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6TH EDITION

SUBSTANCE ABUSE

Information for School Counselors, Social Workers, Therapists, and Counselors

GARY L. FISHER | THOMAS C. HARRISON

SIXTH EDITION

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Information for School Counselors, Social Workers, Therapists, and Counselors

Gary L. Fisher
University of Nevada, Reno

Thomas C. Harrison
University of Nevada, Reno

330 Hudson Street, NY, NY 10013

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To our beautiful and loving partners,
Daniele and Terianne,
and our children and grandchildren,
Colin, Carola, Brooke, Aaron, Candace,
Cassandra, Celena, Kaya, Miles, Sophia,
and Koa and Iain, Ryan, Becky, and Jordan

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ABOUT THE AUTHORS

Gary L. Fisher is Professor in the College of Health Sciences at the University of Nevada, Reno. He was the founder and first director of the Center for the Application of Substance Abuse Technologies, where he developed undergraduate, graduate, and continuing education activities for addiction counselors, prevention specialists, and allied professionals. Dr. Fisher's career has spanned 42 years and includes work as a private practice clinician and a public school psychologist. In addition to this textbook, he is the author of *Rethinking Our War on Drugs: Candid Talk about Controversial Issues* (2006), the senior editor of the *Encyclopedia of Substance Abuse Prevention, Treatment, and Recovery* (2009), and the author of *Understanding Why Addicts Are Not All Alike: Recognizing the Types and How Their Differences Affect Intervention and Treatment* (2011).

Thomas Harrison is the cofounder and first director of the Downing Counseling Clinic at the University of Nevada, Reno. He is also former chair of the Department of Counseling and Educational Psychology, and the former associate dean of the College of Education at the University of Nevada, Reno.

In addition to publishing scholarly articles, Dr. Harrison has also authored six books. His textbooks include *Substance Abuse: Information for School Counselors, Social Workers, and Therapists* (6th edition) and *Consultation for Contemporary Helping Professionals*.

Dr. Harrison received his Ph.D. from the University of Florida in 1983 and developed the University of Florida Athletic Department's Substance Abuse Program and headed that effort for several years. He is a licensed Marriage and Family Therapist and, in addition to his professional duties at the University of Nevada, Reno, he has a private practice in the community.

PREFACE

We teach in a counseling department that offers training in school counseling, marriage and family therapy, and school psychology. Our department requires that all students take a course titled "Models of Prevention, Treatment, and Recovery in Addictions." The goal of the course is to familiarize students with the alcohol and other drug (AOD) field, including basic pharmacology, conceptualizations of AOD, assessment, models of prevention, family issues, and the like.

In teaching this course, we reviewed many textbooks. Many were focused primarily on the pharmacology of alcohol and other drugs. Others were directed toward the person who wanted to work in AOD treatment. Some espoused a narrow orientation to understanding addiction. We never found a book designed for the mental health professional in generalist settings that included all the information we believe to be necessary, and that presented a balanced view of addictions. So we wrote one.

That this book is now in its sixth edition is gratifying, but more importantly: It confirms the need for a generalist text in this area. In Chapter 1, we provide our rationale, explaining why we think mental health professionals (school counselors, social workers, marriage and family therapists, mental health counselors, rehabilitation counselors) need this information. We also offer an overview of the topics covered in this book. Both of us have done most of our clinical work in generalist settings (schools, private practice, community mental health centers, universities), and we have used our experiences to select these topics. Our clients have ranged from those with no alcohol or drug problems to those who have been in numerous treatment programs—and everything in between. We hope that this results in a balanced presentation of some controversial areas.

While writing and revising this book, we have tried to keep in mind the common complaints that students have about textbooks: We have illustrated the application of concepts with many examples from our own clinical experiences; we have tried to personalize the writing and avoid the more stilted language of traditional academia. Let us know if this has worked to make the book more interesting and accessible.

