with clinical decisions based on client characteristics, values, and needs. The concept of EBT seems to be moving away from a one-size-fits-all approach to one that is unique to client circumstances. Research may still inform practice; however, it is integrated with a strong consideration of contextual factors.

EBTs, and the theoretical approaches upon which many are based, are best conceptualized as possibilities, strategies, recommendations, and approaches rather than the end-all, be-all to clinical treatment. If imposed as the final word, without flexibility and client input, therapeutic success is on a slippery slope. One approach will not fit every client, which is why client feedback and input are so important. Mee-Lee et al.
(2010) noted that a current trajectory in the substance abuse and addiction treatment field is a more “consumer-driven, outcome-informed treatment system” (p. 396). As such, a blending of EBTs (and theoretical approaches), the therapeutic alliance, and client factors appear to be a worthwhile stance in the therapeutic endeavor.

This text is not about comparing the effectiveness of different psychotherapy approaches for substance abuse and addiction counseling. Rather, the purpose is to show how theoretical application can enrich substance abuse counseling by offering a multitude of ways to better conceptualize client problems, explanations for how substance use begins, and treatment and intervention strategies that align with theory. In its essence, this text addresses the how to of substance use counseling with theory as the foundation. However, it is important to note that the therapeutic alliance and what the client brings to therapy must never be lost in one’s application of any theory to substance abuse and addiction problems. Use of theoretical approaches without taking into account the alliance, client factors, and client feedback is barking up the wrong tree.

So, where does that leave us and how should we make meaning out of EBTs? The arguments posed by Hubble et al. (2010) cannot be overlooked. Perhaps the good news is that that psychotherapy is effective, although no one approach really appears to be any better than any other approach. Regardless, no matter what theory is implemented, clinicians need to have a strong grounding for the interventions they use, lest they fall into the trap of using a hodgepodge of strategies without any roadmap, direction, or underlying philosophy. Of course, based on client feedback, this roadmap may need to be tweaked or adjusted along the way. If the therapeutic alliance is of critical importance, competent, skillful, and flexible use of theory can enhance this alliance.

For readers who have a strong allegiance to EBT approaches, the chapters in Part II of the text might be of most interest. However, as Duncan et al.’s (2010) work suggests, this does not mean that the theories in Part III are any less effective or important to implement.

CASE STUDY
The Case of Michael

Throughout the text, a running case study will illustrate the theoretical approaches described herein. As such, the case study is presented, and each chapter includes how the client would be counseled using each particular theory. The case is based on a composite of my own clinical experiences. It does not represent a unique individual but incorporates characteristics and real clinical issues drawn from several clients over a number of years. Although some may argue that composite case studies obscure or distort actual clinical events and the course of therapy for a particular client, there are several advantages to their use (Sperry & Pies, 2010).

Composite case studies may actually have more pedagogical worth than real-life case studies (Sperry & Pies, 2010). They allow for writers to better illustrate a theory or approach rather than be limited by a single case that might not be broad enough in its elements. Composite cases represent more than one individual, often several clients, and, therefore, no identifying information can be recognized; the use (continued)
CASE STUDY (continued)

of composite clients has support in the literature because it has been suggested that this approach balances the need to protect client privacy and provide a case example of sound pedagogical value (Sperry & Pies, 2010). Composite clients are effective if they are based on real-world experiences, problems, and situations clients are likely to face. Every attempt has been made to make the case as real life and authentic as possible, drawing from many clinical examples instead of just one. The “running case study” approach has been used in popular counseling theories texts (Corey, 2009).

The following case study describes the background information of Michael L., a client coming to counseling due to increasing substance abuse and several associated problems. In each theory-based chapter, the reader will see an example of how the clinician operates from different theoretical perspectives to help Michael with his substance abuse problems, emphasizing select strategies and techniques used from that particular theory.

Michael L. is a 32-year-old male who recently became verbally and physically disruptive at home. Michael worked at a local mill since he graduated from high school, and within a few years moved up to supervising manager. Although Michael enjoyed his job, he became edgier with his direct reports, prompting his boss to encourage him to seek help. Although his boss wasn’t sure, he suspected alcohol played a role in Michael’s recent poor performance and behavior. Michael was arrested one year ago for public intoxication after a local sporting event but has never had a DUI. Michael’s wife, Julie, has grown increasingly frustrated with his recent behavior and said he is just not the same man when he drinks—describing him as “ugly and angry.” She has threatened to leave him and take their two children, Zach and Maria. According to Michael, Julie is at the “end of her rope” with him, and his recent struggles at work have made her question his love and commitment to his family. Michael admitted that he likes to drink and have a good time and that he has one too many now and then. However, he somewhat minimized the extent of problems caused by his alcohol use. Michael said that he began alcohol use in his 20s. He reported that his father was an alcoholic.

