ADDICTION COUNSELING:
Examination of various Addiction Counseling and Therapy Approaches.[1]

INTRODUCTION

Many who seek recovery from an addiction hope or dream of being cured. They believe that curing their addiction would make them a "former addict" that is able to regard their substance of choice as equivalent to any other substance in the world. Gone would be the core belief system that ascribes magical, mystical, romantic and pleasurable qualities to the substance. Gone also would be the anxiety associated with using the substance again, or having the strong cravings and unmerciful desire associated with a relapse. Absent would be the fears of using or the discomfort some experience when the troubled human being encounters triggers to use or events and environments that have been associated with the use of alcohol or other drugs in the past. To be cured would be to experience release from the chains, the craving, the stigma, and the burden of guilt associated with identification as an alcohol or drug troubled human being. Years of experience have amply demonstrated that cure is never seen in those human beings who have become troubled with addiction. Addictions are chronic diseases, often characterized by episodic relapses in thinking, or sometimes return to use of our substance of choice. Even if that can be avoided, a transition into some other addictive substance or behavior can be just as devastating. If addiction cannot be cured, but only put into remission, is it any wonder that many human beings who seek treatment grow impatient with the struggle and see little hope? A significant cause of this loss of hope is the confusion that many have between curing and healing an addictive disorder.

ARTICLE

Cure requires a return to the physiologic and mental state a human being was in prior to acquiring a disorder. Some infectious diseases are cured. Many bacterial infections are cured as a result of both the administration of antibiotics and the ability of the immune system to complete the process. As a result, one is restored to a state of health without residual wounds or lasting effects of the disorder.

The self-conscious professional is not interested in cure of addiction but rather in healing. The wise counselor knows the true path into the core of the disorder. At the core, the troubled human being must come to terms with certain tightly held toxic beliefs genuine healing is a journey, facilitated by a counselor.

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The healing potential in the professional/troubled human being relationship is facilitated by the inherent powers differential between the professional and the human being that come together to engage in the treatment process. This treatment, commonly referred to in the addiction verbiage as rehabilitation, includes not only the relief of pain and suffering, but also the restoration of hope and promotion of healing for the troubled person.

Each troubled individual attempts to muster enough courage and faith to trust in the professional, and implement the instructions and counsel given. The relationship between counselor and troubled human being is created from compassion, vulnerability and trust. This defines an effective treatment process. The therapeutic relationship becomes a container, a crucible in which we encounter the source of desires, fears, weaknesses, destruction, shortcomings, defects of character and violence.

The role of the counselor is to guide those human beings who have fallen out of balance while living to re-establish harmony and wellness in their lives. Counselors attune themselves to their own innate healing capacity, and use knowledge gained in training, education, and life's struggles to lead those they serve to honesty and self-discovery. Each disorder, every defect encountered can be regarded as a teacher that can demonstrate how we have deviated from our true path, our effective human functioning, our wellness, our family, and from our spiritual growth. Healing can go beyond the self to heal family relationships and community imbalances, for when one person completes an effective shift in their perception and state of being, every other person in their family and social network will be affected.

Since the origin of the healing professions, standards of conduct and ethical codes have been established by and for those who practice healthcare vocations. Sometimes it is difficult to remember that counselors are human beings and subject to the same maladies, desires and shortcomings as those they serve. Despite being held to high moral and ethical standards, some counselors may fail to remain godlike and perfect in the discharge of duties. The temptation to abuse power and privilege for personal gain and gratification may be too enticing. Whenever a counselor's mind begins to attack, to separate itself from another to use them and the situation to advance the ego's own agenda, then true healing becomes impossible, and there is danger of additional pain and suffering for the counselor and the human being served.

Counselors can and do become wounded in service, and encounter their own vulnerabilities in the process of helping others. However, leading another to honesty and self-discovery promotes healing of the true self, and promotes not only meaningful recovery but also spiritual growth for both parties. The counseling process involves finding, touching, and loving the deepest sense and darkest recesses of another, while remaining honest and respectful of their spirit, needs and best interests. The counselor serves as a reflective mirror of what is discovered while simultaneously serving as a role model to inspire the troubled human being to trust the process of discovery. With time and effort a troubled individual may come to discover who they really are, including an honest appreciation of the beauty, talent, aptitude and strength endowed to them in this life yet never fully utilized. The counselor has the privilege of witnessing this transformation; and documenting, celebrating this healing...the very healing that we all have all taken birth for.

The quality of the counseling relationship rather than any particular skill or technique may well be the hidden foundation for true counseling. The therapeutic covenant is a special bond created from compassion, trust, and courage to move forward together, which catalyzes and energizes the therapeutic process, facilitating healing. The professional must at all times

maintain safe and healthy boundaries that protect while empowering, while promoting the free expression of feelings and concerns by the patient.

Changes in technology, conflicting expectations of confidentiality, and disparity in sensitivity to the needs, feelings, and vulnerabilities of the troubled human beings will continue to make the definition and maintenance of these covenants challenging. However, the importance of maintaining the therapeutic covenants will remain crucial for any professional that endeavors to facilitate genuine counseling with those they serve.

The information found within these pages looked at various approaches to addiction counseling, along with the basic concept of each process, and the techniques that can be utilized by the addiction counselor.

It is important to keep an open mind when reviewing these approaches. This dissertation does not attempt to provide one single model as the "best practice" approach. A one-model approach in which all addiction counselors are expected to subscribe is dangerous, due to the fact that it limits the effectiveness of the counselor to work with human beings from all cultures. Just as varied are the human beings that come seeking help, so are the varied approaches utilized by the counselor in that help.

The role of the counselor in addiction treatment is to provide support, education and most importantly, non-judgmental confrontation to those alcohol and or drug troubled human beings. It is essential that a counselor establish a good relationship with the alcohol and or drug troubled human being.

A human being recovering from a specific addiction deserves complete attention from the counselor and to feel understood. Consequently, the counselor should convey to this human being, their understanding of the struggles in all stages of recovery, and are willing to support the human being throughout the recovery process or counseling sessions, i.e. limited sessions sometimes due to HMO insurance regulations or insurance.

