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TRAINING CURRICULUM ON DRUG ADDICTION COUNSELING

TRAINER MANUAL
# TABLE OF CONTENTS

## Part I: The Basics of Individual Drug Addiction Counseling

### Chapter 1. Trainer Orientation

### Chapter 2. What is Drug Addiction Counseling?
- 2.1. Introduction to general counseling
- 2.2. Basic concepts of drug addiction counseling
- 2.3. Key principles in drug addiction counseling
- 2.4. Counseling skills
- 2.5. Counseling techniques
- 2.6. Counseling procedures

### Chapter 3. Drugs, Drug Addiction, and Treatment Approaches
- 3.1. Drugs, drug use and its consequences
- 3.2. Alcohol problems
- 3.3. The basic of addiction
- 3.4. Basic treatment principles
- 3.5. Important factors for successful treatment
- 3.6. Treatment for heroin addiction

### Chapter 4. Motivational Interviewing
- 4.1. The Stages of Change Model and key concepts in motivational interviewing
- 4.2. Principles and steps for motivational interviewing
- 4.3. Linking motivational interviewing to stages of change strategies

### Chapter 5. Key Drug Addiction Counseling Skills and Techniques (Role-play sessions)
- 5.1. Client assessment
- 5.2. Problem solving
- 5.3. Goal setting
- 5.4. Reducing risk

### Chapter 6. Relapse Prevention
- 6.1. Relapse prevention therapy
- 6.2. Refusal skills
- 6.3. Coping with cravings
- 6.4. Stress management
- 6.5. Time management
TABLE OF CONTENTS (cont.)

Part II: Advanced Individual Drug Counseling

Chapter 7. Managing Intoxication and Hostility
  7.1. Anger management
  7.2. Dealing with aggressive and potentially violent behavior
  7.3. Conflict resolution
  7.4. Managing intoxicated clients

Chapter 8. Special Populations
  8.1. Working with families
  8.2. Working with youth
  8.3. Working with women

Chapter 9. Clinical Supervision and Support
  9.1. Framework for clinical supervision
  9.2. The basics of clinical supervision
  9.3. Case conferencing
  9.4. Preventing and managing burnout

Part III: Appendices

Appendix I: Sample training schedule
Appendix II: Sample evaluation form
Appendix III: Sample written exam
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CHAPTER 8

SPECIAL POPULATIONS

Unit 8.1: Working with Families  3
Unit 8.2: Working with Youth  43
Unit 8.3: Working with Women  67
Unit 8.1
WORKING WITH FAMILIES
OVERVIEW

I. Introduction 2 Min
Introduce the unit by explaining that you will discuss how to work specifically with clients and their families.

II. Presentation and Small-Group Exercise 55 Min
Use the PowerPoint slides to present on the issues and concerns that should be addressed when working with clients and their families in drug addiction treatment counseling.

III. Role-Play 30 Min

III. Conclusion 3 Min
Review the key points of this unit and answer participants’ questions (if any).

Unit 8.1: Working with Families

Goal: To help participants understand the basic principles of working with clients and their families in drug addiction treatment counseling.

Time: 90 minutes

Objectives: At the end of this unit, participants will:
- understand the role of families in recovery
- understand the effects that substance use has on families
- understand how families can provide enhanced support to recovering drug users
- understand the key elements of a supportive meeting with families

Methodology:
- Presentation and discussion
- Small-Group Exercise
- Role-Play

Teaching aids:
- PowerPoint slides
- LCD projector
- Flipchart and paper
- Markers
MEETING WITH FAMILIES TO ENHANCE SUPPORT

▶ Say: In this unit, we will discuss the role that families can play in recovery and enhancing support for the recovering drug user. We will focus on the kinds of information and advice counselors can provide, in addition to catered psychosocial support. We will not have an opportunity to cover family therapy, which requires additional training.
LEARNING OBJECTIVES

By the end of this unit, participants will:

- understand the role of families in recovery
- understand the effects that drug addiction has on families
- understand how families can provide enhanced support to recovering drug users
- understand the key elements of a supportive meeting with families

Teaching instructions: Use the bullets on the slide to present directly.
Teaching instructions: Divide the participants into 3 small groups. Ask each group to consider 1 of the 3 questions on the slide (make sure each group chooses a different question). Provide them with 15 minutes to brainstorm answers to their question, and ask 1 participant from each group to report back (5 minutes). Use the information below to fill in the gaps, based on the participants’ answers.

FYI: The family has a central role to play in the treatment of any health problem, including drug addiction. Family work has become a strong theme of many treatment approaches, but the broadening of the drug addiction treatment focus from the individual to the family remains a primary challenge.

Though drug addiction counselors should not practice family therapy unless they have proper training, they can be informed about family therapy in order to discuss it with their clients, and in order to know when a referral is appropriate. Drug addiction counselors can also benefit from incorporating family therapy ideas and techniques into their work with individual clients, groups of clients, and family groups.

What is a family?

There is no single definition of family. However, several broad categories encompass most families who live together in the same house with their offspring:

- Traditional families (two parents, male and female)
- Single parents
- Foster relationships
- Grandparents raising grandchildren

KEY QUESTIONS ABOUT SUBSTANCE USE AND THE FAMILY

- How do families differ in Vietnam? (What is the range of family structures?)
- What impacts does substance use have on families?
- How can drug counselors work with families in a supportive way?
Stepfamilies

Extended families, which include grandparents, aunts, uncles, cousins, and other relatives

Elected families, which are joined by choice, not by the usual ties of blood, marriage, and law (examples include youth who choose to live among peers; godparents and other non-biologically related people who have an emotional tie; and same sex parents)

For practical purposes, family can be defined according to an individual’s closest emotional connections. A counselor or therapist cannot determine which individuals make up the client’s family; rather, counselors can ask, “Who is most important to you?” This allows clients to identify who they think should be included in therapy.

Families in Vietnam

While the description of family above is more global and includes family types from around the world, traditional and extended families in Vietnam are unique. The members of these families are the people that counselors are most likely to be working with.

Impact of drug addiction on families

When a family member uses drugs, the effect on the family may differ according to family structure.

Client lives alone or with partner. The consequences of drug addiction on an adult who lives alone or with a partner are likely to be economic and psychological. Users often need substantial funds to buy drugs, and non-using partners often assume a provider role. Psychological consequences may include denial or protection of the user, chronic anger, stress, anxiety, hopelessness, neglected health, shame, stigma, and isolation.

Client lives with spouse (or partner) and children (minors). A parent's substance use can have cognitive, behavioral, psychosocial, and emotional consequences for children, including:

- impaired learning capacity
- a propensity to use substances
- adjustment problems, including increased rates of divorce, violence, and the need for control in relationships
- other problems such as depression, anxiety, and low self-esteem

In addition, the children of women who use alcohol during pregnancy are at risk for the effects of fetal alcohol spectrum disorders.
Children of drug users often feel guilty and responsible for their parent’s addiction. Older children may be forced prematurely to accept adult responsibilities, especially the care of younger siblings.

**Client is part of a blended family.** Many people who use drugs belong to stepfamilies. Drug addiction can intensify problems and impede a step-member’s integration and general stability.

Drug addiction in this case may lead to parental authority disputes, sexual or physical abuse, and self-esteem problems for children. Drug addiction by stepparents may undermine their authority, lead to difficulty in forming bonds, and impair a family’s ability to address problems and sensitive issues. The children of blended families often live in two households in which boundaries and roles can be misunderstood or vague. Without good communication and careful attention to areas of conflict, children may be at increased risk of social, emotional, and behavioral problems.

**Older client has grown children.** Older adults often live with, or are supported by, their adult children because of financial necessity. Whether grown children and their parents live together or apart, the children must take on a parental, caretaking role in this case. Adjustment to this role reversal can be stressful, painful, and embarrassing, even without the complication of drug addiction.

In some cases, grown children may stop providing financial support because it is the only influence they have over the parent. Some adult children may support the drug use. In other instances, children may cut ties with the parent because it is too painful to have to watch the parent’s deterioration. Cutting ties only increases the parent’s isolation and may worsen drug addiction.
Slide 4

**LEVEL OF INVOLVEMENT WITH FAMILIES**

- **Level 1 - Counselor has little or no involvement**
- **Level 2 - Counselor provides information and advice**
  - Advise families on how to handle the client’s needs
  - For large or demanding families, communicate through one or two key members
  - Identify major family dysfunction that interferes with drug addiction treatment
  - Refer family for specialized family therapy
- **Level 3 - Counselor provides family with psychosocial support**
  - Elicit and empathize with family members’ concerns and feelings related to client’s condition and effect on family
  - Conduct preliminary assessment of family’s level of functioning as it relates to client’s issues
  - Support family members to cope with situation
  - Tailor drug addiction education to unique needs, concerns, and feelings of family
  - Identify family dysfunction and appropriate referral recommendations
- **Level 4 - Counselor provides systematic assessment and interventions**
- **Level 5 - Family therapy**

**Teaching instructions:** Use the information below to highlight the varying degrees of counselor involvement with family members of clients.

**FYI:** Drug addiction treatment professionals intervene with families at different levels during treatment. These levels vary according to how individualized the interventions are to each family, the extent to which the drug addiction treatment provider is trained and supervised in family therapy techniques, and the extent to which family therapy is integrated into the process of drug addiction treatment.

At each level, family intervention has a different function and requires its own set of competencies. The family’s acceptance of problems and its readiness to change determine the appropriate level of counselor involvement with that family.

This unit focuses on skills for Levels 1-3. Levels 4 and 5 are beyond this course.