WHAT'S NEW IN THIS EDITION

With each revision, we update the content throughout. This sixth edition includes:

- A new chapter on Co-Occurring Disorders and Other Special Populations (Chapter 9). There was a section on this topic in the treatment chapter in the previous edition; however, the increasing attention to co-occurring disorders warranted an expanded discussion.
- A new section in Chapter 6 on the DSM-V. This replaces the information in the fifth edition on the DSM-IV-TR.
- A new section in Chapter 12 (Chapter 11 in the fifth edition) on recovery and reintegration in the family after treatment.
- The chapter on gambling and other addictions (Chapter 15 in this edition) was revised in light of the DSM-V. This included new information in the DSM-V on behavioral addictions and the diagnosis of eating disorders. In addition, there is new information on treating eating disorders and on Internet addiction.
- The chapter on HIV/AIDS (Chapter 14 in this edition) was revised to reflect new knowledge in this area. This includes new information on testing for HIV, coinfections, treating those with HIV, and disclosure and confidentiality.

- Chapter 4 on culturally and ethnically diverse populations was also revised to reflect new and updated information, including risk factors for diverse populations, immigration and the effects on substance use and abuse, bullying, and cultural competencies.
- As with each edition, we have updated all survey data and included new information on topics that have arisen in the field since the last edition. This includes synthetic cannabinols (Chapter 2), treatment access and effectiveness (Chapter 8), methamphetamine exposure (Chapter 12), women and substance abuse (Chapter 12), phases of codependency (Chapter 13), transmission of HIV (Chapter 14), and assessment and treatment of gambling disorders (Chapter 15).

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Gary L. Fisher

Thomas C. Harrison

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CHAPTER 1

The Role of the Mental Health Professional in Prevention and Treatment

It has become almost trite to recite the problems related to the use of alcohol and other drugs (AOD)[1] in our society. Various statistics are frequently reported in newspaper articles, surveys, and research studies. The array of graphs, percentages, and dollar amounts in the billions numb the mind. It is not our purpose to contribute to this data avalanche in an effort to convince you that the abuse of AOD causes a variety of serious problems in our country. If you are reading this book, you are probably in a training program to prepare for a career in one of the helping professions and, one hopes, you have some awareness of the severity of this problem. On the other hand, our experience in training mental health professionals has taught us that there is a need for a framework to understand the extent to which AOD issues affect not only the lives of those individuals you will be working with, but also your own lives and the society in which we live. Therefore, allow us to provide this framework with a few facts.

According to annual survey data, in 2013, more than 17 million Americans aged 12 and older needed treatment for an alcohol or illicit drug problem (Substance Abuse and Mental Health Services Administration, 2014). The Substance Abuse and Mental Health Services Administration conducts a yearly survey on the use of all drugs, legal and illegal, in the United States (Substance Abuse and Mental Health Services Administration, 2014). In 2013, 9.4% of all individuals aged 12 and older reported using an illicit drug in the past month. In the 12 to 17 age group, 11.6% had used alcohol in the past month and 6.2% had engaged in binge drinking. In the same age group, 5.6% smoked cigarettes. According to the Centers for Disease Control and Prevention (2014c),

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[1]As is the case with many areas in the helping professions, terminology can be confusing. In this book, we will use the term *alcohol and other drugs* (AOD) to clearly indicate that alcohol is a drug and to avoid having the reader omit alcohol from any discussion about drugs. If tobacco is relevant to a discussion, we will generally refer to "alcohol, tobacco, and other drugs." The term *illegal drugs* will be used to refer to substances such as marijuana, heroin, cocaine, methamphetamine, and ecstasy, which are illegal under most or all circumstances. *Illicit drugs* are illegal drugs as well as legal drugs used inappropriately, such as prescription pain medications.

The use of terms such as alcoholism, drug addiction, chemical dependency, and substance abuse can also be problematic. In Chapter 2, we will give some definitions of terms used in the field, and, in Chapter 6, we provide the criteria to diagnose AOD conditions. However, because these terms are used in this chapter, you should think of alcoholism as an addiction to the drug alcohol. Drug addiction refers to the addiction to drugs other than alcohol. Chemical dependency includes addiction to AOD. Substance abuse means that there have been individual or societal problems as a result of AOD use. After reading Chapters 2 and 6, you should have a more useful understanding of these terms.

approximately 88,000 annual deaths in the United States are attributable to alcohol, the third leading cause of lifestyle-related deaths in our country. In contrast, almost 40,400 annual deaths are attributable to illicit drugs (Centers for Disease Control and Prevention, 2013b). The Centers for Disease Control and Prevention (2015i) reported 480,000 annual deaths in this country as a result of tobacco use.

