

COUNSELING FOR DRUG ADDICTION
Individual, Family & Group

A Field Guide for Trainers

Concepts

Issues

Practical Tools and Resources

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INTRODUCTION

Dear Trainer,

Training people in the field of addiction is a challenging task. As trainers, we are expected to expand their knowledge base, sharpen their clinical skills and generate enthusiasm to work in and contribute to this field.

This manual will help you understand and effectively manage this task.

Certain standardization is maintained with regard to the terminology used in this manual. The patient is referred to as a male, and the family member is represented by the wife / mother and therefore referred to as a female. The counselor is presented as a female professional. This however, does not imply that all drug abusers are male or that all counselors are female. This has been maintained only as a matter of convenience.

The manual has eight chapters. Each chapter includes three parts.

1. **Information section**, where facts are presented in a format which is easy to read and follow
2. **Skills sharpening tools**, wherein problems and issues likely to be raised by trainees are discussed. Additional focused information and implementation tools find a place here.
3. **Internalizing tools** cover case studies to help trainees internalize the concepts and practices.

This manual is the outcome of the painstaking efforts of a team of professionals with over 20 years of experience in the field of addiction prevention, treatment and research in India.

We hope you will like this manual, and use it to transform each of your trainees into well-equipped, confident and skillful professionals. Please write to us to let us know where we could improve. We remain as always your partners in the task of prevention and treatment of addiction.

Yours truly,

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BASIC COUNSELING TECHNIQUES

Counseling is used to help individuals to deal with variety of problem situations. During counseling, the counselor establishes a warm, supportive, therapeutic relationship with the client using a variety of skills. Based on the strength of this relationship, the counselor helps the client explore problem areas, set goals and assists the client to work through problems in order to establish a more meaningful and productive life style. During addiction treatment, individual counseling aims at enabling the client to learn how to identify and pursue realistic and satisfying solutions to his problems, particularly those related to his chemical abuse. In order to make individual counseling effective, the counselor has to understand the client as an individual – the influences which have affected him, his perception of himself and others around him – so that she can help the client realize how those forces have led to unhealthy ways of coping both prior to and after the onset of addiction.. This understanding at the level of feelings rather than at the intellectual level (or the objective level), will enable him to cope with life more satisfactorily. The purpose is to help the client in making decisions about his life and enable him to understand the need to take responsibility for his actions as well as their consequences.

QUALIFICATIONS OF THE COUNSELOR

The qualification required for a counselor is a post-graduation in Social Work or Psychology with training in counseling. However, in the field of addiction, recovering addicts by virtue of their own experience at recovery can work as counselors after adequate training. He should have however maintained atleast 3 years of sobriety during which he has made qualitative changes in his life. He must also be emotionally stable and should have dealt with his personality defects like impulsiveness, irresponsibility, aggressiveness, selfishness and indiscipline.

QUALITIES NECESSARY FOR A COUNSELOR

- Ability to listen – Listening is much more than merely hearing words. It involves intuitive perception, watching for cues other than those conveyed through words (tone of voice, gesture, posture) and understanding the messages that the client is trying to convey, over-emphasize or avoid.
- Empathy – An ability to sense the client’s private world ‘as if’ it were the counselor’s own, but without losing the ‘as if’ quality, is important. Empathy does not imply agreeing to the client’s view of things; she understands and is able to grasp his feelings and thoughts.
- Non-judgmental attitude – Being open to the other person’s point of view is a great asset. The counselor neither agrees nor disagrees; she understands. Such an unbiased involvement is essential to adopt a constructive approach to the client’s problem. The counselor should not have a ‘holier-than-thou’ attitude, nor communicate in any way that she is above the client.
- Genuineness – The counselor is sincerely interested in the care and well-being of the client and does not have to put on an act to convince him of that. She is able to be herself and can truly reflect her thoughts and feelings without discrepancy between what is felt and what is said. She does not give the impression of being all knowing or give false assurance just to impress the client. This however, does not mean that she is brutally honest to the point of hurting the client.
- Emotional maturity – The counselor should have the maturity to set personal and professional boundaries.
- Patience and flexibility – The counselor should be able to adapt her role and pace according to the client’s needs and capacities. Rigidity in roles and approaches may provide comfort for the counselor, but often does little for the client. The counselor should be a sympathetic friend, a leader, a negotiator or an educator and be able to move between these multiple roles.

BASIC PRINCIPLES OF COUNSELING

Respect for the client

The skill of a counselor lies in communicating a sense of self-respect to the client. The client needs to accept the belief that every person possesses the inherent strength and capacity to 'make it' in life, and that each person has the right to choose his own alternatives and make his own decisions. It is also important that respect for the client should be reflected in the manner the counselor conducts herself. She should always be professional; for instance she should not be late for appointments and should never talk to or treat the patient in a derogatory or disrespectful manner.

Being a Role Model

The counselor should set an example to the client through her personal behavior and attitude.

Confidentiality

Maintaining confidentiality is very important in a counseling relationship as this leads to the development of trust. The counselor should not reveal the client's identity, personal details and such information to other people without the client's permission. In addition, she must assure the client that confidentiality will be maintained to gain his trust.