**Level 1 - Counselor has little or no involvement with family**

The counselor:

- contacts families for practical and legal reasons only and provides no services to them
- views the individual in treatment as the only client. There may even be times when counselors feel that the client must have limited or no family contact.
Level 2 - Counselor provides information and advice

The counselor:
- advises families about how to handle the rehabilitative needs of the client
- channels communication through one or two key members
- identifies major family dysfunction that interferes with drug addiction treatment
- refers the family for specialized family therapy treatment

Level 3 - Counselor provides family with psychosocial support

The counselor:
- asks questions that elicit family members’ expressions of concern and feelings related to the client’s condition and its effect on the family
- listens empathetically to family members’ concerns and feelings and, where appropriate, normalizes them
- conducts a preliminary assessment of the family’s level of functioning as it relates to the client’s issues
- supports family members to cope with the situation
- tailors drug addiction education to the unique needs, concerns, and feelings of the family
- identifies family dysfunction and appropriate referral recommendations

Level 4 - Counselor provides systematic assessment and interventions

The counselor:
- engages family members, including reluctant ones, in a family conference or a series of conferences
- conducts a conference with a poorly communicating family in such a way that all members have a chance to express themselves
- systematically assesses the family’s level of functioning
- supports individual members while avoiding coalitions
- reframes the family’s definition of its problem in a way that makes problem solving more achievable
- helps family members generate alternative, mutually acceptable ways to cope with difficulties
Level 5 - Family therapy

The counselor:

- interviews families or family members who are difficult to engage.
- efficiently generates and tests hypotheses about the family’s difficulties and interaction patterns.
- helps to escalate conflict in the family in order to break a family impasse
- constructively deals with a family’s strong resistance to change
- negotiates collaborative relationships with other professionals who are working with the family

It is likely that you will be providing counseling at Levels 2 or 3. Levels 4 and 5 require skills that are beyond the scope of this course. The remainder of this unit will cover the activities and role you should you play in providing support at Levels 2 and 3.
FAMILY THERAPY VERSUS DRUG ADDICTION COUNSELING

- What is family therapy?
  - Collection of therapeutic approaches
  - Family-level assessment and intervention
- What is the difference between drug addiction treatment and family therapy?
  - Unit of treatment is the family - NOT the client with the drug problem
  - Different approach to problems and solutions

Teaching instructions: Use the information below to assist you in presenting on the differences between family therapy and drug addiction counseling.

FYI: Family therapy is a collection of therapeutic approaches to family-level assessment and intervention. A family is a system, and in any system each part is related to all other parts. Consequently, a change in any part of the system will bring about changes in all other parts. Therapy based on this point of view uses the strengths of families to bring about change in a range of diverse problem areas, including drug addiction.

NOTE: Family therapy can only take place when the safety of all participants can be guaranteed and no legal constraints preclude it.
There are a number of benefits and limitations to integrated treatment with family support.

FYI: Benefits to clients

Examining drug addiction through the dynamics of the whole family has a number of advantages.

- Family involvement in drug addiction treatment is positively associated with increased rates of entry into treatment, decreased dropout rates during treatment, and better long-term outcomes.
- When family members understand how they have participated in the client’s drug addiction and are willing to support the client’s recovery, the likelihood of successful, long-term recovery improves.
- When families are involved in treatment, the focus can be on the larger family issues, not just drug addiction.
- Integrated models can help reduce the impact and recurrence of drug addiction in different generations.

Benefits to providers

In addition to the benefits for clients and their families, integrated models are advantageous to treatment providers.
Integrated models:

- permit counselors to attend to the specific circumstances of each family in treatment, thus reducing resistance
- enable counselors to tailor treatment plans to reflect individual and family factors
- enable counselors to adjust treatment approaches according to their own personal styles and strengths (different treatment models can be used within the same agency to meet both client and counselor needs)

Drawing from different traditional therapy models challenges counselors to be creative in their treatment approaches. With integrated models, for instance, drug addiction treatment counselors can work with family members and see how each of their problems affect the family as a whole.

Despite their obvious value and demonstrated efficacy, integrated models for drug addiction treatment with families have some limitations.

- Not for every family
- Require greater knowledge of more treatment modalities, so additional training is necessary.
- Counselors need to understand how to shift from an individual model concentrating on the client to a systemic (relational or behavioral) model focused on changing patterns of family interaction.
Now we will discuss preparation for the initial meeting and the process and stages that you should go through with your client, as well as the things to keep in mind when working with a family. We will finish this unit with a role-play, and you will also have a chance to practice developing a family-inclusive treatment plan.
It is critical to ensure that your client is psychologically prepared for family counseling. Your client is likely to see him/herself as your primary client (not his or her family) and you must be aware that your client will need your support and encouragement to understand that you are there to support him/her. You also need to be seen by the family as objective. Do a preliminary counseling session to prepare your client.

Reassure your client that nothing you have discussed will be revealed to the family members unless your client expressly wishes you to say it (or wishes to tell his/her family on his/her own). Likewise, you must explain to the family that you cannot reveal information from individual client sessions so that they do not have false expectations that you are going to tell them what is wrong with their family member.

In some instances, you will need to speak up if the session gets intense and negatively directed at your client, or if your client is not able to speak up against his/her family when appropriate. You need to find ways in which you can advocate for your client while respecting the statements and points of view of family members.

Your next session should be a debriefing of the family session, and you may want to find out what happened after the session. For some, these sessions may be triggers for relapse, and you need to support and protect your client.

Finally, during family meetings you should build an alliance with all the participants, as these sessions are likely to be periodic, but ongoing.
Most importantly, in preparation for the family session you should do the following:

1. Provide counseling sessions for your client
2. Identify your client’s problems
3. Identify family-related problems (such as whether your client is having problems with, or seeking support from his/her family)
4. Discuss your client’s action plan in working with his/her family

You will also need to address some of the practical elements of having a joint session between your client and his/her family. This includes ground rules.
Say: In preparation (meaning prior to the session) you must take care of the following:

- Structure each meeting by setting an agenda
- Define the meeting contents based on analysis of client’s needs and expectations
- Contact client’s family members for an agreement on the meeting plan: participants, venue, time and content
- Decide who will be the focal contact person for the meeting

**MEETING OUTLINE AND PROCESS**

- Structure each meeting by setting an agenda
- Define the meeting contents based on analysis of client’s needs and expectations
- Contact client’s family members for an agreement on the meeting plan: participants, venue, time and content
- Decide who will be the focal contact person for the meeting
Say: In the opening moments of the session, you must lay down the ground rules for the meeting. The ground rules should include the following:

- Counselors cannot reveal information from individual client sessions
- Both client and family members must listen to each other without interruption
- Participants should avoid raising the past and focus on the future
- Participants will take time out when there is conflict
- Participants should aim to finish on a positive note
- Feedback will be provided in the following way: first on what worked well, and second on what can be improved

It is important that we recognize the past, but not focus on it. It is far more productive to focus on the present and the future, and what positive outcomes we would like to achieve.
Now that you have prepared the groundwork for the family-inclusive session, you may still need to reiterate for both you and your client what the session will entail.

The first interaction is critical. If you do not gain the support of the family at this stage, you may do more harm than good. You must ensure that there are clear goals understood by all. You must be in-charge, remain objective, guide the interaction in a respectful manner, and be prepared to be forceful if the situation gets out of control.

It is critical that you do the following:

- **Build effective communication strategies.** Both you and family members need to be active listeners. You will need to summarize what you have heard before you provide your opinion or thoughts. It is important that the family also does this when discussing issues with your client so that your client knows that the family has heard his/her concerns.
- **Both you and the family must support and reward safe behaviors such as abstinence, and the use of appropriate coping, negotiation and resiliency skills.**
- **Both you and the family must also set limits and clarify the consequences for violating those limits.** This will allow families to clarify their expectations of your clients, as well as the ramifications for not meeting those expectations.
- **You should ensure that your client has the appropriate coping with cravings skills and sufficient support to prevent relapse.**

So what are some goals that you and your client and his/her family might set for these sessions?
Teaching instructions: Use the information below to help present on the various goals of the family counseling session.

FYI: Counselors must be aware that the inclusion of the family in counseling sessions is a process, just as is client recovery. Counselors should prepare clients in a prior session and ask them about their concerns and desires for the family session. This may, depending on the assessment, be the first topic to be addressed.

NOTE: Counselors should only cover a limited number of topics in each family session and should not attempt too much. Topics can be spread over several meetings. Specific goals might include the following:

- **Acknowledge what the family has gone through.** Have everyone recognize that they have all been affected by substance use. Process some of these feelings, but do not let the session turn into an attack on the client. See if they can focus on some positive family aspects, not just the negative aspects. WHETHER OR NOT A FAMILY OPENS UP IS DEPENDENT ON THE RELATIONSHIP YOU HAVE ESTABLISHED. Do not expect too much in your first few sessions.

- **Educate the family about the process of change.** Just because they have a family member that is addicted to drugs does not mean that they understand that this is a disorder and that the individual is sick and needs help and support. They also need to be educated not only on the basics of addiction, but also what it means to be an enabler, and on the basics of chronic relapsing disorders.

GOALS

- Acknowledge what the family has gone through
- Educate the family about drug addiction and change
- Educate the family about cravings, lapses and relapses
- Rebuild trust between the client and his/her family
- Build effective communication strategies
- Support and reward safe behavior
- Set limits and consequences
- Spend time together
Rebuild trust between the client and his/her family. A major task in family recovery is building trust between the user and his/her family. Family members will, at first, be very concerned about how the client will behave. Will he/she steal, work, be lazy or reliable? This is an ongoing process; one session is not likely to build the trust needed for all family members to move forward.

Build effective communication strategies. Utilize the principles of motivational interviewing and effective feedback.

Support and reward safe behaviors. Success builds success.

Set limits and consequences. How can the family do this safely and effectively?

Educate the family about cravings, lapses and relapses. They may not understand these issues at all.

Spend time together. Encourage the family to spend time together and to get to know each other again.
Say: Now we will discuss important steps to take while meeting with families.
Say: It is important for you to spend time at the beginning of the first session to get to know the family members. Establish basic communication ground rules together. You will begin to know each member through his/her participation in the session.

During your session you will also see how the family interacts. Remember:

- Family members may be at different stages of coping
- Allow time for the family to explore their understanding of drug addiction
- Acknowledge and validate previous efforts to find solutions to difficulties they have encountered - this is an opportunity to voice their concerns and needs
- Use reflective listening (e.g. listen and reflect back what you have heard)
- When appropriate, reassure the family that they are participating as expected - remember to look for ways they can support your client
- You should not necessarily provide solutions to every problem - imposing a fixed solution might not work for every family
- At the end of the session, offer the family members supportive self-help material related to substance use or topics raised in the session
**Say:** Families are often most concerned about whether or not their family member can be cured. You will need to be clear about the nature of addiction and that it is chronic relapsing disorder. You should always allow time for families to ask you or your client questions about his/her treatment plan and progress.