PERSONAL CHARACTERISTICS OF AN EFFECTIVE COUNSELOR

A counselor's influence may depend in part on technical skill and in part on the perceptions of the addicted troubled human being. These troubled human beings who perceive their counselors as possessing the therapeutic qualities of expertness, attractiveness and trustworthiness may be less likely to devalue the counselor's intervention and to experience therapeutic change.

Social influence theory may explain some aspects of the counseling process (Goldstein & Simonson,; Strong,). For example, characteristics of the counselor, the troubled human being, the influential message, and the environment contribute to the strength of influence (Lippa,). Thus, the influence of counselors may depend not only on the therapeutic message itself, but also on the human beings' interpersonal perceptions. In particular, counselors perceived, as being expert, attractive and trustworthy may be more influential with the troubled human being than those perceived as not having these qualities (Beutler, Machando & Neufeldt,).

Applying cognitive discord theory (Festinger) to the counseling relationship, it was hypothesized that a counselor's influence on a human being is the product of cognitive lack of harmony created by the counselor's message. The troubled human being can reduce this inharmonious message through personal change (effective influence), devaluation of the counselor,

devaluation of the message, or information seeking. In counseling, a personal change in the human being is less likely when alternative means of discord reduction are available. Specifically, counselors perceived as less expert, attractive, and trustworthy might be less influential inasmuch as clients may be prepared to devalue them and their message. Research has supported Strong's hypothesis regarding influence and therapeutic outcomes (Strong & Dixon).

That was then and this is now. The trend in counseling for the twenty first century stresses the values and behaviors of the counselor. The quality of the relationship between the counselor and the troubled human being seems to be the most important factor to foster growth for the person troubled.

Counseling is an intimate style of learning. Due to this intimacy the counselor must share, without giving too much disclosure, with the troubled individual and become a real person. If a counselor is scared, or does not trust him/herself, the troubled human being can and will sense this fear thereby keeping themselves hidden from the counselor. However, if the counselor is genuine and alive, like the major telephone adds, the counselor can reach out and touch the troubled person who is seeking their help. (LaCrosse)

The counselor then becomes a model for the troubled human being. If the counselor models incongruent behavior, lack of enthusiasm, and less than honest sharing by hiding behind a desk or vague in offering assistance, then expect the troubled human being to mimic the same behaviors as the counselor. It has been shown that when the counselor models realness by engaging in appropriate self-disclosure, the troubled individual tends to do the same. This allows the troubled human being to become more of what they are capable of becoming. The degree to which the counselor becomes alive and real, the level of psychological wellness the counselor is at, the greater the outcome for success with the troubled human becomes.

COUNSELOR AS A THERAPEUTIC PERSON

So what does it take and how can counselors become therapeutic, modeling awareness and growth for those troubled human beings served? Using reflection, there are listed a number of characteristics that were observed and continue to be observed. Therein again lies the admonishment of "best characteristics", in reviewing the examples. As with theory, it would be dangerous to assume these examples are all inclusive of what a good addiction counselor should be.

It is important for counselors to have their own identity. That is, the counselor knows who he or she is, what the counselor needs or wants out of life, and what is truly important. The road the counselor travels is clear all the way to the horizon, yet the counselor is willing to stop every now and then to check the map, to ensure the road is still available. Unlike others, the counselor who knows what he or she want will not mirror others, due to the fact that he or she respect and appreciate themselves.

The addiction counselor is able to recognize and accept his or her own power. These counselors do not have to diminish, feel superior over, or bully others to feel powerful. The power the counselor uses is healthy, is modeled appropriately, while avoiding power's abusive nature. The counselor does not settle for less, rather the counselor extends him or herself to become more. These are the counselors that can think and live outside the box, can leave the security of the known for the unknown. It is the thirst for knowledge that drives and motivates these counselors with the realization that having limited awareness means limited freedom in

helping those troubled. (Covey)

A truly therapeutic addiction counselor will develop his or her own counseling style. This style is based on philosophy of life and the counselors own life experiences. While the counselor may from time to time borrow ideas and techniques from other counselors, there is a strong idealism to avoid a robotic, programmed technique. Additionally, the counselor can experience and know the world in which the troubled human being, who is being served, lives in, yet the counselor does not own it. There is that " I don't know how you feel right now, all I know is how I felt when that happened to me" attitude.

Life for the addiction counselor is alive. The counselor squeezes everything possible out of life. Life for the counselor requires full participation, not settling for just going through the motions of living. The counselor does not let life's events shape him or her, rather he or she will shape the events in their own lives. Another characteristic of a therapeutic counselor is the authenticity, sincerity, and honesty in which the counselor models. There are no false airs to be shown, the counselor is willing to disclose him or herself to selected others, there are no masks to hide behind. The therapeutic counselor can laugh. Laugh at themselves; know how to have appropriate fun. Having a sense of humor allows the counselor to put problems and personal imperfections into perspective. When it comes to making mistakes, the counselor is willing to admit the mistake, learn from the mistake, and more importantly, not dismiss the error lightly, yet does not dwell on the issue.

The counselor can appreciate from whence he or she came, i.e., their culture. There is awareness of how personal culture affects them. There is a deep respect for the diversity of other cultures, while being sensitive to the uniqueness and differences of others. There is the ability to reinvent, revitalize, and change, while working on becoming the human being the counselors always wanted to become. The counselor knows how to make the appropriate choices that shape his or her life. There is a sincere interest in the wellness of other human beings. This wellness is based on respect, care, trust, and a real value of other human beings. While these characteristics are not all inclusive, finally, the counselor is able to maintain healthy boundaries. While each counselor strives to be fully involved with the troubled person being served, the counselor does not carry a suitcase of his or her troubled human beings problems around with him or her. The counselor has acquired the knowledge and the ability to say no. The counselor can recognize burn out and getting crispy around the edges. More importantly, the counselor knows how to take care of him or her, when this happens. Being an effective therapeutic counselor does not mean being a martyr to the cause.

As stated, these characteristics are not are not an all or nothing proposal. Consider sampling a little of each, until the counselor develops his or her own personal therapeutic identity.

