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The First Contact



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Someone you know and love is dying of addiction. No one, even the addict, knows the extent of the disease that is poisoning his or her body. More than half of Americans drink, and many of them innocently fall victim to this silent killer. Addicts live their lives deeply alone, immersed in self-told lies. They could not tell you the truth if they wanted to, because 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 about their pain. 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 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. Addicts are obsessed with doing what they hate doing. The addiction is the only way they know how to feel normal. Not to use causes withdrawal, which is too painful to consider. In time, the addict's brain changes to the point that they cannot get high and they cannot get sober. This is when addicts feel hopeless, helpless, and powerless, and their lives are unmanageable. This is when many of them come in for treatment.

In America, 51.1% of the population drinks alcohol, and a little less than a third of them will have a substance use disorder sometime in their lifetime (Substance Abuse and Mental Health Services Administration [SAMHSA], 2007). In the United States, almost one million people die of substance abuse disorders 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 exercising. 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 find that 78% of high school seniors have tried alcohol. Fifty-three percent have tried illegal drugs. Fifty-seven percent of high school seniors have tried cigarettes, and 27% 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.

- 443,000 die of tobacco products.
- 365,000 die of improper diet and exercise habits.
- 75,000 die of alcohol abuse.
- 75,000 die of microbial agents.
- 55,000 of toxic agents.
- 32,000 die of adverse reactions to prescription drugs.
- 26,000 die of automobile accidents.
- 29,000 die of firearms.
- 29,300 die of homicide.
- 20,000 die of sexual behavior.
- 17,000 die of illegal drugs ("Annual Causes of Death in the United States," 2011).

Treatment Works

Most 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, or from a health care professional. These people make the choice that the negative consequences of continued use outweigh the rewards of continued use. They go through the same motivational steps that a client needs to make in treatment (DiClemente, 2006b). Some clients 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 others 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, O'Malley, Bachman, & Schulenberg, 2008; McLellan, 2006).

Your first meeting with an addict might be accidental or it might be by appointment. During the interview, you—if you look and listen closely—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 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. The person might look depressed and anxious. Her face may be red and swollen, his eyes watery and red, or the person may be markedly thin with scabs caused by “meth bugs.” He might have a fine hand tremor or have difficulty sitting still. Sometimes the person’s head hangs in depression that looks like shame. Something is wrong, and it will nag at you. That clinical thermometer 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 a little 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 addicts before. Addicts seem to have two sides of them. One side knows they are in trouble while the other side 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) (2002a) 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 him or her with change. Your job is to go with the client toward the truth. It does no good to go against the client’s idea of himself or herself. Arguing with the client will not work because the addict is an expert at giving every excuse in the world for abnormal behavior. If you argue, the client will win because he or she will leave your office convinced you are a bad person. Walk *with* the client toward the truth. 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 the client’s world and connect with that gentle voice of reason inside of them. That healthy voice is there, and



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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 a 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; he or she is a good person with a bad disease. The disease of addiction lives in and grows in the self-told lie. The client must lie to himself or herself and believe the lie or the illness cannot continue. The client will have a long list of excuses for his or her 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 him or her 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 lethal 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. If it is very good, it is remembered 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 he or she 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 the client toward a decision he or she finds impossible. You need to help 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. You will continue to investigate—testing; smelling the air; ordering laboratory studies; and talking to family, friends, court workers, school personnel, and anyone else who can help you until 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 his or her 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. 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 the client that he or she does 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. The client knows things that you do not know. The client knows himself or herself better than anyone else does, and he or she needs to learn how to share his or her life with you. Likewise, you have knowledge that the client does not have. You know the tools of recovery.

The client must trust you. To establish this trust, you must be honest and consistent. You must prove to the client, repeatedly, that you are going to be actively involved in his or her individual growth. You are not going to argue or shame the client; you are going to try to understand him or her. 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 might catch you in a lie, even a small one, your alliance is weakened.