You should also be prepared to discuss the nature of change. Families should understand that the timing is customarily slow and evolutionary. You may wish to engage the family in your client’s treatment hopes and goals, and realistic timing for achieving those goals, to ensure they understand the process of recovery.

Both family members and recovering users need to understand the concept of relapse and how families can assist with preventing relapse.

Be prepared to diffuse conflicts by finding agreements or compromises between families and your clients. By using reflective listening and summarization, you can focus on points of common interest and ensure that everyone is on the same page.
Your client is likely to have a long history of substance use during which he/she may have destroyed family ties and relationships. Your client’s placement in the family (husband, mother, oldest or youngest brother or sister, etc.) will have had unique consequences. You may need to address a history of conflict and poor conflict resolution. One of your challenges will be to spend some time helping your client and his/her family to rebuild trust.

You can do this in a variety of ways. You may want to use open discussion, story telling and illustration. You may encounter families that are generally conflict avoidant, especially in the first session. You will need to be creative in raising and addressing conflict. This slide includes some key points that may assist you in addressing conflict and trust issues.

- Invite each person to talk about their underlying concerns
- Reflect points of positive concern (such as parents’ desire to protect their child)
- Seek recognition of changes that have already been made
- Try to balance problem-focused questions with solution-focused questions
Triggers are situations, events or issues that can cause lapse or relapse among recovering users. Blame can also be a trigger. This slide demonstrates how a cycle of blame can increase risk for recovering users. In this example, a parent wants to protect her child and believes that the child needs constant reminding to avoid a specific behavior (say, hanging out with an old friend who uses drugs). The parent is just trying to be supportive. However, in this example, the parent frames things in terms of previous failures, not in terms of avoiding a current risk. Your client may see things from a different perspective: “My parent doesn’t trust me”. This perceived blame may lower your client’s self-esteem or upset your client. So, instead of supporting your client, the parent has inadvertently placed your client at greater risk.

What can family members do to support a recovering drug user when they are concerned about risk?
There is no one specific method for supporting and rewarding safe behavior and addressing trust. You will need to utilize both the individual session with your clients and the family sessions to find the best approach.

How might you accomplish this during your session with the family?

Assist your client and his/her family in developing strategies for supporting and rewarding participation in ‘safe’ situations.

1) Begin by inviting everyone to contribute his or her ideas
2) Generate two lists: a ‘safe situations’ list, and a ‘risky situations’ list
3) Be sure to balance protecting your client from risky situations with giving him/her a sense of freedom and responsibility
4) Discuss how some of your client’s behaviors support recovery and how some place him/her at risk
**SUPPORTING AND REWARDING SAFE BEHAVIOR (2)**

- Help the family develop a plan and strategies that:
  - promote participation in safe situations
  - reduce involvement in risky situations
- Review progress
- Make adjustments
  - Use a problem-solving approach

**Say:** Be sure that the plan will:

- promote your client’s participation in safe situations
- reduce your client’s involvement in risky situations

You should also be sure to:

- review progress
- make adjustments to the plan as the family progresses during these family sessions
- use a problem-solving approach

**Note:** Sometimes recovering drug users place themselves at risk and their family is not aware.

Another approach to address trust is to work together to determine what is a ‘safe’ or ‘risky’ situation. Ask open-ended questions to determine risky and safe situations. Then get each person to think through the list of risky and safe situations from the other person’s point of view.

Ask your client:

“If you go into this situation, what do you think your parents will be worried about?”

Ask your client’s family members:

“What do you think your family member (son/daughter/brother/sister/husband/wife) is seeking in this situation?” These approaches are challenging because each family situation is different, and you cannot predict where these questions will lead. You must assess the situation and make appropriate adaptations to these strategies. These strategies do not work for all families.
There are instances where your client and his/her family may need to establish limits and consequences for breaching the limits. It is critical that families clearly state the boundaries (e.g. You must be home by 10PM). The consequences for breaching boundaries must be agreed upon by the client. These consequences must be applied consistently but not in an overly harsh manner. This allows your client to take responsibility for his/her actions.

**ESTABLISHING LIMITS AND CONSEQUENCES**

- Consequences for breaching limits should be:
  - stated clearly and applied consistently
  - developmentally appropriate
  - acceptable to the young person
- Will not work without client's agreement
- Should not be overly harsh

▲ **Say:** There are instances where your client and his/her family may need to establish limits and consequences for breaching the limits. It is critical that families clearly state the boundaries (e.g. You must be home by 10PM). The consequences for breaching boundaries must be agreed upon by the client. These consequences must be applied consistently but not in an overly harsh manner. This allows your client to take responsibility for his/her actions.
\textbf{Say:} One area that requires focus and is often neglected is strengthening of family ties. You may want to recommend that the family spend targeted, focused time together outside of therapy.

Drug use often deteriorates the bonds between family members and non-drug-using friends. Clients need to learn to rebuild these bonds and to feel comfortable spending time with non-drug-using family members and friends. You may want to have both your client and his/her family members explore and explain separately how they might strengthen their relationships by spending more time together and improving communication.

You might want to ask them when the last time was that they all had a good time together. What did they do?
Your client and his/her family may wish to engage in monitoring and responding to high-risk situations. It is critical that your client feels comfortable disclosing potential triggers and cravings to use. Families should know the difference between a slip, lapse and relapse. Ideally, your client should want to share his/her challenges and problems with his/her family such that both your client and his/her family can focus on recovery.

Families may be able to identify early warning signs and behaviors associated with relapse. Families also need to know that addiction is a chronic relapsing disorder and that relapse is a normal part of recovery. It is critical that your client receives support both from you and his/her family to return to sobriety if a slip occurs. It is also important that both clients and families understand that disappointment is natural and it will not help to dwell on it. Both clients and families should maintain a focus on self-control and sobriety.

The involuntary government 06 rehabilitation center punitive consequences for relapse make the situation more complicated in Vietnam. You will need to be aware of the potential for entry or return to 06 centers and consider this while developing a monitoring plan with your clients and families.
CONSIDERATIONS BEFORE CLOSING A SESSION

- Summarize the positive points or outcomes of the session
- Focus on the things you would like to see occur differently in future sessions
- Summarize activities and/or homework client/family members will do before next session (if any)

▲ Say: Just as you establish the purpose and objectives of the session when you begin, you should reinforce these and include some additional points when you close. Remember not to rush the closing session.

At minimum, be sure to do the following:

- Summarize the positive points or outcomes of the session
- Focus on the things you would like to see occur differently in future sessions
- Summarize any activities or homework that your client and/or family members should perform by the next family session

Make sure during discussion with the family that you do not label the client as the problem. Rather, frame the problem as the substance use and its impact on everyone, not just the client.
FAMILY COUNSELING Role-Play

- **Five roles:** counselor, client, mother, brother, and uncle
- **Time:** 40 minutes
- **Objectives:**
  - Discuss current problems of the client; agree on a plan that can help client stay away from heroin with the strong support from family members
  - Provide family members with information about stages of change, the difference between slips, lapses, and relapses, and how to support client
- **Results:** A specific plan to which everyone agrees

**Teaching instructions:**
Ask for 5 volunteers from the participants who feel comfortable conducting a role-play in front of the group.

Assign the following roles: Mother, Brother, Uncle, Client, and Counselor.

Using the information in the slide, review the objectives of the role-play with the volunteers, and encourage them to get into character.

You will need to provide the volunteer designated as the counselor with a layout for a treatment plan, to be completed with the family. An example might include the following:

**Name of Client:**

**History of Client:**

**Family members present:**

**What are the concerns of each member?**
- Mom
- Brother
- Uncle
- Client
What decisions were discussed and agreed upon with the family and client?
Areas to be addressed?
How will they be addressed?
Activities to be completed?

What are the next steps in the plan/approach?

Who is responsible for each step?

Continue to the next slide and read the background information together with the larger group to set the stage for the role-play, and then allow the group to play out the scenario (20 minutes).
ROLE-PLAY DETAILS

- **Background:**
  Minh Tuan, male, 18 years old, grade 12 school student, single, living with mother and brother. Father died. Family is poor. Mother runs a street-based teashop; brother works outside to earn a living for the whole family.

- **History of drug use:**
  Started smoking heroin at 16; changed to injecting one year later. Has not shared N&S. Injected 3 times/day (150,000vnd/day) before treatment. HIV status unknown. Currently not using drugs for two months as forced to quit by family - quit by staying at home.

**Teaching instructions:** Read the information on the slide slowly to allow the participants to hear the details for this scenario. Then proceed to the next slide.
ROLE-PLAY DETAILS

Family relations:
- **Mother:** Takes care of client the most - does not allow client to go out to hang out with his friends
- **Brother:** Also cares for client, but often blames and shouts at client, thinking it will work. He is the main supporter of the family. Thinks that “He (client) doesn’t know how hard it is to earn a living. We had to be strict about his drug use. We took him to a government 06 center for treatment because we suffered enough because of him. Father died because of him, too.”
- **Uncle:** Has significant influence on client’s family, especially the brother. Psychologically supports client’s family after father died.

Teaching instructions: Read the information on the slide slowly to allow the participants to hear the details for this scenario. Then proceed to the next slide.
ROLE-PLAY DETAILS

- **Client’s problems:**

  The client is in conflict with his brother regarding how to deal with his addiction to heroin. His mother doesn’t want to send him to the 06 center for treatment, but is confused about how to control his drug use at home. He is suffering from cravings and these worsen due to troubles with his brother and mother.

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**Teaching instructions:** Read the information on the slide slowly to allow the participants to hear the details for this scenario. Then proceed to the next slide.
Teaching instructions: Once everyone is clear on the scenario, allow the group to begin its family counseling role-play. Allow between 15-20 minutes for the role-play. Once the role-play is over, facilitate a large-group discussion with all participants, using the suggested queries below as a guide.

What are some of the strengths of the plan? What might be some potential challenges?

What issues arose during the role-play? Conflict? Lack of communication? Breach of the ground rules? What else?

How did the counselor handle these difficulties? What could have been done differently? How?
Teaching instructions: Review the key points of this unit. Use the bullets on the slide to present directly.