The relationship between AOD, crime, and violence has also been clearly established. The National Center on Addiction and Substance Abuse at Columbia University published an extensive study of this relationship. Of the 2.3 million Americans in jails and prisons, 1.5 million met the criteria for a substance use disorder (see Chapter 6) and another 458,000 had a history of AOD problems, were under the influence of AOD at the time crimes were committed, committed crimes to buy AOD, were incarcerated for an AOD violation, or some combination of these factors. AOD were a factor in 78% of violent crimes; 83% of property crimes; and 77% of crimes involving public order, immigration or weapon offenses, and probation/parole violations (National Center on Addiction and Substance Abuse at Columbia University, 2010). In reviewing literature on the relationship between child abuse and substance abuse, Lee, Esaki, and Greene (2009) indicated that between one-half and two-thirds of abuse cases involved caretaker substance abuse, and 80% of cases resulting in foster care were linked to substance abuse. In studying the relationship between substance abuse and domestic violence, Fals-Stewart and Kennedy (2005) found that 50% of partnered men in substance abuse treatment had battered their partner in the past year. Fals-Stewart (2003) reported that these patients were 8 times more likely to batter on a day in which they had been drinking.

The monetary costs of AOD abuse also provide tangible evidence of the significance of these problems. In a study for the Centers for Disease Control and Prevention (2011), the 2006 costs of alcohol abuse were estimated at $223.5 billion. More than 70% of the costs of alcohol abuse were due to lost work productivity, 11% due to health-related issues, 9% attributable to law enforcement and criminal justice involvement, and 6% due to automobile accidents. Other drug abuse costs the United States $193 billion annually (National Institute on Drug Abuse, 2015). Ironically, for every dollar that states spend on substance abuse and addiction, about 96 cents is spent on shoveling up the wreckage caused by AOD use and only about 2 cents is spent on prevention and treatment (the rest is spent on research, regulation, and interdiction; National Center on Addiction and Substance Abuse at Columbia University, 2009).

We risk contributing to the data avalanche to illustrate that the abuse of AOD is like a tree with many branches. The trunk is AOD abuse, but the branches are the multitude of other problems caused by or related to AOD. To avoid totally clogging your mind with statistics and/or completely depressing you before you read the rest of this book, we neglected to describe other branches of the tree such as the decreased work productivity, excessive school truancy and work absenteeism, and detrimental effects on partners, children, and fetuses resulting from AOD abuse. However, these and other branches exist and are the concern of all helping professionals.

THE NEED FOR GENERALIST TRAINING

Some years ago, one of the authors of this text was asked by a local school district to conduct an independent psychological evaluation of a 14-year-old student who was a freshman in high school. The young man's parents were dissatisfied with the school district's evaluation of their son and had asked for another opinion. The youngster was failing most of his classes and was skipping school frequently. The parents were quite sure that their son had a learning disability that would explain his difficulties. The district's school psychologist had tested the student and not found a learning disability. The school counselor had suggested that there may be an emotional problem and recommended family counseling. In addition, a weekly progress check was initiated at school so the

parents could be kept informed of assignments and homework that their son needed to complete. They had also hired a tutor. However, none of these interventions seemed to be helping, so the independent evaluation was requested.

In reviewing the test information, no indications of a learning disability were found. An AOD assessment (which will be discussed in Chapter 6) was conducted, and there was evidence that the young man was using AOD on a daily basis. The parents said that they allowed their son and his friends to drink in their home because they believed that this would prevent them from using "drugs" and from drinking and driving. The parents were defensive about their own AOD use and rejected suggestions that the cause of their son's problems could be related to his AOD use. A couple of months later, there was a request for the young man's records from an AOD treatment program. He was referred to the program following an arrest for stealing alcohol from a convenience store.