If you work in a treatment facility or group practice, the client must learn that your staff works as a team. You can share with the whole team what the client tells you—even in confidence. The client will occasionally test this. The client will tell you that he or she has something to share, but that it can only be shared with you. The client wants 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 the client that if he or she feels too uncomfortable sharing certain information that the client should keep it secret for the time being. Maybe they can share this information later when they feel more comfortable.

The client must understand that you are committed to his or her recovery, but you cannot recover for the client. You cannot do the work by yourself. You must work together, cooperatively. You can only teach the tools of recovery. The client 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):

- 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 do not 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 a person's expression, you validate his or her worldview.*)

Client: I do not 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 is 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 his or her point of view, you will get clues about what will motivate the client to change. This client is mad at his wife and he 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.

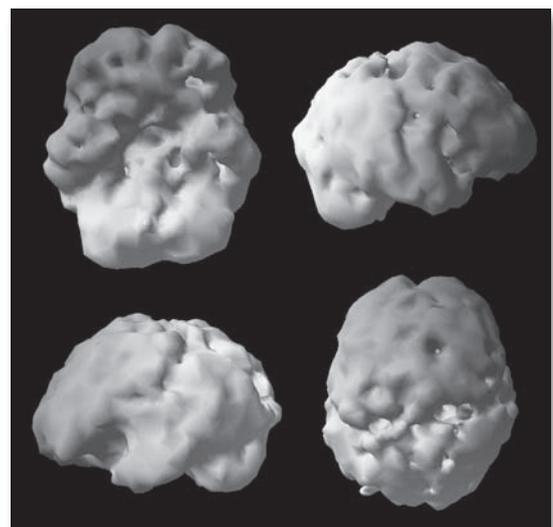
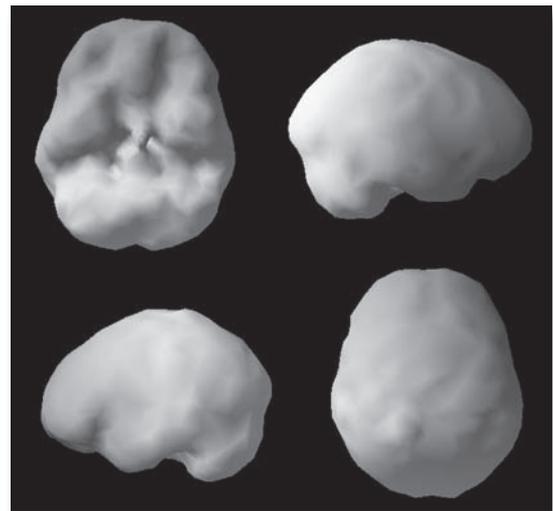
Professional: Give me a guess.

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.

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



More substance abuse pictures are available at www.brainplace.com.

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 a single photon emission computed tomography (SPECT) scan 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 did see it, and he could not 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: Bob, have you ever worried about your drinking?

Client: No, honestly, I have not. *(This comes across as real. When the words and the client's 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, do you not 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? *(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 did not 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 or her 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) 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 a person cannot stop something they want to stop, it is 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) (<http://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 alcohol or drugs ever caused your 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 a 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 at a time and no more than three nights a week. Women should be advised to drink no more than two drinks at a time and no more than three nights per 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, 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, 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 (bartending).

Risk factor 6: Addiction is prevalent in the peer group.

Risk factor 7: Addiction is preferred in deviant subcultures.

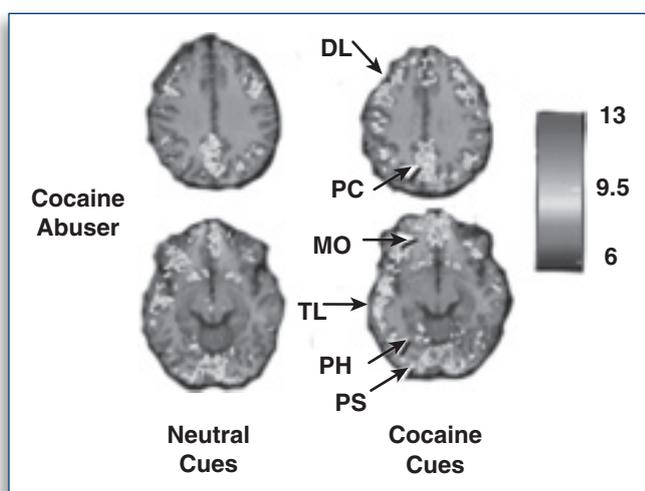
Risk factor 8: Social instability is found.