Thank the participants for their participation in the discussions and ask them if they have any questions. Answer the questions that pertain to this or previous units. If participants ask questions about material that will be covered in a later unit, request that they save their questions for that unit.

**SUMMARY**

- Families can contribute to maintaining stability and abstinence, and provide support and rewards for safe behaviors.
- Family involvement requires client consent.
- Ground rules need to be established as part of the first meeting.
- Counselors need to help clarify expectations, build trust, and educate the family.
- Families need to be aware of destructive information sharing.
- Families should look toward the future rather than concentrating on past failures.
- Families that spend time together can promote positive behaviors.
OVERVIEW

I. Introduction 2 Min
Introduce the unit by explaining that you will discuss the special issues to be addressed when working with youth and adolescents in drug addiction treatment.

II. Presentation 55 Min
Use the PowerPoint slides to present on working with youth.

III. Conclusion 3 Min
Review the key points of this unit and answer participants’ questions (if any).

Unit 8.2: Working with Youth

Goal: To help participants understand the basic principles of working with youth and adolescents in drug addiction treatment counseling.

Time: 60 minutes

Objectives: At the end of this unit, participants will:
- understand that adolescence is a developmental stage in life
- know how to identify possible significant others and how they may impact young people’s drug use
- have explored some clinical strategies that assist in working with young people
- begin discussing risk-reduction approaches to working with young clients
- develop skills on initiating drug use discussions and developing therapeutic relationships with young people

Methodology:
- Presentation and discussion
- Small-Group Exercise

Teaching aids:
- PowerPoint slides
- LCD projector
- Flipchart and paper
- Markers
Slide 1

WORKING WITH YOUTH

Say: In this unit, we will discuss the special issues to be addressed when working with youth and adolescents in drug addiction treatment.
OBJECTIVES

By the end of this session, participants will:

- understand that adolescence is a developmental stage in life
- know how to identify possible significant others and how they may impact young people's drug use
- have explored some clinical strategies that assist in working with young people
- begin discussing risk-reduction approaches to working with young clients
- develop skills on initiating drug use discussions and developing therapeutic relationships with young people

Teaching instructions: Use the bullets on the slide to present directly.
SMALL-GROUP EXERCISE

What......

- are the challenges of working with adolescents?
- should you focus on during a counseling session with adolescents?
- are the issues that may affect the outcomes of the counseling session?
- are the issues that may affect young clients’ ability to stop using drugs?

Teaching instructions: Divide the participants into 4 groups and ask each group to address 1 of the questions on the slide (be sure that each group addresses a different question than the other groups). Ask them to brainstorm answers to their question and write down whatever comes to their minds. Allow the groups about 5 minutes to brainstorm and record their ideas. Then ask a member from each group to report back to the large group on their findings (10 minutes).
We can divide up the characteristics you discussed in your groups into 3 main categories: physical, behavioral and emotional.

Let’s discuss physical first. Adolescents undergo tremendous physical change during adolescence. The brain undergoes change all the way through the late teens and, for most, into the early twenties. In addition to this, there are other features.

Characteristics of males include:

- Larger growth
- Facial and pubic hair grow
- Testes enlarge and the voice changes
- Male hormone testosterone increases dramatically
- Stronger

Characteristics of females include:

- Breast development
- Menstruation begins
- Hormone levels also begin to change

For both males and females:

- Wisdom teeth
- Sexuality issues and sexual desire increase
- Acne
They also undergo **behavioral changes:**

- Become more adventurous and experimental
- Are more likely to take risks
- Clumsy
- Explore
- Want to be the winner
- Feel ‘immortal’ in the face of danger and physical risks
- Go through a period of rebellion where they are trying to find out who they are - this often results in rebellion against parents and bonding with peer groups

In addition to the physical and behavioral changes, they also undergo **emotional changes:**

- Often do not think about the long-term consequences of their actions
- Need acceptance and status among their peers
- May be unpredictable in terms of mood and behavior
- May have difficulty handling stress and frustrations
- May have difficulty talking about their own feelings
- Argue easily
- Show off
- Want to be treated as adults
- Have mood swings
NORMAL DEVELOPMENTAL TASKS OF ADOLESCENCE

- Adjust to physical changes
- Learn to understand and take responsibility for their sexuality
- Work towards independence from parents
- Develop a sense of who they are (personal identity)
- Develop social and working relationships
- Choose and make plans for a career

**Say:** *During their development, adolescents not only experience these physical, behavioral, and emotional changes, but they also must develop techniques for coping and adjusting to these changes.*

They need to:

- learn to understand and take responsibility for their sexuality
- work towards independence from their parents
- develop a sense of who they are (personal identity)
- develop social and working relationships
- choose and make plans for a career
**Teaching instructions:** Divide the participants into groups of 5. Ask the question below and allow the groups 10 minutes to brainstorm answers to the question.

**Say:** What does this city under development have to do with adolescent development?

**Teaching instructions:** After allowing about 10 minutes for group work, take 5 minutes to go around the room and ask each group to report out their thoughts. Use the information provided below to fill in the gaps that participants may not have addressed in their discussions.

**FYI:** The picture is a construction site, a metaphor for the developmental processes that occur in adolescence. The metaphor works for the physical, emotional and behavioral aspects of adolescence, in addition to relating to what is happening in the brain. Connections in the brain are actively growing and changing as part of adolescent development. Adolescents are also reacting to the changing environment in which they live. There is an interactive, developmental process that occurs during adolescence which contributes to adaption, but which can also contribute to the emotional chaos of adolescence.

The main point is that young adults are a mix of grown and growing components that are ever adapting and changing.

**Say:** Next we will discuss the brain and how these developmental issues, in addition to adolescent brain development, have important implications for dealing with adolescent drug users.
CONSTRUCTION AHEAD

- During late childhood, the number of connections between neurons increases.
- However: for girls (around age 11) and boys (around age 12½) - some of these connections are removed naturally.

**Say:** During late childhood, the brain’s cells (neurons) and their connections (dendrites) increase. By the end of childhood, the brain has 1,000,000,000,000,000 (one quadrillion) connections!

But around age 11 in girls and 12½ in boys, some of these connections are pruned off.

The brain controls our behaviors and our thoughts. Both overt behavior and consciousness are manifestations of the brain. While other people can see an individual’s overt behaviors, consciousness is apparent only in an individual’s mind.

**FYI:** Different regions of the brain regulate different functions

How does the brain carry out multiple tasks at one time? The answer is that the brain splits the larger task—driving, for example—into smaller ones: seeing, hearing, moving, and so forth. Even those tasks are split into their component parts. One part of the brain analyzes the movement of objects that we see, while another part is responsible for recognizing them. In short, specific parts of the brain carry out specific tasks. This means that whenever that task needs to be done, the appropriate information is processed by that part of the brain.

In the case of decision-making about drug use, different parts of the brain have different functions. The front of the brain, which is called the forebrain, has executive responsibility of making decisions about risk. It is a highly developed area that has the ability of abstract thought and planning, and of the association of thoughts with memories. The mid-brain is the region that contains areas that are important for motivation and learning about important environmental stimuli, and reinforcing behaviours that are pleasurable and life sustaining. These two areas of the brain developed at different rates and are critically evolving during adolescence. The midbrain matures before the forebrain. Consequently,
many adolescents perceive dangers but do not know how to respond to them in a safe or appropriate way. One of the many dangers they will face is pressure to try various drugs.
CONSTRUCTION AHEAD

- When the pruning is complete, the brain is faster and more efficient.
- But... during the pruning process, the brain is not functioning at full capacity.

**Say:** When the pruning is complete, the brain is faster and more efficient. But, during the pruning process, the brain is not functioning at full capacity.

Because the pruning process occurs in stages throughout the brain, it is informative to examine this process in more detail.
Say: The pruning of brain neurons generally occurs from the back of the brain to the front. Thus, neurons at the back of brain finish the pruning first, making these neurons the first to mature. Neurons at the front of the brain finish pruning last, and it is these neurons that do not complete maturation until about age 24.

FYI: There are 4 primary brain structures from the back to the front of the brain – the cerebellum, nucleus accumbens, amygdala and prefrontal cortex – that are noteworthy in terms of how their different development may impact adolescent behavior. The nucleus accumbens and amygdala are in the midbrain.

The first area to complete pruning is the cerebellum. Located at the back of the brain, this structure controls physical or motor coordination.

Next are the nucleus accumbens, which is responsible for motivation, and the amygdala, which identifies and controls emotion. The nucleus accumbens is responsible for how much effort the organism will expend in order to seek rewards. A developing nucleus accumbens is believed to contribute to the often-observed tendency for teenagers to prefer activities that require low effort yet produce high excitement. Real world observations support this: teenagers tend to favor activities such as playing video games, skate boarding, and substance use. The amygdala is responsible for integrating how to react emotionally to pleasurable and aversive experiences. It is hypothesized that a developing amygdala contributes to two behavioral effects: the tendency for adolescents to react to situations with “hot” emotions rather than more controlled and “cool” emotions, and the propensity for youth to misread neutral or inquisitive facial expressions from other individuals as a sign of anger. (Instruct parents: “Smile as you ask your teenager ‘How was school today?’”)
One of the last areas to mature is the prefrontal cortex, located just behind the forehead. Sometimes referred to as “the seat of sober second thought,” it’s the area of the brain responsible for the complex processing of information, ranging from making judgments, to controlling impulses, foreseeing the consequences of ones’ actions, and setting goals and plans. An immature prefrontal cortex is thought to be the neurobiological explanation for why teenagers show poor judgment and too often act before they think.
**Say:** At last, most people's brains achieve a balance by age 24.
Say: Let us take a few moments to summarize our understanding of the brain and the particular areas we need to keep in mind when working with adolescent clients.

The areas we have discussed include the midbrain (including the mesolimbic region), which is responsible for motivation, exploration and learning, social behavior and impulse control; and the prefrontal cortex, which is responsible for executive function, including goal setting, planning, priority setting, and impulse inhibition.

Changes that occur in the brain through pruning and rewiring are partially in response to experiences, traumatic or nurturing incidents, genetic makeup, and the environment. This can be described in terms of the brain’s plasticity or vulnerability. Remember that the adolescent brain is under construction and goes through a constant series of changes and adaptations. It appears that the emotional brain develops before the thinking brain. Hence, adolescents may take risks without fully thinking through the consequences.