BECOMING AN EFFECTIVE MULTICULTURAL COUNSELOR
Traditionally, the United States has been defined as a melting pot in which various cultures are assimilated and blended as immigrants mold their beliefs and behavior to the dominant white culture. The melting pot image has given way to a more pluralistic ideal in which immigrants maintain their cultural identity while learning to function in the society. Not only are immigrants still flocking to America from Cuba, Haiti, Vietnam, Guatemala, El Salvador, and other countries, but minorities already living in the United States have asserted their right to have equal access to counseling (Arcinega and Newlou). This diversity creates three major difficulties for multicultural counseling: the counselor's own culture, attitudes, and theoretical perspective; the client's culture; and the multiplicity of variables comprising an individual's identity (Pedersen).

A major assumption for culturally effective addiction counseling and is the acknowledgement of the ways in which the addiction counselor comprehends other cultures, and the limits culture places on that comprehension. It is essential for the counselor to understand his/her own cultural heritage and worldview before he/she sets about understanding and assisting other people (Ibrahim). This understanding includes an awareness of one's own philosophies of life and capabilities, a recognition of different structures of reasoning, and an understanding of their effects on one's communication and helping style. Lack of such understanding may hinder effective intervention.

Part of this self-awareness is the acknowledgement that the "counselor culture" has at its core a set of white cultural values and norms by which clients are judged. This acculturation is simultaneously general, professional, and personal. Underlying assumptions about a cultural group, personal stereotypes or racism, and traditional counseling approaches may all signal acquiescence to white culture. Identification of specific white cultural values and their influence on counseling will help to counter the effects of this framework (Katz).

Adherence to a specific counseling theory or method may also limit the success of counseling. Many cultural groups do not share the values implied by the methods and thus do not share the counselor's expectations for the conduct or outcome of the counseling session. To counter these differences, effective counselors must investigate their clients' cultural background and be open to flexible definitions of "appropriate" or "correct" behavior (LaFromboise).

Another counseling barrier is language. Language differences may be perhaps the most important stumbling block to effective multicultural counseling and assessment.(Romero) Language barriers impede the counseling process when clients cannot express the complexity of their thoughts and feelings or resist discussing affectively charged issues. Counselors, too, may become frustrated by their lack of bilingual ability. At the worst, language barriers may lead to misdiagnosis and inappropriate placement.

As counselors incorporate a greater awareness of their clients' culture into their theory and practice, they must realize that, historically, cultural differences have been viewed as deficits. Adherence to white cultural values has brought about a naive imposition of narrowly defined criteria for normality on culturally diverse people. Multicultural counseling, however, seeks to rectify this imbalance by acknowledging cultural diversity, appreciating the value of the culture and using it to aid the client. Although the variety of cultures is vast, the following examples indicate the types of cultural issues and their effects on the counseling situation.

In the cultural value system of Chinese Americans, passivity rather than assertiveness is revered, quiescence rather than verbal articulation is a sign of wisdom, and self-effacement rather than confrontation is a model of refinement. (Ching and Prosen) Since humility and modesty are so valued, it is difficult for counselors to draw out a response from a Chinese American in a group setting. The reticence which reinforces silence and withdrawal as appropriate ways of dealing with conflict may be interpreted as resistance by the uneducated counselor. Democratic counselors may also be uneasy with the role of the "all-knowing father" that the Chinese respect for authority bestows on them.

Africans place great value on the family, especially their children, who are seen as a gift from God, and on social relationships, with a great emphasis on the community and their place in it. In this context social conflict resolution becomes important, so that peace and equilibrium may

be restored to the community, while personal conduct becomes secondary. (McFadden and Gbekobov)

Many African values also influence contemporary American Black behavior, including the notion of unity, the survival of the group, oral tradition, extended kinship networks, self-concept, concept of time, and control of the environment.

In his discussion of counseling the Northern Natives of Canada, Darou notes that counseling is seen as cultural racism when it does not fit native values. These values are: cooperation, concreteness, lack of interference, respect for elders, the tendency to organize by space rather than time, and dealing with the land as an animate, not an inanimate, object.

Bernal and Flores-Ortiz point out that Latin cultures view the family as the primary source of support for its members. Any suggestion that the family is not fulfilling that obligation can bring shame, added stress, and an increased reluctance to seek professional services. Involving the family in treatment will most likely insure successful counseling outcomes with Latinos.

There is always the danger of stereotyping human beings and of confusing other influences, especially race and socioeconomic status, with cultural influences. The most obvious danger in counseling is to oversimplify the human being's social system by emphasizing the most obvious aspects of their background. While universal categories are necessary to understand human experience, losing sight of specific individual factors would lead to ethical violations. Individual human beings are influenced by race, ethnicity, national origin, life stage, educational level, social class, and sex roles. Addiction counselors must view the identity and development of culturally diverse people in terms of multiple, interactive factors, rather than a strictly cultural framework. A pluralistic counselor considers all facets of the client's personal history, family history, and social and cultural orientation.

One of the most important differences for multicultural counseling is the difference between race and culture. Differences exist among racial human groups as well as within each group. Various ethnic identifications exist within each of the five racial groups. Some examples include: Asian/Island Pacific (Japanese, Korean, and Vietnamese); Black (Cajun, Haitian, and Tanzanian); Hispanic (Cuban, Mexican and Puerto Rican); Native American (Kiowa, Hopi, and Zuni); and White (British, Dutch, and German). Even though these ethnic groups may share the physical characteristics of race, they may not necessarily share the value and belief structures of a common culture. Counselors must be cautious in assuming, for instance, that all Blacks or all Asians have similar cultural backgrounds. McKenzie, notes that West Indian American clients do not have the same cultural experience of Afro-American Blacks and are culturally different from other Black subculture groups. Counselors who can understand West Indian dialects and the accompanying nonverbal language are more likely to achieve positive outcomes with these clients.

Although it is impossible to change backgrounds, addiction counselors can avoid the problems of stereotyping and false expectations by examining their own values and norms, researching their troubled individuals backgrounds, and finding counseling methods to suit those needs. Counselors cannot adopt the troubled human being's ethnicity or cultural heritage, but they can become more sensitive to these things and to their own and their clients' biases. Clinical sensitivity toward client expectation, attributions, values, roles, beliefs, and themes of coping and vulnerability is always necessary for effective outcomes. Three questions which counselors might use in assessing their approach are as follows (Jereb): (1) Within what framework or

context can I understand this client (assessment)? (2) Within what context do client and counselor determine what change in functioning is desirable (goal)? (3) What techniques can be used to effect the desired change (intervention)? Examination of their own assumptions, acceptance of the multiplicity of variables that constitute an individual's identity, and development of a client centered, balanced counseling method will aid the multicultural counselor in providing effective help.