One of us was supervising a master's student who was in a marriage and family therapy internship. The intern had been seeing a family of four (mom, dad, and two children, aged 3 and 9) who were referred to our university counseling clinic by Children's Protective Services. A child abuse report had been filed at the 9-year-old's elementary school because of bruises on the youngster's face. The father explained that he had slapped his son because of his frustration with the boy's behavior and "back-talking." The parents complained of frequent conflicts related to parenting techniques and family finances. The intern had developed an intervention plan that included referring the parents to a parent education program and working with the family on "communication skills" including "I-messages" and conflict resolution procedures. The intern was frustrated because the parents had failed to follow through on the parent education classes and had not made much progress in improving their communication patterns. It was suggested that the intern assess the AOD use of the parents, and she did so at the next session. The mother and father had a heated argument about the father's drinking. They did not show up for their next appointment and, when the intern called, the mother said that they were discontinuing counseling because the father said it was a waste of time.

We regularly consult with a social worker in private practice. One of the social worker's clients is a woman in her early 30s who sought counseling for "depression." The woman had been married twice and described a series of failed relationships. Her first husband was an alcoholic and the second was a polydrug abuser. For two years, she had been living with a man who was in recovery from cocaine addiction. However, she found out that he had been having numerous affairs during their relationship. The woman, who has a master's degree, could not understand why she continued to become involved with this kind of man. She felt that there must be something wrong with her because the men in her life needed alcohol, other drugs, or other women. Her father was an alcoholic and verbally abusive, and she had also been sexually molested by her paternal grandfather.

In the three situations described, the "helping professionals" (school psychologist, school counselor, marriage and family therapy intern, social worker) were not involved in providing substance abuse treatment, but they needed information and skills in the AOD field to perform their job functions in a competent manner. The authors of this text have worked in schools as a teacher and a school psychologist, in a mental health clinic, in a university athletic department, and in private practice. We currently train school counselors and marriage and family therapists as well as substance abuse counselors. We have found that the frequency of AOD-related problems is so pervasive in the helping field that the lack of training in this area would result in inadequate preparation for mental health professionals. When you read the statistics on the relationship between domestic violence, child abuse, other crime, and AOD, it should be clear that this relationship also applies to criminal justice personnel.

It would be unreasonable to expect all helping professionals to have the same set of skills as substance abuse counselors. We don't expect substance abuse counselors to be able to plan educational interventions or to do family therapy. Similarly, school and mental health counselors, social

workers, and marriage and family therapists do not need to be able to monitor detoxification or to develop treatment plans. However, all mental health professionals will encounter individuals who need assessment and treatment for AOD problems and clients who are having problems as a result of relationships with individuals with AOD problems. Included in the related problems that mental health professionals (school counselors, mental health counselors, rehabilitation counselors, psychologists, social workers, and marriage and family therapists) will encounter are children who have been fetally affected by parental AOD use, the psychological impact on children and adults who live or have lived with caretakers who abuse AOD, and the intrapersonal and interpersonal problems of individuals who are in relationships with people who abuse AOD. Many of you have read about fetal alcohol syndrome, adult children of alcoholics, and codependency, which are included in these "related" problems. All of these issues will be discussed in this text.

We hope that you are convinced that mental health professionals need training in the AOD field, not only to identify those clients who need further assessment and treatment, but also for the multitude of related problems that all mental health professionals will encounter on a regular basis. As with many areas in the mental health field, there are differing views on the causes and treatment of alcoholism and drug addiction based on the variety of disciplines concerned with these problems and the philosophical orientation of different individuals.

PHILOSOPHICAL ORIENTATION

Jerome is a 47-year-old African American man who had been arrested for a DUI (driving under the influence). It was his third DUI, and he had previously been in an alcohol treatment program. He had been arrested previously for writing bad checks and spousal abuse. He is unemployed and dropped out of school in the 10th grade. An assessment revealed a long history of AOD use beginning at age 12. Jerome's mother was an alcoholic, and he was raised by his grandmother. He does not know his biological father.

Jerome's problem may be viewed in different ways by different professionals, depending on their training and experiences. A sociologist may focus on the environmental and cultural factors that modeled and encouraged AOD use. Some psychologists might attend to the fact that Jerome experienced rejection by his biological parents that led to feelings of inadequacy. The use of AOD might be seen as a coping mechanism. A physician might be impressed by the family history of alcoholism and hypothesize that Jerome had a genetic predisposition for chemical dependency. A social worker may think that Jerome's unemployment and lack of education resulted in discouragement and consequent AOD use. A criminal justice worker may see his behavior as willful misconduct and believe that punishment is necessary.