All of these developmental issues have direct implications for treatment and care for adolescent drug users.
Slide 12

**THE ADOLESCENT BRAIN: SUMMARY (2)**

- Work in progress
- Disconnect between feeling brain and thinking brain
- Susceptible to change by good and bad experiences
- Susceptible to drug rewards means that there is heightened risk of addiction

**Say:** There are a few key points about the adolescent brain I want to review before we move on.

- The adolescent brain is a work in progress
- Adolescents have twice the energy of adults, with half the self-control
- Adolescents are susceptible to change by experience: both good and bad
- Adolescents are susceptible to drug rewards, and therefore heightened risk of addiction

Adolescents also perceive risks and experience anxiety differently. Adolescents that have a low risk perception of drug taking, and do not experience the same kind of anxiety that adults do in risky situations, are more likely to engage in substance use.

*Given these issues, what treatment components are essential for an effective intervention?*
Teaching instructions: Use the information below to discuss some of the elements that make youth-focused treatment programs effective.

FYI: Effective youth-focused treatment programs employ sound assessment that identifies the severity of the problems that clients are facing, their drug use history, and existing social support. Research shows that clients who start using drugs while relatively young often have more serious problems. Client assessment should focus on physical health, alcohol and drug use, employment/education status, emotional stability, family/social support and legal issues.

Following assessment, effective programs develop individual treatment plans catered to the client, with appropriate referral services. Additional services might help young clients build self-esteem or teach them to manage highly emotional states. As obvious as the need for these services might be, this can be challenging as they are often not available, especially in resource-poor settings.

A treatment program should be comprehensive and integrate direct drug and alcohol services, with referral and support where possible, to medical care, dental care, and vocational rehabilitation etc.

Effective youth-focused treatment programs also involve families and/or caregivers in the treatment program (as appropriate). Engaging parents or primary caregivers increases the likelihood that a teen will stay in treatment and that treatment gains will be sustained after treatment has ended. In most cases, the more the family is involved, the better the outcome.
Programs should also maintain sound organizational principles, with an appropriate staff-to-client ratio, qualified and professional staff, and services that cover the continuum-of-care from prevention of drug related harms, to counseling and referral, to treatment and recovery.

Finally, effective treatment programs document treatment outcomes, in addition to process measures like numbers served and number of sessions. Documentation should include relapse rates, abstinence rates, and changes in client outcomes, including changes in housing, health, emotional stability, legal issues, and/or employment.
When working with adolescents, remember...

- Scare tactics don’t work
- Adolescents need structure and clear, fair limits
- Adolescents respond well to having freedom of choice
- Adolescents learn best by experience and need to test things out for themselves
- Adolescents like to have their privacy respected
- Try to ‘listen’ more, ‘talk to’ less
- Be available as an adult, rather than trying to be one of them
- Try not to let their challenges and/or rebellion stir you up

Teaching instructions: Divide the participants into small groups (of roughly 5). Ask the small groups to review the bullets on this slide and then ask them to discuss in their groups if there are any issues that need clarification or on which there may not be agreement. Allow them a few minutes to brainstorm, then go around the room and elicit thoughts from members of each group.
Points to be considered when working with adolescents:

- Use appropriate counseling skills and techniques
- Correct misinformation
- Counselors do not have to have been drug users to be able to counsel young people
- Don’t expect to know all the adolescent language
- Be flexible in considering treatment modalities
- Adolescents may identify more with the counselor than the agency
- It may take longer to build trust/rapport
- Abstinence may not be the goal for some adolescents
- Risk reduction may be more realistic

Teaching instructions: Ask the same small groups to review the bullets on the slide and then ask them to discuss in their groups any issues that need clarification or on which there may not be agreement. Allow them a few minutes to brainstorm, then go around the room and elicit thoughts from members of each group.
Teaching instructions: Divide all participants into groups of 3. One will be the client, one will be a family member, and one will be the counselor. Ask those who will be clients to meet with you so that you can brief them on how they should present themselves to the counselor. Do not let the counselor and the observer hear the discussion.

Tell the client the following: “You have a headache and feel tired and very irritable because you have not used for two days. You do not want to give any information to the counselor because you think he/she is the enemy, just like your parents; he/she wants to control you.”

Allow the groups to role-play for about 15 minutes. Then, ask each team member to prepare index cards with the characteristics of the client and the characteristics of the family member. Tell participants not to show these to each other.

Afterwards, ask each group to report back on what it was like, especially for the counselor. Then, ask them to tell you some of the characteristics they wrote down for the client and the family member.
Say: You may have noticed in some of the role-plays that the adolescent client exhibited a lack of trust in the counselor. The fact is, absolute confidentiality in the counseling sessions cannot be guaranteed, so you will need to discuss the limitations. Building trust may take several sessions.

In addition, a client’s attendance at one session does not guarantee that he/she will complete treatment. Often clients will skip sessions for various reasons from relapse to seemingly absurd reasons like a phone call from a friend. Do not get frustrated. Instead, look for opportunities to build trust and strengthen the therapeutic relationship.
SUMMARY

- Adolescence can be a mixture of positive and negative changes.
- These changes are behavioral, emotional and physical.
- Because of how their brains are developing, adolescents are more likely to be prone to addiction.
- Drug treatment programs catered to adolescents need to take adolescent special needs into consideration.

Teaching instructions: Review the key points of this unit. Use bullets on this slide to present directly.

Thank the participants for their participation in the discussions and ask them if they have any questions. Answer the questions that pertain to this or previous units. If participants ask questions about material that will be covered in a later unit, request that they save their questions for that unit.
Unit 8.3

Working with Women
OVERVIEW

I. Introduction 1 Min
Introduce the unit by explaining that you will discuss the issues to be addressed when working with female clients in drug addiction counseling.

II. Small-group discussion 35 Min

III. Presentation 55 Min
Use the PowerPoint slides to present on the issues to be addressed when working with female clients in drug addiction counseling.

IV. Conclusion 4 Min
Review the key points of this unit and answer participants’ questions (if any).

Unit 8.3: Working with Women

Goal: To help participants understand the basic principles of working with women in drug addiction counseling.

Time: 95 minutes

Objectives: At the end of this unit, participants will:
- understand some of the specific issues women face in drug addiction and drug treatment
- understand specific challenges women face in accessing treatment services
- know some of the effective clinical relapse prevention strategies catered to female clients

Methodology:
- Presentation and discussion
- Small-Group Exercise

Teaching aids:
- PowerPoint slides
- LCD projector
- Flipchart and paper
- Markers
- Handout #8.3 Working with women: Additional information
In this unit, we will discuss the issues to be addressed when working with female clients in drug addiction counseling.
LEARNING OBJECTIVES

By the end of this unit, participants will:

■ understand some of the specific issues women face in drug addiction and drug treatment
■ understand specific challenges women face in accessing treatment services
■ know some of the effective clinical relapse prevention strategies catered to female clients

Teaching instructions: Use the bullets on the slide to present directly.
Slide 3

Say: It is important for counselors to be aware that there has been a limited amount of research on women and drug addiction, and many of the current treatment models were generated with a focus on men. However, this is changing.

FYI: Prior to 1990s:

- Drug addiction treatment literature was based on mostly male samples or mixed-gender samples with mostly males, with very little focus on gender differences.
- Women were often excluded from studies due to their childbearing potential or other factors.
- It was unclear if effective drug addiction treatment programs could be applied the same way for women.
- No one had investigated the possibility that gender-specific issues might be relevant for treatment entry, retention, and post-treatment clinical outcomes.

From 1990 to 2006, the landscape changed.

In 1994, the National Institute of Health in the United States published Guidelines on the Inclusion of Women and Guidelines for Minorities as Subjects in Clinical Research. Since then, an increased number of published reports have examined drug addiction treatment for women. The gender differences we will explore in this unit will include differences in drug use and treatment entry. Although drug addiction does not discriminate between genders, women have special needs in recovery.

There are specific psychological and emotional problems and psychosocial factors that should be addressed in treatment planning and approaches. By addressing these needs, women can increase their chances for long-term recovery.
**Say:** Let’s try an activity to explore our thoughts about gender differences.

**Teaching instructions:** Ask the participants to find a same-sex partner (allow opposite sex partnerships if one sex outnumbers the other). Have each partnership take a piece of paper and draw a line down the middle of the page to make 2 columns. They should label one column “Men” and the other “Women.” Ask each partnership to brainstorm some of the gender-specific characteristics of men and women and write them down in the separate columns. After brainstorming for about 10-15 minutes, ask each partnership to discuss how these differences might affect the treatment and relapse prevention approaches you would use. Partnerships can use the other side of the paper to write down their thoughts. Allow about 20 minutes for group discussions on similarities and differences, and then proceed to the next slide.
Drug use among women in Asia is often considered a minor problem largely because the percentage of female IDUs is estimated at 10% or less (Reid, 2002). However, some suggest that this figure will increase and that monitoring of the situation needs to be improved. In more developed countries, such as the U.S., the U.K. and Australia, the proportion of female IDUs is often as high as 25%. In China, most drug users are men, but the number of women using drugs is increasing. In Yunnan and Guangxi provinces, women make up 16 to 25% of all drug users in treatment and tend to be younger than male drug users. Other countries in Asia where there are significant numbers of female IDUs, include Nepal, India, Pakistan, Bangladesh, Indonesia, Vietnam, Thailand, Sri Lanka, the Philippines, Taiwan, Japan and Malaysia.
**Slide 6**

**WOMEN: BIOLOGICAL DIFFERENCES**

- Higher risk of alcohol-related harms
  - Prone to alcohol-related brain damage at lower levels of drinking and in shorter time
  - Develop liver disease sooner and at lower drinking levels
  - Higher risk of developing more severe forms of liver disease

Gynecological problems such as:
- Inhibition of ovulation
- Obstetric problems
- Birth defects

**Say:** In addition to the factors we have already discussed, there are biological differences between men and women that should be taken into account when working with women. Women develop alcohol-related liver disease sooner and at lower drinking levels than males. Because of this, appropriate clinical tests should be performed during the assessment phase of treatment, as women are at higher risk of developing more severe forms of liver disease.