ROLLO MAY

Existentialism is concerning with the meaning of human life. Rollo May introduced European existential thought into American psychology. Humanism and Existentialism are similar, but one difference is noted in the text: Humanists see people as basically good; existentialists see human nature as neutral. Whether the person becomes good or evil is a matter of personal choice. One can decide to good or evil.

May's "nervous breakdown" in Europe he defined this way: "the rules, principles, values by which I used to work and live simply did not suffice anymore." Others would call this an existential crisis: what is the meaning of my life? May decided to "listen to my inner voice" He returned from Europe and enrolled in Union Theological Seminary to study the basic questions related to the human experience. There he met the eminent Paul Tillich, Protestant theologian and existential philosopher.

In his second book, The Springs of Creative Living: A Study of Human Nature and God (1940), May defined healthy religion: "Call it confidence with the universe, trust in God, belief in one's fellow-men, or what not, the essence of religion is the belief that something matters—the presupposition that life has meaning." The healthy religious person has found meaning in life, and the atheist is one who has not.

Tenets of Existentialism

The following terms and concepts make up May's theory of personality:

Dasein (literally, to be there): all-hereness; an individual's experiences and interpretations of the world right here, right now; the person is a "being-in-the-world"; caught up in the world, taking a stand on one's life, active and engaged at all times. This dynamic process of choosing, valuing, accepting, rejecting, means that humans are constantly becoming something different.

Alienation: one's estrangement from some aspect of his or her existence (nature, others, or self), resulting in loneliness, emptiness, and despair.

Freedom: the most important principle of existentialism: freedom to choose allows each of us to transcend the immediate circumstances of our lives; we do not have to be victimized by nature, others or self, unless, of course, this freedom is underdeveloped or denied.

Responsibility: With freedom comes the assumption of full responsibility for what we have become. Nothing or no one can be blamed for who we are. Freedom and responsibility are inseparable.

Authenticity: the fully functioning person; the self-actualizing person; living in positive relationships, creating challenges for personal growth, minimizing anxiety: these are the criteria for authenticity.

Death: "To grasp what it means to exist, one needs to grasp the fact that he might not exist." The inevitability of death should be a major incentive to live the full and meaningful life. Your years on earth are not a dress rehearsal. This is all you get. What are you going to do with the time that you have here? Death can be literal, but one can also die symbolically by not leading the authentic life.

Human Dilemma: the fact that humans can view themselves as both the subject and the object at the same time. Humans can see themselves as an object to which things happen; we are continually influenced by stimuli presented to us (Skinner's theory); whether we respond or not to the stimuli depends on our rationality (Rogers' theory); our ability to self-relate is what distinguishes us from the rest of nature; "man's ability to stand outside himself"; we can view ourselves viewing, a metacognitive skill.

Normal and Neurotic Anxiety: anxiety and freedom always go together. Anxiety is defined as the resulting response to anything that threatens our freedom. May's definition of normal anxiety: "the apprehension cued off by a threat to some value which the individual holds essential to his existence as a self." Anxiety is necessary for growth and expansion of self; moving forward into the unknown is anxiety producing, an unfortunate companion of freedom of choice. Healthy anxiety should be recognized and accepted as inevitable. Neurotic anxiety is the feeling that comes when one decides to conform, accept conditions of worth of others, and give up possible personal growth, all in the name of safety and security. Neurotic anxiety, leading to psychological stagnation and intense feelings of guilt, is the subject of therapy.

Normal and Neurotic Guilt: normal guilt comes when one doesn't live up to his/her potential as a human being; it is part of the human condition, like anxiety; normal guilt can be used constructively when it is recognized and consciously reduced by appropriate action; neurotic guilt is the result of giving up and taking no risks for growth and expansion of self.

Values: what we deem important and meaningful. In infancy: love, care, nourishment; in childhood and adolescence: approval, success, status among peers and autonomy from parents; in adulthood: those which transcend the immediate situation in time and encompass past and future, extending outward toward the good of the community and the larger world; holding mature values is more important than satisfying those values, i.e. search for beauty and truth is more important that actually finding it. Without functional values, we are alienated from the world and lose our sense of identity, worth, and significance; there is a sense of helplessness and aimlessness; "if you don't stand for something, you'll fall for anything": values and commitment go hand in hand; mature values allow a person to deal effectively with reality, to empathize with others, and to form meaningful interpersonal relationships, and to be future-oriented; without an adequate system of values, people depend on things outside themselves to indicate worth and significance—status, income, possessions, prestige.

Love: the authentic love relationship must have these four types of love:
- ❑ Sex: biological drive, satisfied by intercourse; goal is termination, gratification, relaxation
- ❑ Eros: the desire for union with another person; goal is continue the experience, and to seek wholeness or interrelatedness among our experiences with others
- ❑ Philia: friendship or brotherly love; acceptance of the other person and enjoyment of him/her; an expansion of Eros; a relaxation in the presence of the other
- ❑ Agape: unselfish giving of one's self to another, without concern for reciprocity; unconditional positive regard

Daimonic: from Greek, meaning both divine and diabolic; any natural function that has the power to take over the whole person—sex, Eros, anger, rage, craving for power or achievement; may be either creative and healthy or destructive, or usually both. The desire to achieve is a kind of affirmation of self, but if it becomes an obsession, it takes over the whole person without regard for the person's well being or the well being of others; all of life is a constant search for the optimal level of each of our personality traits.

Psychotherapy: the goal is to convert neurotic anxiety and guilt to normal anxiety and guilt; to help the client actualize his/her potentialities. What is the client trying to express by the presenting problems?; to help the client find meaning in circumstances s/he would otherwise find meaningless or hopeless. Therapy should be an encounter between two selves coming together and sharing their existence; empathy for the client is a key ingredient.