These differing views of the causes and treatment of Jerome's problem are not unusual in the mental health field. However, what is unique in the AOD field is that many drug and alcohol counselors, others involved in the treatment of alcoholics and other addicts, and many people who are recovering from AOD problems believe that Jerome has a disease that has affected him mentally, physically, socially, emotionally, and *spiritually*. This spiritual component separates AOD problems from other mental health problems and has had implications for the understanding and treatment of AOD problems. (We will discuss spirituality in AOD recovery in Chapter 10.) One implication is that methods to attend to the spiritual aspect of treatment (e.g., Alcoholics Anonymous) are a common component of treatment. Another implication is that there are many individuals involved in the treatment of AOD problems who do not have formal training as counselors but who are "in recovery" and hold a fervent belief in a particular orientation to treatment. This belief may be based not on scientific evidence, but instead on their own experience and the experience of other recovering individuals. This phenomenon is similar to an individual's religious beliefs that cannot

(and should not) be disputed by research since the beliefs are valid for that individual. Clearly, the potential for disagreement and controversy exists when scientific and spiritual viewpoints are applied to the same problem, which has certainly been the case in this field.

In Chapter 3, we will discuss the different models of addiction and will thoroughly discuss the "disease concept" of addiction. Our point here is that we believe that the AOD field requires an openness on the part of the mental health professional to consider a wide variety of possible causes of AOD problems and to employ a multitude of methods by which people recover from these problems. We have worked with people who discontinued their use of AOD without any treatment, individuals who stopped after walking into a church and "finding Jesus," clients and students who swear by Alcoholics Anonymous (AA), and people who have needed a formal treatment program.

If you work in a treatment program, you tend to see people who have experienced many life problems related to AOD use. It is easy to develop a viewpoint about substance abuse based on these clients' experiences. It is important to remember that treatment providers do not see those people who modify or discontinue their AOD use through methods other than formal treatment.

This book is written from the perspective of the mental health professional working in a generalist setting rather than from the perspective of a substance abuse counselor in a treatment setting. Therefore, we will provide the type of information we believe all mental health professionals need in the AOD field to work effectively in schools, community agencies, and private practice, rather than providing all the information needed to work as a substance abuse counselor in a treatment setting. We want to provide a balance in the types of viewpoints that exist in this field so that you can understand these perspectives. We will describe the popular literature in certain areas (e.g., adult children of alcoholics) and contrast this with research in the area so that you can understand that clinical impressions and research do not always match. Finally, we want to communicate our belief that it is not advisable to adopt universal concepts of cause and treatment in this field. In other areas of mental health treatment, we encourage practitioners to assess a client and to develop treatment strategies based on the individual and group characteristics of the client. The same rules should apply in the AOD field.

PROFESSIONAL ORIENTATION

Over the years, this text has been used in undergraduate and graduate courses for students preparing for careers in criminal justice, social work, marriage and family therapy, mental health counseling, rehabilitation counseling, school counseling, school psychology, and substance abuse counseling. As a student, the manner in which you use the information in this book in your career will be dependent on factors such as your personal experiences with the topics, the philosophical orientation of your program, when you take this course in your studies, and your eventual job placement. For example, a social worker who is employed by a hospice may not have as much regular contact with substance abuse issues compared to a social worker involved with investigating child abuse cases. An elementary school counselor will encounter plenty of family issues related to AOD but less abuse by students compared to a high school counselor. The point is that, although you may have a clear vocational goal, it is not possible for you to know in what job setting you will find yourself in 5 or 10 years. Your program of study may have an orientation to understanding human behavior that is not consistent with what you read in some chapters. That is to be expected and is part of the learning process for students preparing for careers in the helping professions. Regardless, we want to encourage you to avoid filtering what you learn through a lens of "I don't need to know that because I won't be dealing with that in my career" or "I don't believe that. It doesn't fit with my view of human behavior." Challenge anything you read here but keep an open mind.