Alcohol was the presenting substance-related concern, but upon further inquiry, Michael reported using cocaine to help him cope with the stress he was under at work and at home. He noted that he struggled with boredom and loneliness and that his bar buddies introduced him to cocaine about two years ago. He has been using it ever since. Asked what he gets out of using cocaine, Michael stated that he feels “alive” and “energized” on coke and that it allows him to temporarily forget about life. It takes away the anxiety, boredom, and daily grind of having a difficult job and raising a family. Michael admitted that Julie does not know about his cocaine use. This, he reported, makes him feel all the more guilty about where his life is heading.

Michael stated he feels like “half the person I used to be.” Complaining of fatigue and feeling down and angry, he struggles to find meaning in his life. He cares deeply for his family but can’t seem to connect with them in the genuine, loving way he did in the past. If Michael has a bad day at work, he often displaced these angry feelings on his wife and children. Julie confirmed in subsequent sessions that Michael just seemed like a different person, yelled at the kids for no reason, and seemed “down in the dumps.” Michael noted that he has always struggled with low feelings, but they had recently intensified. He did not see any connection between his substance use and depression.
Michael's background seems to go a long way toward explaining many of his current struggles. He grew up as the older of two children. He and his sister, Amanda, lived with their mother and father until Michael was 12 years old, at which time their father left the family. His father drank excessively, and Michael called him an “alcoholic.” As a result, the relationship between his mother and father was tumultuous to say the least, and alcohol seemed to play a large role in the conflict. Michael denied any physical abuse in the household but noted that his father's verbal abuse was rampant, especially toward his mother. When asked to give one word to describe his household growing up, Michael replied, “Angry.” He cannot remember a time when his parents were not fighting with each other. At times, the incessant fighting and screaming became so unbearable that Michael would retreat to his room and cry himself to sleep. Michael vividly recalls going on trips to the local store with his mother, looking over at her, and seeing tears run down her face. He recalls several times when he heard his father’s car coming up the driveway at 3:00 a.m. and his keys jingling outside the door. His father would stumble into the house, intoxicated, with a very worried and upset spouse waiting for him.

To this day, Michael loves his sister and stated they have always gotten along. They were close, especially during the years when their father was drinking at his heaviest. Because his father left when he was 12, he was forced to take care of his mother and sister, often fulfilling the husband and fatherly roles before he was ready.

Based on Michael's description of the presenting issues, the clinician proceeded to complete a five-axis diagnosis:

**Axis I:** Alcohol Dependence, With Physiological Dependence
- Cocaine Abuse
- Major Depressive Disorder, Recurrent, Moderate, Provisional

**Axis II:** No diagnosis, prominent use of displacement and denial

**Axis III:** Pre-diabetic

**Axis IV:** Marital problems; Occupational problems

**Axis V:** GAF 53 (current)

Michael clearly met criteria for an alcohol problem (Axis I), and this most likely made his other problems worse. He met criteria for Alcohol Dependence because he reported symptoms related to both tolerance and withdrawal. In addition, he would continue drinking despite numerous negative consequences (arguments with spouse, problems with work). The clinician also believed that Michael was struggling with cocaine abuse and depression (Axis I), as evidenced by feeling down, low energy, and weight gain. However, at this time, the depression diagnosis is provisional because more information is needed to confirm.

(continued)

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2The diagnosis presented here is based on the *DSM-IV-TR* (2000). As of this writing, the *DSM-V* is due out in May 2013. Many changes to the titles of disorders and criteria are being considered. A review of these changes relevant to substance abuse diagnoses is presented in Chapter 4. Nonetheless, a review of the diagnosis just presented suggests that Michael struggles with significant substance use issues in addition to mood problems.
No personality disorder was present (Axis II). However, Michael used the defense mechanisms of displacement and this was placed on Axis II.

After receiving a recent physical for work, Michael's physician stated he was pre-diabetic (Axis III) and that he needed to watch his weight and diet. Michael used to exercise regularly but lately has let that go. Michael's moderate-to-severe symptoms warranted a GAF of 53.

Overall, the clinician noted that Michael was struggling with issues of substance use and depression, was in danger of developing diabetes, and was functioning suboptimally. His struggles were especially salient in the marital and occupational domains.