Importance of Myth: May agreed with Jung that myths give expression to the universal truths of human nature, and guide human existence; these are narratives that make sense in a senseless world; myths provide universal themes to the individual regarding birth, death, love, marriage, good (Christ), evil (Satan), freedom, independence' memory and myth are inseparable; our earliest memories become our personal myths, that influence our perceptions about the world, others and self. Great literature gives expression to all-important aspects of human nature.

WILLIAM GLASSER

First published in 1965, Reality Therapy describes Dr. William Glasser's break with conventional Freudian psychoanalytic practice. The conventional practice at that time operated from the perspective that patients suffered because of personal moral standards that were unreasonably high. The therapist, operating as a shadowed substitutionary authority figure, guided the patient to behaviors that were less inhibited and would bring greater happiness to the individual. Reality therapy, as described by Dr. Glasser, takes a very different approach. The problem is not that the patient's standards for behavior have been too high; the problem is that the patient's behavior has been insufficient. A therapist using the principles of reality therapy helps patients to face reality and meet their needs in the world as it truly is.

In addition to the generally understood physiological needs, humans have two basic psychological needs: love and personal self-worth. Both needs flow between the self and others. We need to love and we need to be loved. We need a personal sense of our own value; we also need to be valued by others. According to Glasser, if an individual cannot fulfill these two needs in the "real world," the individual will dissociate from reality or engage in irresponsible behavior or both.

Glasser rejects the concept of mental illness and focuses on the patient's behavior in his approach to therapy. The therapist becomes involved with the patient and helps the patient to examine his current behavior with a goal of improvement in the future. Examination of a patient's past and probing his subconscious are not useful to reality therapists. The therapist relates directly to the patient rather than plays the role of a transference figure. Irresponsible behavior is confronted, not explained, as the therapist helps the patient to learn ways of acting that will fulfill his psychological needs.

Responsibility is the key concept in reality therapy. Glasser defines responsibility as "the ability to fulfill one's needs and to do so in a way that does not deprive others of the ability to fulfill their

needs." " Any behavior which does not match this standard is regarded as irresponsible. According to Glasser, humans learn responsibility through relationships, primarily as children from parents. However, the process of becoming responsible is a life-long one. As situations change, each individual must adjust and find new ways of acting responsibly to meet his needs. When this is not done, irresponsible behavior results.

Although Glasser may be too dismissive of mental illness, especially in light of recent research showing a physiological basis for some types of mental illness, his approach to therapy is a solid one for many cases, particularly those which bring parishioners to their pastors. His emphasis on the involvement of the counselor or therapist with the individual is very encouraging. With a focus on the present behavior rather than past events and subconscious motivations, counselors do not need a high level of training in order to be effective. They need only be able to recognize and reward responsible behavior and to offer correction to irresponsible behaviors.

COGNITIVE BEHAVIORAL THERAPY

Cognitive Behavioral Therapy (CBT) is a brief form of psychotherapy used in the treatment of adults and children with depression. Its focus is on current issues and symptoms versus more traditional forms of therapy, which tend to focus on a person's past history. The usual format is weekly therapy sessions coupled with daily practice exercises designed to help the patient apply CBT skills in their home environment.

CBT for depression involves several essential features: identifying and correcting inaccurate thoughts associated with depressed feelings (cognitive restructuring), helping patients to engage more often in enjoyable activities (behavioral activation), and enhancing problem-solving skills. The first of these components, cognitive restructuring, involves collaboration between the patient and the therapist to identify and modify habitual errors in thinking that are associated with depression. Depressed patients often experience distorted thoughts about themselves (e.g. I am stupid), their environment (e.g. My life is terrible) and their future (e.g. There is no sense in going forward, nothing will work out for me). Information from the patient's current experience, past history, and future prospects is used to counter these distorted thoughts. In addition to self-critical thoughts, patients with depression typically cut back on activities that have the potential to be enjoyable to them, because they anticipate that such activities will not be worth their effort. Unfortunately this usually results in a vicious cycle, wherein depressed mood leads to less activity, which in turn results in further depressed mood, etc.

The second component of CBT, behavioral activation, seeks to remedy this downward spiral by negotiating gradual increases in potentially rewarding activities with the patient. When patients are depressed, problems in daily living often seem insurmountable. In the final process, the CBT therapist provides instruction and guidance in specific strategies for solving problems (e.g. breaking problems down into small steps).

Cognitive-Behavioral Therapy: An Overview

Cognitive-behavioral coping skills treatment (CBT) is a short-term, focused approach to helping cocaine-dependent individuals (the term cocaine abuser or cocaine-dependent individual is used to refer to individuals who meet DSM-IV criteria for cocaine abuse or dependence.) become abstinent from cocaine and other substances. The underlying assumption is that learning processes play an important role in the development and continuation of cocaine abuse and dependence. These same learning processes can be used to help individuals reduce their

drug use.

Very simply put, CBT attempts to help patients recognize, avoid, and cope. That is, RECOGNIZE the situations in which they are most likely to use cocaine, AVOID these situations when appropriate, and COPE more effectively with a range of problems and problematic behaviors associated with substance abuse.

Several important features of CBT make it particularly promising as a treatment for cocaine abuse and dependence:

CBT is a short-term, comparatively brief approach well suited to the resource capabilities of most clinical programs.

CBT has been extensively evaluated in rigorous clinical trials and has solid empirical support as treatment for cocaine abuse. In particular, evidence points to the durability of CBT's effects as well as its effectiveness with subgroups of more severely dependent cocaine abusers.

CBT is structured, goal-oriented, and focused on the immediate problems faced by cocaine abusers entering treatment who are struggling to control their cocaine use.

CBT is a flexible, individualized approach that can be adapted to a wide range of patients as well as a variety of settings (inpatient, outpatient) and formats (group, individual). CBT is compatible with a range of other treatments the patient may receive, such as pharmacotherapy. CBT's broad approach encompasses several important common tasks of successful substance abuse treatment.

Components of CBT
CBT has two critical components: Functional analysis and Skills training.

Functional Analysis
For each instance of cocaine use during treatment, the therapist and patient do a functional analysis, that is, they identify the patient's thoughts, feelings, and circumstances before and after the cocaine use. Early in treatment, the functional analysis plays a critical role in helping the patient and therapist assess the determinants, or high-risk situations, that are likely to lead to cocaine use and provides insights into some of the reasons the individual may be using cocaine (e.g., to cope with interpersonal difficulties, to experience risk or euphoria not otherwise available in the patient's life). Later in treatment, functional analyses of episodes of cocaine use may identify those situations or states in which the individual still has difficulty coping.