Women are more prone to alcohol-related brain damage at lower levels of drinking and in a shorter time than males.

Females can develop a variety of gynecological problems as a result of alcohol and drug use, such as inhibition of ovulation obstetric problems. They can also develop fetal alcohol spectrum disorders that lead to birth defects.
PSYCHOLOGICAL DIFFERENCES

- Men and women are basically alike in terms of:
  - personality, cognitive ability and leadership
- Men grasp situations on a macro level while women rely on detail and subtleties.
- Men are more likely to take risks.
- Men think more independently while women are more willing to follow suggestions.
- Women self-appraisal is lower than that of men.
- Men have pronounced needs to fulfill their goals while women rank relationships first.
- Men get sick twice as much while women tend to be more concerned about their health.
- Women endure pain and monotonous work better.

Teaching instructions: Use the bullets on the slide to present directly. Participants may not agree with all points; be prepared for questions and/or concerns.
Say: **Women have a number of unique psychosocial factors that must be addressed, in addition to coping with cravings, stress management, and triggers for relapse.**

- One study found that **74% of the female treatment population has experienced sexual assault at some time.**
- **Thirty-four percent of these women had experienced childhood sexual abuse.**
- **A recent Australian study found that 37% of women in treatment for alcohol and other drug problems had experienced childhood sexual assault.**
Sex work is found in every country in the world. Sex workers are at great risk of contracting and transmitting HIV and other STIs if they do not use condoms. However, many clients of sex workers do not want to use condoms and, for various reasons, sex workers have trouble negotiating condom use with their clients. This puts sex workers and their clients, sexual partners, and potential children at risk of contracting HIV.

When working with female sex workers (FSW) who are IDUs or female IDUs, counselors should keep in mind some of the following issues:

**Difficulty negotiating condom use.** Many women work as sex workers because of poverty: to provide the basic necessities for their families. They often have little power or training to negotiate condom use with their clients.

**Violence.** Sex workers who insist on condom use may face violence from clients and/or brothel owners.

**Youth.** Young women who are sold into sex work also have little power to insist on condom use and/or are marketed as ‘unsoiled goods’.

**Trafficking.** The trafficking of women across borders and from remote areas means they may not speak the local language; they may not understand local educational materials/messaging.

**Injecting drug use.** Women who work as sex workers and who inject drugs may contract HIV from sharing needles and syringes, even if they use condoms in their work.

**Insufficient condoms.** Sex workers may not have access to a sufficient number of condoms.
Lack of health care. Sex workers may not have access to health care to get treatment for STIs, which increases their risk of contracting HIV.
Say: Studies in Asia have shown an overlap between sex work and injecting drug use, with approximately half of female IDUs estimated to be sex workers (MAP, 2005; Tuan et al., 2004). In Guangxi province in China, 80% of female drug users are sex workers. Female IDUs may become involved in sex work to pay for their drugs. In some situations, brothel owners introduce sex workers to drugs. Also, women who are coerced or sold into sex work may resort to drug use.

**In Vietnam:**

- 20-40% female sex workers (FSW) are injecting drug users (IDU)
- FSW who are IDUs experience interdependent problems that drive them to high-risk situations

So how can we support the reduction of HIV transmission among women and increase their access to drug treatment?
Say: So why are there gender disparities in treatment-seeking behaviors?

Some women define their substance-related problem as a general health, mental health or family problem. They may seek care from non-substance use disorder settings.

There also appears to be a correlation between treatment seeking and the number of years since the onset of addiction. There appears to be little gender difference from 1-8 years, but between 8-25 years, men are 13-20% more likely to enter treatment.

The specific barriers to treatment seeking for women include the following:

- Pregnancy
- Lack of childcare
- Economic barriers
- Higher perceived stigma for alcohol and drug use (than for males)
- Less of a likelihood to have partner support
- Higher risk for certain co-occurring psychiatric disorders such as mood, eating, anxiety, and post-traumatic stress disorder
- A history of trauma
- General social stigma and discrimination
Some of the more common characteristics among women who choose to seek treatment include the following:

- Increased severity of drug disorder
- Non-minority ethnicity
- Older (age)
- High education
- Previous treatment

One of the most common characteristics of women who are less likely to enter treatment is the presence of mental health conditions.

There are two specific issues that should be addressed in a respectful and culturally appropriate manner: domestic violence and sexual abuse. We will discuss these topics in the next few slides.
Say: As a counselor, you need to be aware of issues of potential domestic violence among your clients. What is domestic violence?

Teaching instructions: Allow the participants a few minutes to provide responses, then use the information below to fill in the gaps as you address the bullets on the slide.

FYI: Domestic violence is the use of intentional emotional, psychological, sexual, or physical force by one family member or intimate partner to control another.

There are multiple areas that may require additional services for survivors of domestic violence.
Say: Counselors must be cautious and sensitive when asking about sexual abuse. Ensure a safe and private place to discuss these issues where other staff will not overhear your discussions.

Do not raise the issue until you have established a well-developed relationship.

Avoid using terms such as abuse, assault, incest or rape. Instead use terms that indicate the information you are seeking involved pressured, unwanted sexual contact. If seeking information about physical or emotional abuse, ask about how parents maintained discipline.

Validate the client’s feelings by accepting the anger, grief and confusion that they may express. Never rush the conversation, and once the client has begun confiding in you, DESPITE the time, (other clients waiting, lunchtime) DO NOT rush the client out of the session. You may even wish to offer them the option of coming back sooner for another session, rather than waiting for their usual appointment.
Say: There are a few considerations counselors should take into account when working with female drug users who are also sex workers.

This special group of clients should have the option of individual counseling and/or group counseling.

They should also have their choice of the sex of the counselor. Female clients may be more likely to have a productive therapeutic relationship with a member of the same sex. Clients’ wishes should be taken into account.

Clients should be able to wait for their sessions in discreet waiting rooms where they feel secure and safe.

Beginning and ending on time is a sign of respect for your client. Sessions should always begin with a welcoming greeting.

FYI: In addition, you should do the following:

- Accept the reality that for most sex workers, reducing the number of clients is an unrealistic strategy - don’t be judgmental
- Use peer educators to get the message across - train sex workers who will be acceptable to other sex workers (one possibility is to have a support group lead by a recovering FSW or F-IDU)
- Involve sex workers in the design of programs and materials
- Ensure a consistent and adequate supply of condoms - there is no point in encouraging sex workers and clients to use condoms if there are none available
Discuss injecting drug use and provide information on safer drug use, including needle and syringe programs, cleaning techniques, substitution programs etc.

Provide links with health care facilities and encourage regular STI check-ups for sex workers, with guaranteed confidentiality

Provide counseling and HIV testing for sex workers who request it

Discuss injecting drug use and provide information on safer drug use, including needle and syringe programs, cleaning techniques, substitution programs etc.

- Provide links with health care facilities and encourage regular STI check-ups for sex workers, with guaranteed confidentiality
- Provide counseling and HIV testing for sex workers who request it
Say: Effective treatment programs with a focus on women have a client intake and assessment process that helps the staff identify the severity of the addiction, drug use history, and existing social support. Research has shown that clients that start using relatively young often have more serious problems. Ideally, assessment should assist staff in creating a client profile that addresses physical health, alcohol and drug use, employment/education, emotional stability, family/social support and legal issues.

Staff should be qualified to deal with female clients and should be prepared to deal with special circumstances that may make recovery and ultimately retention more difficult.

A good treatment program also documents its treatment outcomes - not only process measures such as numbers served, number of sessions, or contacts, but also relapse rates, abstinence rates, and changes in client housing, medical, emotional, legal, and/or employment.
As a complement to the counseling you are providing, be sure to introduce wraparound services. They may also be required to meet the additional needs of your female clients. If you can address these additional needs, you may assist your client further to reduce their risks. This slide shows some examples of wraparound services.

<table>
<thead>
<tr>
<th>WRAPAROUND SERVICES</th>
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<tbody>
<tr>
<td>Childcare</td>
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<tr>
<td>Vocational services – accommodation</td>
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<tr>
<td>Legal support</td>
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<tr>
<td>Income generating activities</td>
</tr>
</tbody>
</table>
Teaching instructions: Review the key points of this unit.

Say: Some of the key messages to take from this unit include the following:

- Treatment for female drug users and female sex workers who use drugs can have positive outcomes - despite a dearth of research on this population and despite the fact that most of the treatment research and programming has focused on male drug users.
- Female drug users are unique and have different needs and experiences than male drug users.
- Sexual abuse and domestic violence histories should be explored.

Teaching instructions: Thank the participants for their participation in the discussions and ask them if they have any questions. Answer the questions that pertain to this or previous units. If participants ask questions about material that will be covered in a later unit, request that they save their questions for that unit.
Handout 8.3

Working with women: Additional information

Physical health

Domestic violence survivors often present with injuries, the long-term consequences of battering, and physical health problems commonly associated with drug addiction (e.g., skin abscesses and hepatitis). Cuts and bruises from domestic violence tend to be on the face, head, neck, breasts, and abdomen. Abdominal pain, sleeping and eating disorders, recurrent vaginal infections, and chronic headaches are also common among survivors.

When a woman presents for treatment with obvious signs of, or complaints about, physical battering or sexual abuse, staff should consider enlisting medical help so the client can obtain proper medical assistance for her injuries.

Other health concerns that need attention early in treatment include screening and care for pregnancy, HIV infection, and other sexually transmitted infections (STIs). Battered women are at high risk for STIs because they are frequently unable to negotiate safe sex with their partners and are often subjected to forced, unprotected sex. They also may have been forced by their partners to share needles.

One of the coping mechanisms used by many survivors is the repression of physical sensations, including physical pain. Often the survivor’s awareness of physical pain and discomfort resurfaces only when the traumatic effects of the abuse have been relieved.

Psychosocial issues

Shift of focus and responsibility to the abuser

One important element of treatment for drug addiction is encouraging the client to assume responsibility for her addiction. For a client who has experienced abuse, it is critical at the same time to dispel the notion that she is responsible for her partner’s behavior. She is only responsible for her own behavior.