**Additional Information**

Additional information became evident in the initial assessment. Alcohol was the key organizing theme in the household when Michael was a child. It was everywhere—in the refrigerator, his father's stocked bar, the cabinets, and in the basement. Alcohol was always served at family gatherings. Michael's father grew more and more emotionally distant as alcohol slowly consumed his life. The angry emotional tone frightened Michael and Amanda because they were never sure which father would come home after work. Michael reported that the sadness he saw in his mother was especially difficult. His father's departure left the house in chaos, without any structure. Although Michael was secretly glad to see his father leave, he admitted that he still loved him because of their father-son connection and because “not all times were bad.” Michael subsequently took on more responsibility at home, taking care of his sister and mother. Michael felt he had to “grow up” quickly during that time. He harbors resentment because he could not take part in typical teenage activities.

The preceding case study provides the background for the long case demonstrations in each theory-based chapter. Unless otherwise stated, the reader should assume that Michael is in the transition-abstinent-early recovery stages related to the theories presented in Part II of the text (Motivational Interviewing, CBT, etc.) and the early recovery–ongoing recovery stages related to the theories presented in Part III (Adlerian, Gestalt, etc.). Other parameters of the case may be provided in each theoretical chapter. Additional smaller vignettes are used throughout the text to illustrate key points or techniques; in all cases, names and identifying information have been disguised.

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**MULTICULTURAL ISSUES IN SUBSTANCE ABUSE COUNSELING**

Just as clinicians must understand one's cultural background to better conceptualize say, depressed feelings, the same holds true for substance abuse and addiction problems. When formulating tentative hypotheses about substance abuse and addiction, a thorough understanding of diversity issues greatly increases the chances for an accurate assessment and competent treatment. Given that today's minority population will make up approximately one-third of the U.S. population in the next two decades (Fisher & Harrison, 2009), sensitivity, awareness, and knowledge of diversity issues in substance abuse counseling are needed now more than ever.

According to Miller (2005), *multicultural* refers to working with differences. Working with differences, of course, is not limited to ethnicity or race but can include...
working with someone who is a different gender, who is disabled, or who experiences challenges because of their socioeconomic group. Miller provided general suggestions for substance abuse and addiction clinicians who want to be sensitive and effective with individuals from other cultures. Among them were the following: (a) clinicians must be aware of their own cultures and how these impact their lives, (b) clinicians should be aware of the socio-historical-environmental aspects of some groups and how they have traditionally been treated in the United States, and (c) clinicians need to work at developing a “dialogue-friendly” milieu to help communication across cultural lines.

The following example might make these guidelines more concrete. Assume a Caucasian clinician is working with an African American client struggling with heroin addiction. A multiculturally competent clinician would be sensitive to the social struggles African Americans have endured throughout U.S. history, from slavery to continued racism and oppression. A disproportionate amount of African Americans live in poverty in our cities due to institutional racism and inadequately funded social services. Keeping this history and background in mind, it also is important for the clinician to create a dialogue-friendly atmosphere: being genuinely interested, appreciating cultural differences, and getting the client’s perspective on his current substance use problem, rather than assuming it is the same as with any other client. This counseling stance builds rapport and encourages an atmosphere of respect and collaboration.

Substance abuse and addiction treatment is unique in that there might be some universals in the experiences of all clients struggling with substance use issues (Matthews & Lorah, 2005). Substance addiction is an “equal opportunity disease”—it doesn’t discriminate. People come together across gender, culture, ethnicity, and religion in their suffering and triumph. Yet substance abuse, addiction, and recovery may have different meanings and interpretations depending on one’s gender, culture, ethnicity, or religion. For example, the 12-Step mutual help group process of “giving yourself” to a higher power and “admitting that one is powerless” may offend many women who have had to endure a long history of societal oppression, limited rights, and feelings of powerlessness. Women for Sobriety, discussed in Chapter 8, was created to address this gender bias in traditional venues of substance recovery by emphasizing encouragement and empowerment for women who struggle with addiction. Multicultural considerations are critical to successful substance abuse and addiction counseling and are infused throughout the text, with each theory-based chapter focusing on the multicultural implications of using that particular theory. For a good overview of multicultural issues in addictions counseling, see Fisher and Harrison (2009) and Miller (2005).

**Summary**

This introductory chapter contains a general outline of each theory in the text and emphasizes the importance of theories and how their application can enhance substance abuse counseling. A proposed road map to implementing different theoretical models is offered. Clarification of evidence-based treatments is provided; clinicians must always honor what the client brings to therapy and the therapeutic alliance, in addition to theory application. The running case study will serve as the main vehicle from which each theory in the text is demonstrated. Finally, multicultural considerations in substance abuse counseling are of paramount importance, and thus are given focus in each theory-based chapter.
References


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