Skills Training
CBT can be thought of as a highly individualized training program that helps cocaine abusers unlearn old habits associated with cocaine abuse and learn or relearn healthier skills and habits. By the time the level of substance use is severe enough to warrant treatment, patients are likely to be using cocaine as their single means of coping with a wide range of interpersonal and intrapersonal problems. This may occur for several reasons:

The individual may have never learned effective strategies to cope with the challenges and problems of adult life, as when substance use begins during early adolescence.

Although the individual may have acquired effective strategies at one time, these skills may

have decayed through repeated reliance on substance use as a primary means of coping. These patients have essentially forgotten effective strategies because of chronic involvement in a drug-using lifestyle in which the bulk of their time is spent in acquiring, using, and then recovering from the effects of drugs.

The individual's ability to use effective coping strategies may be weakened by other problems, such as cocaine abuse with concurrent psychiatric disorders. Because cocaine abusers are a heterogeneous group and typically come to treatment with a wide range of problems, skills training in CBT are made as broad as possible. The first few sessions focus on skills related to initial control of cocaine use (e.g., identification of high-risk situations, coping with thoughts about cocaine use). Once these basic skills are mastered, training is broadened to include a range of other problems with which the individual may have difficulty coping (e.g., social isolation, unemployment). In addition, to strengthen and broaden the individual's range of coping styles, skills training focuses on both intrapersonal (e.g., coping with craving) and interpersonal (e.g., refusing offers of cocaine) skills. Patients are taught these skills as both specific strategies (applicable in the here and now to control cocaine use) and general strategies that can be applied to a variety of other problems. Thus, CBT is not only geared to helping each patient reduce and eliminate substance use while in treatment, but also to imparting skills that can benefit the patient long after treatment.

Critical Tasks
CBT addresses several critical tasks that are essential to successful substance abuse treatment.

Foster the motivation for abstinence. An important technique used to enhance the patient's motivation to stop cocaine use is to do a decisional analysis, which clarifies what the individual stands to lose or gain by continued cocaine use.

Teach coping skills. This is the core of CBT - to help patients recognize the high-risk situations in which they are most likely to use substances and to develop other, more effective means of coping with them.

Change reinforcement contingencies. By the time treatment is sought, many patients spend most of their time acquiring, using, and recovering from cocaine use to the exclusion of other experiences and rewards. In CBT, the focus is on identifying and reducing habits associated with a drug-using lifestyle by substituting more enduring, positive activities and rewards.

Foster management of painful affects. Skills training also focus on techniques to recognize and cope with urges to use cocaine; this is an excellent model for helping patients learn to tolerate other strong affects such as depression and anger.

Improve interpersonal functioning and enhance social supports. CBT includes training in a number of important interpersonal skills and strategies to help patients expand their social support networks and build enduring, drug-free relationships.

Parameters of CBT
An individual format is preferred for CBT because it allows for better tailoring of treatment to meet the needs of specific patients. Patients receive more attention and are generally more involved in treatment when they have the opportunity to work with and build a relationship with a single therapist over time. Individual treatment affords greater flexibility in scheduling sessions

and eliminates the problem of either having to deliver treatment in a "rolling admissions" format or asking patients to wait several weeks until sufficient numbers of patients are recruited to form a group. Also, the comparatively high rates of retention in programs and studies may reflect, in part, particular advantages of individual treatment.

However, a number of researchers and clinicians have emphasized the unique benefits of delivering treatment to substance users in the group format (e.g., universality, peer pressure). It is relatively straightforward to adapt the treatment described in this manual for groups. This generally requires lengthening the sessions to 90 minutes to allow all group members to have an opportunity to comment on their personal experiences in trying out skills, give examples, and participate in role-playing. Treatment will also be more structured in a group format because of the need to present the key ideas and skills in a more didactic, less individualized format.

CBT has been offered in 12 to 16 sessions, usually over 12 weeks. This comparatively brief, short-term treatment is intended to produce initial abstinence and stabilization. In many cases, this is sufficient to bring about sustained improvement for as long as a year after treatment ends. Preliminary data suggest that patients who are able to attain 3 or more weeks of continuous abstinence from cocaine during the 12-week treatment period are generally able to maintain good outcome during the 12 months after treatment ends. For many patients, however, brief treatment is not sufficient to produce stabilization or lasting improvement. In these cases, CBT is seen as preparation for longer-term treatment. Further treatment is recommended directly when the patient requests it or when the patient has not been able to achieve 3 or more weeks of continuous abstinence during the initial treatment. We are currently evaluating whether additional booster sessions of CBT during the 6 months following the initial treatment phase improves outcome. The maintenance version of CBT focuses on the following:

Identifying situations, affects, and cognitions that remain problematic for patients in their efforts to maintain abstinence or which emerge after cessation or reduction of cocaine use.

Maintaining gains through solidifying the more effective coping skills and strategies the subject has implemented.

Encouraging patient involvement in activities and relationships that are incompatible with drug use. Rather than introducing new material or skills, the maintenance version of CBT focuses on broadening and mastering the skills to which the patient was exposed during the initial phase of treatment.

Treatment is usually delivered on an outpatient basis for several reasons:

CBT focuses on understanding the determinants of substance use, and this is best done in the context of the patient's day-to-day life. By understanding who the patients are, where they live, and how they spend their time, therapists can develop more elaborate functional analyses.

Skills training is most effective when patients have an opportunity to practice new skills and approaches within the context of their daily routine, learn what does and does not work for them, and discuss new strategies with the therapist.

CBT has been evaluated with a broad range of cocaine abusers. The following are generally not appropriate for CBT delivered on an out-patient basis:

Those who have psychotic or bipolar disorders and are not stabilized on medication

Those who have no stable living arrangements

Those who are not medically stable (as assessed by a pretreatment physical examination)

Those who have other concurrent substance dependence disorders, with the exception of alcohol or marijuana dependence (although we assess the need for alcohol detoxification in the former)

No significant differences have been found in outcome or retention for patients who seek treatment because of court or probation pressure and those who have DSM-IV diagnoses of antisocial personality disorder or other Axis II disorders, nor has outcome varied by patient race/ethnicity or gender.