A domestic violence survivor client must realize that she does not and cannot control her partner’s behavior, no matter what he says. Treatment should help move her toward becoming an autonomous individual who is not at the mercy of external circumstances. It is critical to provide concrete steps to ensure her safety or, if she decides to leave the batterer, to set up a new life. As she frees herself from the violence, she will feel more independent. A counselor can help reinforce the client’s view of herself as capable and competent by eliciting information about her efforts to address the violence, even if they were unsuccessful. A counselor can point out that her efforts reflect determination, creativity, resourcefulness, and resilience - many of the same qualities that will equip her to take responsibility for her drug addiction.
Improving decision-making skills

Many drug users have poorly developed decision-making skills. When a female client is battered, that inadequacy may be compounded by the domestic abuse. For some battered women, the batterer has controlled every aspect of their lives, and a “wrong” decision (as perceived by the batterer) may have served as another excuse to batter her. The paralyzing effect of being battered for making independent decisions must be overcome as the survivor begins to exercise choices, without fear of reprisal. One of the first steps in empowering the client is to help her develop, strengthen, focus, or validate her decision-making skills. For some domestic violence survivors, learning to make decisions is a new skill that must be acquired for the first time, rather than a lost skill that must be relearned.

Clients who are able to explore their own wants, needs, and feelings, a process that can be unfamiliar and sometimes uncomfortable, move closer to making longer-term decisions. It is important not to underestimate the importance of making seemingly mundane decisions.

Like most recovering drug users, the survivor client must examine those areas of her life that will either support or undermine her recovery. Like others in treatment, she must disengage from drug-using friends, and she will need support as she begins the task of making new social contacts that support her recovery.

Another therapeutic task for those undergoing drug addiction treatment is reevaluating relationships with partners who support and encourage drinking or drug taking. In a pattern that parallels the experience of many survivors of domestic violence, female drug users are often introduced to and supplied with drugs by male partners. Among the myriad reasons for continuing use are to maintain a relationship, to please a partner, or to share a common activity. For many of these women, recovery will not be possible without separation from their partners - a reality that may be extremely difficult for them to acknowledge, accept, and translate into action. Furthermore, because battering can lead to low self-esteem and confidence in one’s ability to make decisions, many clients are likely to need additional help in evaluating and identifying sources of stress in their relationships.

When working with some survivor clients, drug addiction treatment providers may have to discard traditional notions about the wisdom of making major life decisions, such as moving, early in the course of treatment. For a domestic violence survivor who fears being pursued by a batterer, relocation to another community may be a priority. As part of treatment, the stress of a client’s uprooting herself and her children and the accompanying risk of relapse must be weighed against safety issues. Should a client decide to move, every effort should be made to refer her to appropriate resources and supportive services within the new community.
Ensuring emotional health

Post-traumatic stress disorder (PTSD) is diagnosed using the following criteria: the person experienced, witnessed, or was confronted with an event or events that included actual or threatened death or serious injury, or a threat to the physical integrity of self or others [and] the person's response involved intense fear, helplessness, or horror.

Other criteria include recurrent nightmares, difficulty sleeping, flashbacks, and hyper vigilance - symptoms shared by many battered women.

Emergence of trauma from childhood abuse

Many survivor clients also suffered abuse as children. Emotional and psychological trauma from childhood abuse is often repressed and may surface once the client is in a safe setting, such as an inpatient drug addiction treatment facility. The emergence of this memory can be an overwhelming experience, and treatment providers should not attempt to address it before the survivor is ready, and the program staff are unprepared to handle the results. If the issue surfaces in a group setting, the drug addiction counselor should allow the survivor client to express her emotions initially. Thereafter, however, a client should be referred to a therapist with special training in treating victims of childhood abuse.

Life event triggers

Recovering drug users should be trained to deal with relapse triggers. These are events or circumstances that produce cravings and predispose them to resume their use of alcohol or other drugs. A potential trigger for relapse can be something as seemingly benign as walking through a neighborhood where the recovering individual once purchased drugs. A domestic violence survivor is vulnerable to an additional set of triggers - situations or experiences that may unexpectedly cause her to feel the fear and victimization she experienced when being battered. Such life event triggers may cause the client to relapse and should be addressed directly by counselor and client. Examples of life event triggers are sensory stimuli (sights, sounds, smells), the close physical proximity of certain people, particularly men, or situations that trigger unpleasant memories (such as witnessing a couple arguing). They also include stressful situations that evoke trauma responses and recreate the sense of victimization. Such triggers may push these feelings to the surface many years later, after the survivor is out of the abusive relationship; some disappear over time, but others may always be present to some degree. Counselors should help patients identify these stressful situations and rehearse alternative responses, just as they should for substance use triggers.
Increased stress with abstinence

Survivors of domestic violence usually experience strong emotional reactions when they stop abusing alcohol or other drugs. They may be flooded by formerly repressed emotions and physical sensations.

Once they have maintained abstinence, some survivors may suffer because of having additional time and energy formerly spent procuring drugs, leaving them feeling empty or directionless and with too much time to dwell on their life situation.

Perceptions of safety

Paradoxically, the very concept of “safety” may itself seem “unsafe” to a survivor of domestic violence. As one survivor expressed it, “The minute you (think you) are safe, you are not safe.” For these clients, feeling safe from the perpetrator, even if he is dead or incarcerated, is equated with letting one’s guard down and making oneself vulnerable to attack. Survivors tend to be hyper vigilant and are accustomed to being on guard at all times. Treatment providers need to understand and respect the domestic violence survivor’s concept of and need for safety. It is critical to help clients rebuild general trust as part of their long-term therapeutic goals.

Medications

For some survivors, anxiety, depression, suicidal thoughts, and sleep disorders are severe enough to require medication during their treatment for drug addiction. In such cases, it is of utmost importance to strike a balance between the need for medication and the avoidance of relapse. On the one hand, the recurrence of the physical and emotional consequences of abuse may tip a survivor into emotional trauma; on the other hand, however, the client may risk relapse with the possible misuse or abuse of the prescription medication.

Post-abstinence issues

Practical concerns overwhelm many survivors of domestic violence after they become abstinent. These include resolution of legal problems, housing, transportation, employment or supported vocational training, and childcare, among others. Linkages with other programs and agencies become extremely important in meeting these clients’ needs. In addition, survivor clients are likely to need education or reeducation about meeting sexual needs without drugs or alcohol. Referral to training by experts in this area is recommended to ensure that this topic is approached sensitively. In addition, classes in healthy nutrition are a useful adjunct to treatment for survivor clients (as for other recovering drug users).
Social functioning

Although a strong family or friendship support system can be invaluable to drug users as they leave their drug using culture behind and reintegrate with the community, the domestic violence survivor who is recovering from drug addiction may find it especially hard to reestablish ties, make new friends, or, in some cases, build a completely new life for herself.
### FHI Addictions Counseling Training Manual - Glossary of Terms