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



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.

In the assessment, you must determine if the clients fit into your range of experience and care. Do you have the ability to deal with his or her problem, or do you need to refer to someone else? Does the client have a problem with chemicals or an addictive behavior? Is he or she 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 he or she need treatment? Is he or she motivated for treatment? What kind of treatment does she or he 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.

There are a number of companies that sell inexpensive, disposable breathalyzers and drug screening instruments, including Prevent (1-800-624-1404); Bi-TechNostix (1-888-339-9964); Random Drug Screens, Inc. (1-803-772-0027); Drug Screens, Inc. (1-800-482-0693); hair screens; Pharmchec Drugs of Abuse Patch, which lasts 2 weeks; a new GGT alcohol screen that will test for alcohol injection for 80 hours after use; ankle bracelets that measure alcohol in the sweat of probationers 24 hours, 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 (SAMHSA, 2007). Two quick screening tests for alcoholism have been developed: the Short Michigan Alcoholism Screening Test (SMAST) (see Appendix 2), (Selzer, Winokur, & van Rooijen, 1975) and the CAGE questionnaire (Ewing, 1984; Selzer et al., 1975). The Michigan Alcoholism Screening Test (MAST) or SMAST has greater than 90% sensitivity to detect alcoholism. It can be administered to either the client or the spouse.

The Substance Abuse Subtle Screening Inventory (SASSI) (1-800-726-0526; www.sassi.com) was developed to screen clients when defensive and in denial. The SASSI measures defensiveness and 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 with whom you are still unsure about the diagnosis 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) (1-215-399-0980) 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, Bukstein, & Tarter, 1991; McLellan, Luborsky, & Woody, 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 his or her drinking (Mayer & Filstead, 1979; Mee-Lee, 1988; Mee-Lee, Hoffman, & Smith, 1992) (1-800-755-6299). The 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.

How to Intervene

- **Nonproblem Usage:** If the client is low-risk for addiction, you should provide positive prevention messages that support the client has continued positive lifestyle. A client 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, his or her addictive behavior. A client such as this should be strongly encouraged to abstain from all illegal drugs and addictive behaviors. You should discuss the biopsychosocial complications of addiction (see Appendix 8). A client who is encouraged to cut down on his or her addictive behavior should be provided with the brochure from NIAAA (see Appendix 9). 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. The client needs to hear that this illness is not his or her fault and that there is excellent treatment available that will help the individual to stay clean and sober. The client needs 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 AA meetings regularly, and 90% can stay sober if they go through treatment, attend meetings, and go to continuing care once a week for a year (Hoffmann, 1991, 1994; Hoffman & Harrison, 1987). The client should also be told about the potential benefits of naltrexone, accamprosate, and disulfiram when used along with formal treatment programs. Carefully discuss the ASAM client placement criteria to help you and the client 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?

Figure 1.6 Positive and Negative Prognostic Factors

Positive Prognostic Factors
<ul style="list-style-type: none"> • 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
<ul style="list-style-type: none"> • 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)

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 the client to see the inaccuracies in his or her thinking and move away from the lies toward the truth.

The Stages of Motivation

Precontemplation

The individual is not intending to take action in regards to his or her 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 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 & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992; Prochaska, Norcross, & DiClemente, 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).

A client in the preparation stage has a plan of action to cut down or quit his or her 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 his or her 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, the client is still changing his or her behavior to be better and is 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 continuing 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. Denial is unconscious, and one 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 the client to reevaluate his or her self-image and explain how this is negatively affected by the addictive behavior. Encourage the client 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; Prochaska & DiClemente, 1983; Prochaska et al., 1992; Prochaska et al., 1994).

Figure 1.7 Processes of Change for the Client in 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.

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.