CBT is highly compatible with a variety of other treatments designed to address a range of comorbid problems and severities of cocaine abuse:
- Pharmacotherapy for cocaine use and/or concurrent psychiatric disorders
- Self-help groups such as Cocaine Anonymous (CA) and Alcoholics Anonymous (AA)
- Family and couples therapy
- Vocational counseling, parenting skills, and so on

When CBT is provided as part of a larger treatment package, it is essential for the CBT therapist to maintain close and regular contact with other treatment providers.

All behavioral or psychosocial treatments include both common and unique factors or "active ingredients." Common factors are those dimensions of treatment that are found in most psychotherapies - the provision of education, a convincing rationale for the treatment, enhancing expectations of improvement, provision of support and encouragement, and, in particular, the quality of the therapeutic relationship. Unique factors are those techniques and interventions that distinguish or characterize a particular psychotherapy.

CBT, like most therapies, consists of a complex combination of common and unique factors. For example, in CBT mere delivery of skills training without grounding in a positive therapeutic relationship leads to a dry, overly didactic approach that alienates or bores most patients and ultimately has the opposite effect of that intended. It is important to recognize that CBT is thought to exert its effects through this intricate interplay of common and unique factors.

A major task of the therapist is to achieve an appropriate balance between attending to the relationship and delivering skills training. For example, without a solid therapeutic alliance, it is unlikely that a patient will stay in treatment, be sufficiently engaged to learn new skills, or share successes and failures in trying new approaches to old problems. Conversely, empathic delivery of skills training as tools to help patients manage their lives more effectively may form the basis of a strong working alliance. (NIDA)

ARNOLD LAZARUS
Behavior therapy offers various action-oriented methods to help human beings change what they are doing and thinking. (Glass and Arnkoff) Behavior therapy is based on the principles and procedures of the scientific methods. Experimentally derived principles of learning are systematically applied to help human being change their maladaptive behaviors. Conclusions are based on what has been observed rather than on personal beliefs. The distinguishing

characteristics of behavioral practitioners are their systematic adherence to specification and measurement. They state treatment goals in concrete and objective terms in order to make replication of their interventions possible. Throughout the course of addiction counseling, the counselor is assessing the problem behaviors and the conditions that are maintaining them. Research methods are used to evaluate the effectiveness of both assessment and treatment procedures. Thus, behavioral concepts and procedures are stated explicitly, tested empirically, and revised continually.

With behavior therapy, the addiction counselor deals with the troubled human being's current problems and the factors influencing them, as opposed to historical determinants. Counselors assume that a human being's problems are influenced by present conditions. Addiction counselors then us behavioral techniques to change the relevant current factors that are influencing the human beings behavior.

In behavior therapy, human beings are expected to engage in specific actions to deal with their problems. Rather than simply talking about their current condition, the human being creates some action to bring about change. Human beings are instructed to monitor their behaviors both during and outside the counseling sessions, learn and practice coping skills, and role play new behaviors, This is an action oriented approach to addiction counseling.
Behavior therapy is generally carried out in the human being's natural environment. The approach is largely educational. It emphasizes teaching human being's skills of self-management, with the expectation that the troubled human being will be responsible for transferring what they learn in the counselor's office to their everyday lives. Homework assignments are an integral part of behavior therapy.

Behavioral procedures are tailored to fit the unique needs of each troubled human being. Several therapy techniques may be used to treat a human being's problems. The practice of behavior therapy is based on a collaborative partnership between the counselor and the troubled human being in two major respects. First, every attempt is made to inform the human being about the nature and course of treatment. Second, human beings are often trained to initiate, conduct, and evaluate their own treatment under the guidance of the counselor. (Spiegler and Guevremont)

Victor Frankl
What is logotherapy?
Literally, logotherapy means 'therapy through meaning'. It's an active-directive therapy aimed at helping troubled human beings, specifically with meaning crises, which manifest themselves either in a feeling of aimlessness or indirectly through addiction, alcoholism or depression. Logotherapy employs techniques useful for phobias, anxiety, obsessive-compulsive disorders and medical ministry. Other applications include working with troubled adolescents, career counselling and helping human beings find more meaning in life.

It's existentialist because it emphasises the freedom of the will and the consequent responsibility. It also, of course, asserts the importance of the meaning of life. Whilst Freud said humans have a will to pleasure and Adler the will to power, Frankl says human beings have a will to meaning. If this will to meaning is frustrated, spiritual neuroses result. Frankl argued that the spiritual dimension of human beings should be added to the physical and psychological dimensions. For Frankl, ultimate meaning does exist and is unique to each human being and each situation. Each moment offers a sequence of unrepeatable situations each of which offers a specific meaning to be recognised and fulfilled. Meaning cannot be invented but must be

discovered.

But Logotherapy was also the result of Frankl's own ideas and improvisations, not all of which are very obviously connected with his experiences in the camps or the meaning of life. The counselor encourages the troubled human being to intend or wish for, even if only for a second, precisely what they fear.

Used for obsessive, compulsive and phobic conditions (not for suicidal or schizophrenic troubled human beings).

Useful in cases of underlying anticipatory anxiety, often works very quickly.

Mobilises the human capacity for self-detachment, often with a sense of humour

CONCLUSION
What is a theory or model?
A theory is an idea about how things work, what causes something to happen, or an attempt to explain something in the world that is difficult to completely understand.

To illustrate, imagine there is a need to go many years back in time. There is a large cave with a group of Neanderthals living in the cave. Thunderstorms would be very frightening to this group of human beings. You have observed lightning and know that sometimes it kills people or starts a fire. This group of human beings would want to know why thunderstorms happened so they could predict what would happen during a storm and maybe do something to control or prevent them. Unfortunately, you do not have any science to help you do this.

In an effort to understand thunderstorms, you share ideas with this group of human beings about what causes thunderstorms to happen. You might conclude that the Gods are angry.

This is a theory.