<table>
<thead>
<tr>
<th>TERM</th>
<th>DICTIONARY DEFINITION</th>
<th>ADDICTIONS COUNSELING DEFINITION</th>
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<tbody>
<tr>
<td>abstract thinking</td>
<td>thinking that is not based on a particular instance; theoretical</td>
<td>the ability to think about something from a range of different perspectives</td>
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<tr>
<td>addiction</td>
<td></td>
<td>the overpowering physical or emotional urge to continue alcohol/drug use in spite of an awareness of adverse consequences; there is an increase in tolerance for the drug and withdrawal symptoms sometimes occur if the drug is discontinued; the drug becomes the central focus of life</td>
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<tr>
<td>addiction counseling</td>
<td></td>
<td>professional and ethical application of basic tasks and responsibilities which include clinical evaluation; treatment planning; referral; service coordination; client, family, and community education; client, family, and group counseling; and documentation</td>
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<tr>
<td>affirmation</td>
<td>the act of stating something as a fact; asserting strongly</td>
<td>agreeing with what a client is saying in a supportive way</td>
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<td>ambivalence</td>
<td>the state of having mixed feelings or contradictory ideas about something or someone</td>
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<tr>
<td>arguing</td>
<td>exchanging or expressive diverging or opposite views, typically in a heated or angry way</td>
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<tr>
<td>attending</td>
<td></td>
<td>listening to verbal content, observing non-verbal cues, and providing feedback that assures you are listening</td>
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<tr>
<td>autonomy</td>
<td>freedom from external control; independence</td>
<td>respecting a client’s ability to think, act and make decisions for him/herself</td>
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<tr>
<td>behavior modification</td>
<td>the application of conditioning techniques (rewards or punishments) to reduce or eliminate problematic behavior, or to teach people new responses</td>
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<tr>
<td>behavioral counseling</td>
<td>counseling that is based on the premise that primary learning comes from experience</td>
<td>an approach that views counseling and therapy in learning terms and focuses on altering specific behaviors</td>
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<tr>
<td>big deep moments</td>
<td></td>
<td>moments in a conversation that have significant impact on a person's thinking and commitment for change</td>
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<tr>
<td>burnout</td>
<td>physical or mental collapse caused by overwork or mental stress</td>
<td>depletion of motivation, interest, energy, resilience and often effectiveness of counselors caused by overwork or mental stress</td>
</tr>
<tr>
<td>case conferencing</td>
<td></td>
<td>a structured meeting between professionals to discuss relevant clinical aspects of a client</td>
</tr>
<tr>
<td>cliché</td>
<td>a phrase or expression that is overused and betrays a lack of original thought</td>
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<tr>
<td>client</td>
<td></td>
<td>individuals, significant others, or community agents who present for alcohol and drug use education, prevention, intervention, treatment, and consultation service</td>
</tr>
<tr>
<td>client-centered</td>
<td>conducted in an interactive manner responsive to individual client needs</td>
<td>an approach to counseling that allows clients to retain ownership of their issues and building on their abilities to change behavior</td>
</tr>
<tr>
<td>closed question</td>
<td>question with more than one possible answer from which one or more answers must be selected</td>
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<tr>
<td>cognitive counseling</td>
<td>counseling that is based on the belief that our thoughts are directly connected to how we feel</td>
<td>an approach to counseling which focuses on improving clients’ ability to test the accuracy and reality of their perceptions</td>
</tr>
<tr>
<td>collusion</td>
<td>secret or illegal cooperation or conspiracy</td>
<td>clinical collusion: conspiring with another individual against a client’s interest; remaining silent/not intervening when a client says or does something that (the counselor) knows is morally/legally wrong</td>
</tr>
<tr>
<td>competency</td>
<td></td>
<td>the requisite knowledge, skills, and attitudes to perform tasks and responsibilities essential to addiction counseling</td>
</tr>
<tr>
<td>confidential</td>
<td>intended to be kept secret</td>
<td>intended to be kept secret for the protection and safety of the client</td>
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<tr>
<td>confronting</td>
<td>compelling (someone) to face or consider something</td>
<td>expanding (or challenging) a client’s awareness via reflections and questions focused on actual and potential inconsistent and illogical ways of thinking and communicating</td>
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<tr>
<td>continuum of care</td>
<td></td>
<td>the full array of alcohol and drug use services responsive to the unique needs of clients throughout the course of treatment and recovery</td>
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<tr>
<td>corrective feedback</td>
<td>information about reactions to a person’s performance/behavior intended to modify or improve the behavior</td>
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<tr>
<td>counseling</td>
<td>provision of advice, especially formally</td>
<td>an interactive exchange process between counselor and clients to help clients condentially explore their problems and enhance their capacity to solve their own problems</td>
</tr>
<tr>
<td>counselor</td>
<td>a person trained to give guidance on personal, social or psychological problems</td>
<td>counselors are similar to therapists in that they use a variety of techniques to help clients achieve stronger mental health. (one of the most commonly understood methods involves a one-on-one exploration of a client’s inner beliefs and background (psychotherapy) or a similar exploration in a group setting (group therapy).)</td>
</tr>
<tr>
<td>craving</td>
<td>a powerful desire for something</td>
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<tr>
<td>denial</td>
<td>the action of declaring something to be untrue</td>
<td>failure to accept an unacceptable truth or emotion or to admit it into consciousness; used as a defense mechanism</td>
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<tr>
<td>directive</td>
<td>involving the management or guidance of something</td>
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<tr>
<td>disagreeing</td>
<td>having or expressing a different opinion</td>
<td></td>
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<tr>
<td>discrimination</td>
<td>the unjust or prejudicial treatment of different categories of people or things, usually based on race, sex, gender…etc</td>
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<tr>
<td>double-sided reflection</td>
<td>reflecting both the current, resistant statement, and a previous, contradictory statement that the client has made</td>
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<tr>
<td>empathy</td>
<td>the ability to understand and share the feelings of another</td>
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<tr>
<td>exploration</td>
<td>thorough analysis of a subject or theme</td>
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<tr>
<td>extrinsic</td>
<td>not part of the essential nature of someone or something; coming or operating from outside</td>
<td>something that comes from the outside; an outside feeling or point of view</td>
</tr>
<tr>
<td>goal</td>
<td>the object of a person's ambition or effort; an aim or desired result</td>
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<tr>
<td>goal-centered</td>
<td>based on the short-, intermediate- and/or long-term goals of an individual or group</td>
<td>working toward achieving specific implicit or explicit objectives of counseling</td>
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<tr>
<td>harm</td>
<td>physical injury (especially that which is deliberately inflicted)</td>
<td>any event or stimulus that causes a negative outcome</td>
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<tr>
<td>harmful use</td>
<td></td>
<td>patterns of use of alcohol or other drugs for non-medical reasons that result in health consequences and some degree of impairment in social, psychological, and occupational functioning for the user</td>
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<tr>
<td>interpreting</td>
<td>understanding an action, mood or way of behaving as having a particular meaning or significance</td>
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<tr>
<td>intervention</td>
<td>action taken to improve a situation</td>
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<tr>
<td>intoxication</td>
<td>of alcohol or a drug, the state of losing one's control over one's faculties/behaviors</td>
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<tr>
<td>jargon</td>
<td>special words or expressions that are used by a particular profession or group and are difficult for others to understand</td>
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<tr>
<td>judging</td>
<td>forming an opinion or conclusion about something</td>
<td>forming an opinion about something and projecting it on to other people</td>
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### Glossary of Terms (cont.)

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<thead>
<tr>
<th>TERM</th>
<th>DICTIONARY DEFINITION</th>
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<tbody>
<tr>
<td>lapse</td>
<td>a temporary failure of concentration, memory or judgement</td>
<td>the reuse of drugs after a period of stopping</td>
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<tr>
<td>moralizing</td>
<td>commenting on issues of right and wrong, typically with an unfounded air of superiority</td>
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<tr>
<td>motivational</td>
<td>a client-centered, semi-directive method of engaging intrinsic motivation to change behavior by developing discrepancy and exploring and resolving ambivalence within the client</td>
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<tr>
<td>interviewing</td>
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<tr>
<td>nonjudgmental</td>
<td>avoidance of moral arguments</td>
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<tr>
<td>open-ended question</td>
<td>question whose answers have no determined limit or boundary</td>
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<tr>
<td>ordering</td>
<td>commanding or giving instruction authoritatively</td>
<td></td>
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<tr>
<td>over interpreting</td>
<td></td>
<td>placing too much emphasis on a specific client response (verbal or nonverbal)</td>
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<tr>
<td>paraphrasing</td>
<td>expressing the meaning of something someone has written/said using different words, especially to achieve greater clarity</td>
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<tr>
<td>personal resilience</td>
<td>ability to withstand or recover from difficult situations on one’s own</td>
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<tr>
<td>prevention</td>
<td>the theory and means for delaying or denying uptake of drug use in specific populations. prevention objectives are to protect individuals prior to signs or symptoms of substance use problems; to identify persons in the early stages of substance abuse and intervene; and to end compulsive use of psychoactive substances through treatment</td>
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<tr>
<td>principle</td>
<td>a fundamental source or basis of something</td>
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<tr>
<td>probing</td>
<td>asking for more information and/or clarification about a point that you think is important</td>
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<tr>
<td>procedure</td>
<td>an established or official way of doing something</td>
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<tr>
<td>psychoactive substance</td>
<td>a pharmacological agent that can change mood, behavior, and cognition process</td>
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<tr>
<td>rapport</td>
<td>a close and harmonious relationship in which the people or groups concerned understand each others feelings or ideas and communicate well</td>
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<tr>
<td>reflective listening</td>
<td>to listen carefully to what the client has said and repeat back what was said in a directive way</td>
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<tr>
<td>reframing</td>
<td>framing or expressing words, concepts or plans differently</td>
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<tr>
<td>relapse</td>
<td>the return to the pattern of substance abuse as well as the process during which indicators appear prior to the client’s resumption of substance use</td>
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<tr>
<td>reliability</td>
<td>the degree to which something is consistently good in quality or performance</td>
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<tr>
<td>resistance</td>
<td>any feeling thought and communications on part of the clients that prevent them from participating effectively in counseling.</td>
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<tr>
<td>resourcefulness</td>
<td>having the ability to find quick and clever ways to overcome difficulties</td>
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<tr>
<td>respect</td>
<td>a feeling of deep admiration for someone or something elicited by their qualities, abilities or achievements</td>
<td></td>
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<tr>
<td>risk</td>
<td>a situation involving exposure to danger</td>
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<tr>
<td>rolling with resistance</td>
<td>meeting resistance to change from a client by moving in the direction he/she is headed with a response that is intended to diffuse the resistance</td>
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<tr>
<td>self-efficacy</td>
<td>belief in a client's own ability to undertake a task(s) and/or fulfill goals</td>
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<tr>
<td>self-responsibility</td>
<td>(responsibility for one's self) - the state or fact of having the duty to deal with one's self</td>
<td></td>
</tr>
<tr>
<td>significant others</td>
<td>sexual partner, family member, or others on whom an individual is dependent for meeting all or part of his or her needs</td>
<td></td>
</tr>
<tr>
<td>simple reflection</td>
<td>to repeat or rephrase what the client has said</td>
<td></td>
</tr>
<tr>
<td>skill</td>
<td>the ability to do something well; expertise</td>
<td></td>
</tr>
<tr>
<td>sobriety</td>
<td>the quality or condition of abstinence from psychoactive substance abuse</td>
<td></td>
</tr>
<tr>
<td>stage of change theory</td>
<td>a theory that espouses that behavior change does not happen in one step, rather, people tend to progress through different stages on their way to successful change; each progresses through the stages at his/ her own rate</td>
<td></td>
</tr>
<tr>
<td>substance use</td>
<td>consumption of low and/or infrequent doses of alcohol and other drugs, sometimes called &quot;experimental,&quot; &quot;casual,&quot; or &quot;social&quot; use, such that damaging consequences may be rare or minor</td>
<td></td>
</tr>
<tr>
<td>summarizing</td>
<td>giving a brief statement of the main points of (something)</td>
<td></td>
</tr>
<tr>
<td>supervision</td>
<td>observation and direction execution of a task, project or activity</td>
<td>the administrative, clinical, and evaluative process of monitoring, assessing, and enhancing counselor performance</td>
</tr>
<tr>
<td>sympathizing</td>
<td>agreeing with a sentiment or opinion</td>
<td></td>
</tr>
<tr>
<td>sympathy</td>
<td>understanding between people; a common feeling because you have experienced the same or similar event.</td>
<td></td>
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<tr>
<td>TERM</td>
<td>DICTIONARY DEFINITION</td>
<td>ADDICTIONS COUNSELING DEFINITION</td>
</tr>
<tr>
<td>-----------------</td>
<td>--------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
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<tr>
<td>technique</td>
<td>a way of carrying out a particular task</td>
<td></td>
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<tr>
<td>therapeutic</td>
<td></td>
<td>the relationship between a mental health professional and a client it is the means by which the</td>
</tr>
<tr>
<td>alliance</td>
<td></td>
<td>professional hopes to engage with, and effect change in, a client</td>
</tr>
<tr>
<td>threatening</td>
<td>causing someone to be vulnerable or at</td>
<td></td>
</tr>
<tr>
<td></td>
<td>risk</td>
<td></td>
</tr>
<tr>
<td>voluntary</td>
<td>done, given or acting of one's own free</td>
<td></td>
</tr>
<tr>
<td></td>
<td>will</td>
<td></td>
</tr>
</tbody>
</table>