ATTITUDES AND BELIEFS

Close your eyes for a minute and visualize an alcoholic. What did your alcoholic look like? For most people, the alcoholic is a white male, middle-aged, who looks pretty seedy. In other words, the stereotypical skid row bum. Did you visualize somebody who looks like former President Bush? Did you visualize one of your professors? Did you visualize a professional athlete?

Attitudes and beliefs about alcoholics and drug addicts have an effect on the mental health professional's work. Imagine that you are a mental health counselor and a well-dressed, middle-aged woman comes to see you complaining of symptoms of depression. If you hold false beliefs about alcoholics, such as that they must be dirty and drunk all the time, you might fail to diagnose those clients who do not fit your stereotype.

To help students understand their own attitudes about alcoholics and drug addicts, we have our students attend an AA or Narcotics Anonymous meeting as a class assignment. We encourage you to do this as well (if you do go to a meeting, make sure you attend an "open" meeting [see Chapter 11]). In addition to acquiring a cognitive understanding of this type of support for alcoholics and addicts, students report interesting affective reactions that provide information about their attitudes. For example, many students report that they want to tell others at the meeting that they are there for a class assignment and that they are not alcoholics. Our response is that unless you believe that alcoholism or drug addiction is simply a condition that some people develop and has nothing to do with morals or a weak will, you would not care if you were mistakenly identified as alcoholic or drug addicted. If you do care, you must believe that alcoholics and drug addicts have some type of character flaw. This realization helps many potential mental health professionals modify their attitudes and beliefs about alcoholism and drug addiction.

A second type of affective reaction that students report is being surprised with the heterogeneity of the group. At most meetings, they see well-dressed businessmen and women, young people, blue-collar workers, unkempt people, articulate individuals, and people obviously impaired from their years of using AOD. Seeing such a variety of people tends to destroy any stereotypes the students may have.

Although we believe that potential mental health professionals may hold any belief system they want, the belief that alcoholism or drug addiction is due to a moral weakness or a character flaw may have a detrimental effect on providing or finding appropriate help for those with AOD problems. For example, imagine that you are a marriage and family therapist and that you are seeing a couple in which one partner is drinking excessively. You believe that changing heavy drinking to moderate drinking is largely a matter of willpower and desire, and you communicate this to the drinking partner. If this individual is addicted to alcohol, your belief system will be incompatible with this client's reality. Your client may experience shame, because he or she is not strong enough, or anger at your lack of understanding. Resistance and termination are frequent outcomes, and the client fails to get the proper help. Therefore, if you do believe that excessive AOD use is largely due to moral weakness or character flaws, you would be well advised to refer these cases to others.

DENIAL, MINIMIZATION, PROJECTION, AND RATIONALIZATION

Imagine (or maybe you don't have to imagine) that you are in love with someone you believe to be the most wonderful person in the world. You cannot imagine living without this person and firmly believe that you need this person to survive. Your mother sits you down one day and tells you that you must no longer associate with this person. She tells you that this person is destroying your life, that you have changed since becoming involved with this person, and that all of your family and friends believe that you need to break off the relationship before something terrible happens to you.

How would you react? You might tell your mother that she is crazy and that all her complaints about this person are untrue (denial). Perhaps you acknowledge that your person does have some little quirks, but they really don't bother you (minimization). You tell your mother that she and the rest of your family and friends are really jealous because they do not have someone as wonderful as you (projection) and that you may have changed but that these changes are for the better and long overdue (rationalization).

We use this analogy so you can develop an empathic understanding of what many AOD-addicted individuals experience. Obviously, the "love object" in this case is the individual's drug of choice. The addicted individual may be seen as having an intimate and monogamous relationship with alcohol or other drugs and may believe that he or she needs the drug to function and survive. In the same way that people deny that a relationship has become destructive, the addicted individual may deny that alcohol or other drugs have become destructive in spite of objective evidence to the contrary. The defense mechanisms of denial, minimization, projection, and rationalization are used so that the person does not have to face a reality that may be terrifying: a life without alcohol or other drugs.