A model is a more detailed description of why something happens and how it happens, and is based on theory. In this case, you develop "The Gods are Angry" model of thunderstorms.
A model also suggests what course of action human beings can take to control or prevent what is happening. Under "The Gods are Angry" model of thunderstorms, it might be concluded that to control or stop thunderstorms there is a need to pacify the Gods.

A scientific theory is one that can be tested through experimentation or study. For example, if a counselor knows nothing about cars, the counselor might develop a theory about how cars work. A counselor might theorize that there is a big wheel under the hood with several hamsters running around inside, transferring power to the wheels and generating electricity. Admittedly, it's a silly theory, but it could be considered a scientific theory because it can be tested. How can the counselor test it? The counselor just has to lift the hood of the car, and the theory would be tested and proven wrong.

There have been several theories and models of addiction, and it is important to understand them because each suggests a different treatment or approach to helping human beings who have problems because of drugs or alcohol.

Moral Model

Moral theories and models are based on beliefs or judgments of what is right or wrong, acceptable or unacceptable. These judgments imply that human beings who use drugs or alcohol are bad or sinful people. There is something morally wrong with human beings who use drugs or alcohol. This model contributes little to our understanding of why human beings use drugs and alcohol heavily and offers no real help to those who have problems in their lives because of alcohol or drugs.

Treatment: The suggested treatment under this model would be punishment. Bad human beings should be punished. Punishment could range from social disapproval to locking these troubled individuals up in jail.

Biological Models
Biological models of addiction assume that human beings addicted to drugs or alcohol has a biological abnormality that causes them to become addicted. Like the moral model, there is something wrong with these troubled individuals. However, what is wrong is assumed to be something physical that is beyond the control of the individual. These troubled human beings are not sinful or bad, but they are sick. These models are sometimes referred to as Disease Models.

There is some evidence that in some, but not all, alcohol or drug troubled human beings there is an inherited predisposition to become alcohol or drug troubled. This means that for certain human beings it may become more easily or quickly addicted than other human beings. It does not mean that all with this predisposition will go on to develop alcoholism or addiction. This explanation does not explain addiction or alcoholism in all cases; there are many alcohol or drug troubled human beings who have no family history of addiction.

These models suggest that a biological abnormality causes an alcohol troubled human beings desire for another drink to increase after taking one drink, and that long-term drinking or drug use leads to damage of brain centers responsible for willpower and judgment. According to these models, alcoholism and addiction are incurable diseases and the best that can be hoped for is to achieve remission.

Treatment: The assumption here is that there is no cure, and one will be an addict or alcoholic for the rest of his or her life. Through abstinence, one can achieve remission. Another assumption is that the alcohol or drug troubled human being has no willpower, poor judgment, and one drink leads to an increased desire for another. Moderate drinking is not viewed as an option and abstinence is viewed as the only acceptable treatment goal. There are many programs based on these models such as Alcoholics Anonymous, 12 step programs. Many people have been helped through these programs.

Sociological Models
It has been suggested that societies that produce higher levels of inner tension such as guilt, stress, suppressed aggression, conflict and sexual tensions have higher rates of heavy drinking and drug use. This idea suggests that the primary role of alcohol and drug use is to reduce anxiety. Another idea under this model is that societies that are permissive of and/or encourage drug or alcohol use have higher rates of problem drinking and drug use. This model also examines the influence of those who stand to make a profit, such as the makers of alcohol. Consider the many beer commercials on television, or the promotion of sporting events by tobacco manufacturers.

Treatment: Under this model treatment would involve changing our society. While such efforts can have an impact, sociological change is slow. For an individual who has problems in his or her life due to alcohol or drug use, changing the world is too slow a process to be of immediate help.

Psychological Models
Psychological models view heavy alcohol and drug use as problem behaviors. A human being drinks or uses drugs in an effort to enjoy the effects of alcohol or drugs. Under these models a drug or alcohol troubled human being is not bad or deficient in any way. Any human being can become addicted to drugs or alcohol because of the way the body and mind works, and because of how alcohol and drugs affects the body and mind.
Treatment: There are many different psychological theories that have been applied to help a troubled individual with drug or alcohol problems including transactional analysis, pscyhoanalytic theories, and personality theories, each suggesting different courses of treatment. Most of the newer programs for drug and alcohol treatment are based on Social Learning Theory.

Social Learning Model
This is a psychological model of understanding problematic drug and alcohol use. It is based on results of scientific experimentation and study. It proposes that drug or alcohol use is learned and continues because the human being gets some desired outcome from it. Human beings also learn to drink or use in response to certain stimuli--people, places, things, events, thoughts and feelings. Under this model, drug or alcohol troubled individuals are not bad or defective people with some abnormality. Any human being can become addicted to drugs or alcohol because of the way that alcohol and drugs affects the mind and body.

Treatment: Under this model the human being works to unlearn drug and alcohol use behavior, and to learn new behaviors to replace them in order to get the benefits he or she received from alcohol or drugs.

The opinion, moral and sociological models offer no or little real help for a troubled person who wants to change their drinking or drug use behavior. The biological model has spawned research into the long-term effects of alcohol and drugs and how intoxicants have their effect on human beings. This research has been important in terms of understanding the physical dependence and withdrawal.

Alcoholics Anonymous, 12 Step Programs, and several other programs based on the biological model have helped many alcohol or drug troubled human beings overcome problems related to drug and alcohol use and represented a great improvement over the moral model.
However, the biological model has not been of help to everyone. Many troubled human beings do not want to accept a label as an alcoholic or addict. Many reject the idea that addiction and alcoholism are incurable diseases. Some troubled individuals do not believe that abstinence is the only option and wish to work towards a moderation goal, or they want to abstain but reject the other assumptions of the biological model. For these human beings, the Social Learning Model offers another alternative treatment.

As noted throughout this dissertation, a number of various approaches have been offered for the counselor to look at and decide which will be right for their use in the field of addictions. A good car mechanic utilizes many various tools in which to create a smooth running vehicle. It would be dangerous for the mechanic to use only an open-ended wrench to repair each broken

item on the vehicle. So it is with the counselor. It would be dangerous for the addiction counselor to use only one model of treatment for each troubled human being that comes to them. What is important to understand and must be adhered to in order to be an effective counselor is: Having the sufficient knowledge of several theories and models in which to choose the appropriate tools. This then will create a smooth running human being.

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