Although we know that it may be easy for you to intellectually understand, these concepts as applied to alcoholics and other drug-addicted people, we have found it useful for our students to have a more direct experience with their own use of defense mechanisms. At the first session of our substance abuse class, we ask the students to choose a substance or activity and abstain from this substance or activity for the semester, and that the first thing that popped into their heads and was rejected because it would be too hard to give up is the thing they should choose. Students usually choose substances such as alcohol, coffee, chocolate, or sugar, or activities such as gambling (we live in Nevada, where gambling is legal) or watching television. Some choose tobacco and an occasional courageous student will choose an illegal drug. The students record their use of the defense mechanisms through journal entries and write a paper about the experience at the end of the semester.

If you are wondering whether some students "blow off" the assignment and just make up the material in their journals and papers, the answer is "of course." When the assignment is given, this issue is discussed. The students are told that they can do anything they want to; the instructor will never know the difference. However, there is some reason for potential mental health professionals to take a close look at themselves if they are unwilling to abstain from a substance or activity for 15 weeks, particularly when they will be encouraging clients to abstain from alcohol or other drugs for a lifetime.

We encourage you, our reader, to examine your own use of denial, minimization, projection, and rationalization, particularly in regard to your own use of AOD. Mental health professionals are not immune to AOD problems and are just as likely to use these defense mechanisms as anyone else is. As you read the rest of this book, take some time to examine your own substance-using behavior. If there is a problem, this would be the ideal time to get some help. This would certainly be preferable to becoming one of the many impaired professionals who may cause harm to their clients and themselves.

HELPING ATTITUDES AND BEHAVIORS

Although we have encountered many mental health professionals with AOD problems, we have found that a more pervasive problem may be the potential mental health professionals who gravitate to the helping professions because of unresolved issues in their lives. Although there may be a sincere desire to help others, these potential mental health professionals may actually be unhelpful to clients. For example, in our counselor education program, we find that many of our students are adult children of alcoholics. Now, that is no problem in and of itself. In fact, as we will discuss in Chapter 13, many adult children of alcoholics have the same or fewer problems than other adults. However, being raised

by one or more alcoholic caretakers may lead to certain characteristic ways of behaving that could have implications for a mental health professional's effectiveness. For example, a graduate student in marriage and family therapy whom we will call Debbie (we are changing all of the names of students and clients we are using in this book to protect anonymity) decided to pursue a career in the helping professions because everyone told her that she was easy to talk to and was a good listener. Debbie said that she was one of those people to whom total strangers immediately told their life stories.

Debbie was raised by her biological parents, both of whom were alcoholics. Within her family, she had developed a method of behaving that would minimize the probability of conflict developing. She did most of the cooking and cleaning at home, took care of her younger siblings, and worked very hard at school. Debbie reported being in a constant state of anxiety because of her worry that she had "missed" something that would send one of her parents into a rage.

In hindsight, it is easy to see that Debbie developed a false belief that she could control her parents' moods and behavior by making sure that everything was perfect at home and by her achievements at school. It is not unusual for children raised by alcoholic caretakers to develop a role designed to divert attention away from the real problem in the family. (Again, this will be discussed in detail in Chapter 13.) However, the development of this childhood role had implications for Debbie's work as a marriage and family therapist. We noticed that she was quite hesitant to confront clients and that she seemed very uncomfortable with conflict. Debbie had more than the usual anxiety for a student when counseling and brooded excessively when her clients did not immediately feel better. Clearly, the characteristic ways Debbie had learned to behave as a child were having a detrimental effect on her development as a marriage and family therapist in spite of the fact that people found her easy to talk to.

Another of our graduate students in counseling, Patricia, was taking our substance abuse counseling course. She failed her midterm examination. Patricia came to see the instructor and explained that the content of the course generated a great deal of emotion for her because her parents were alcoholics and she had been married to a drug addict. Because of these emotions, she said that she had difficulty concentrating on the lectures and the reading material and in following through on class assignments (students were required to attend an AA and an Al-Anon [for family members of alcoholics] meeting). The instructor communicated his understanding that the course could have that impact on people with history and experiences in the substance abuse area and suggested that Patricia drop the course (he offered a passing withdrawal) and pursue counseling for herself. Patricia chose to avoid working on these issues, she stayed in the course, and failed.

Because most of you who are reading this text are graduate students, this may strike you as rather harsh. However, consider the alternative. Let's say that the instructor had offered his understanding and allowed Patricia to remain in the course without dealing with these issues and passed her. Would Patricia be able to work effectively with individuals and families in which there were alcohol or other drug problems, with adult clients who were raised by substance abusing caretakers, or with clients living with alcohol or other drug-abusing partners? In an attempt to avoid these problems, she might do a poor job of assessment, or she might ignore the signs and symptoms of alcohol or other drug problems. Or she might ignore or fail to inquire about substance abuse in the family of origin or in the current family of her clients. In short, we believe that her unwillingness to face these problems would result in her being a less effective counselor.

What about Debbie? Her excessive anxiety and concern with her performance prevented her from objectively looking at her clients and her own counseling behaviors. Debbie's fear of conflict resulted in an unwillingness to confront her clients, which limited her effectiveness. Fortunately, Debbie was receptive to feedback and suggestions. She did some work on her own issues, and she has become a fine marriage and family therapist.

This discussion is not meant to discourage those of you who are adult children of alcoholics, are in recovery from an alcohol or other drug problem, or have lived or are living with an addicted

person from pursuing your careers. It is our experience that most people who want to become helping professionals have a need or desire to help people that is based on family-of-origin issues that may adversely affect their work. This is certainly the case with both of us. It is not a problem if you enter a training program in one of the helping professions because of your own need to be needed. It is a problem if you avoid examining your own issues and fail to take steps to resolve these issues in order to avoid ineffective (or in some cases, harmful) work with clients.

In this particular field, we find helping professionals who cannot work effectively with clients because of their own AOD use or their experiences with AOD use in their families of origin and/or with partners. In the rest of this book, we will attempt to provide you with information that will enable you to deal effectively with the direct and indirect problems resulting from AOD use that social workers, school counselors, mental health counselors, marriage and family therapists, and other helping professionals will encounter. However, all of this information will be useless if your own use patterns or issues are unresolved and if they impact your work. Because denial is so pervasive, we encourage you to seek objective feedback regarding the necessity to work on your own use of alcohol or other drugs or on other issues and, if necessary, to choose a course of action with professional assistance. But please, for your own benefit and for the benefit of your future clients, don't choose to avoid these issues.

OVERVIEW OF THE BOOK

In our choice of chapter topics and the orientation of each chapter, we have tried to maintain the primary goal of providing useful information in the AOD field to general mental health professionals. Therefore, Chapter 2 (Classification of Drugs), Chapter 3 (Models of Addiction), Chapter 8 (Treatment of Alcohol and Other Drugs (AOD)), and Chapter 11 (Twelve Step and Other Types of Support Groups) are overviews of these topics. We have attempted to provide enough detail about treatment and Twelve Step groups to reduce any myths about these activities and to allow mental health professionals to make informed referrals. Issues that usually provoke some controversy among generalists (e.g., the disease concept, relative dangers of different drugs) are also discussed.

In several chapters, we have attempted to integrate the role of the mental health professional in working with clients with AOD problems with the specialist in the field. In Chapter 6 (Screening, Assessment, and Diagnosis), Chapter 7 (Motivational Interviewing and Brief Interventions), and Chapter 10 (Relapse Prevention and Recovery), our goal is that you will understand the types of AOD services that mental health professionals in generalist settings provide.

In this latest edition, we have added a chapter (9) titled Co-occurring Disorders and Other Special Populations. Although these topics were covered in earlier editions, there is an increasing trend throughout treatment programs to provide treatment for substance use disorders and other mental disorders simultaneously. Because of this trend, mental health providers are having more direct treatment contact with clients diagnosed with substance use disorders. Therefore, we believe that all helping professionals need to be familiar with co-occurring disorders and the treatment implications of working with these clients.

Chapter 12 (Children and Families), Chapter 13 (Adult Children and Codependency), and Chapter 15 (Gambling and Other Behavioral Addictions) involve issues related to AOD problems. In many instances, mental health professionals may work with clients having these problems. In each of these chapters, we have attempted to provide sufficient depth of coverage so that you will have a conceptual framework to understand the relationship of these topics to AOD and to understand the implications for treatment.

Chapter 4 is an in-depth discussion of multicultural issues in the AOD field. As with all mental and other health-related topics, it is essential to understand both individual and group characteristics of clients. The cultural context of AOD use is of crucial importance in both prevention and treatment.