To be in Command

Once an assessment is made and counseling has begun, the counselor should be able to guide the client away from trivialities or irrelevancies. The counselor who allows herself to be manipulated without knowing it will not be able to command the client's respect.

Emphasizing the Client's Personal Responsibility for Recovery

The counselor should be able to guide the client in the early stages of recovery and make him understand that the recovery process ultimately rests with the client.

Providing Direction and Encouraging Self-Direction

The counselor must strike a balance between providing direction and allowing the client to be self-directed. It is essential that the counselor create a structure in the session that includes giving the client feedback on his progress in recovery. She identifies the relevant topics for discussion, based on what the client seems to need, and introduces those topics. At times the counselor may direct the patient to change certain behavior, for example, to start attending self-help meetings.

However, the patient should also be encouraged to be self-directed. For example, within the framework of a particular topic, perhaps coping with 'social pressure to use', the patient may explore how to manage this problem best, and the counselor will respond to the patient's ideas. If the patient seems unable to change some aspect of addictive behavior, the counselor should accept the situation and assist him to explore those perceptions or situations in a way that might allow him to deal with them differently. A balance needs to be maintained so that there is respect for the patient, acceptance of where he is, and still provide motivation for abstinence and recovery.

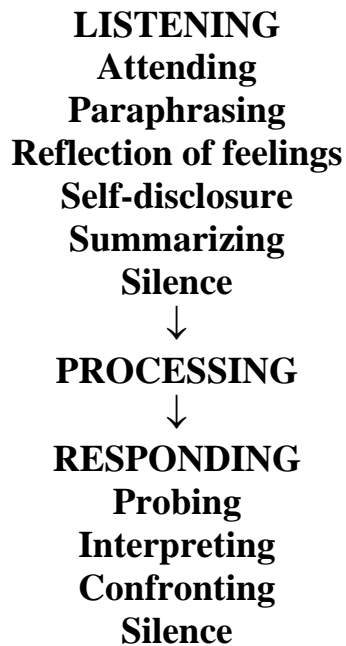
Conscious of Her Own Issues

The counselor needs to be aware of the possibility of her own issues being triggered by a patient's problems; she must consciously refrain from basing her response in the context of her own personal issues. For example, a counselor in recovery may feel that it is personally important for her to break ties with addicted peers to maintain sobriety. If this counselor happens to work with a patient who has an addicted sister with whom the patient has a valuable relationship, it is important that the counselor be flexible and respond creatively to the patient's own perception of the problem.

THERAPEUTIC COMMUNICATION SKILLS USED IN COUNSELING

The outcome of a meeting between the counselor and the client will depend a great deal on how comfortable the client feels with the counselor, so that he may entrust his genuine feelings to her, including information which he may feel is very private and personal and which he is reluctant to share. This can be achieved by the use of certain communication skills that create an atmosphere of support for the client and the process.

The process of communication between the client and the counselor in the counseling situation is a continuous two-way sequence. This sequence of events ensures that the counselor listens (receives the message); processes (considers the message in combination with previous knowledge and experience); and responds (delivers a response to the original message).



LISTENING

Attending

This refers to a concern by the counselor with all aspects of the client's communication. It includes listening to the verbal content, observing non-verbal cues and then communicating back to the client that she is paying attention. The skill of attending is the foundation on which all other skills are built.

Guidelines for effective attending:

- communicate listening through eye contact and facial expression
- maintain a relaxed physical posture and lean forward occasionally, using natural hand and arm movements
- verbally 'follow' the client, using a variety of brief encouragements such as 'um-hm', 'yes', or repeating key words.

Attending helps the client to

- relax and feel comfortable
- express his ideas and feelings freely in his own way
- trust the counselor
- feel more responsible for what happens in the session by enabling him to direct the session.

Attending enables the counselor to

- obtain accurate inferences about the client through careful observation.

The client may ask the counselor about the availability of medical help to deal with the withdrawal symptoms. The counselor may notice that he sits on the chair wringing his hands and looking very anxious. Even if the client does not say so verbally, the counselor recognizes the need for reassurance. So, instead of responding with a general statement that medications will be provided, the counselor needs to help him express his fears and answer specific questions that he may have.

Paraphrasing

Paraphrasing is a response that restates the content of the client's previous statement. It concentrates primarily on the words spoken, the content which refers to events, people and things. In paraphrasing, the counselor reflects to the client the verbal essence of his last comment or last few comments. More often, paraphrasing uses words that are similar to the client's, but fewer in number.

Client – My mother constantly irritates me. She picks on me for no reason at all. She likes only my younger brother and pampers him all the time. She is the reason for my drug taking. Even if I give up drugs, she will not change.

Counselor – You are having problems in getting along with your mother. You are concerned about your relationship with her.

'Paraphrasing' can be an indicator to the client of the counselor's accurate verbal following. It sharpens the client's meaning to have his words rephrased concisely and often leads him to expand his discussion on the same subject. It can spotlight an issue, thus offering a direction for the client's subsequent remarks.

Paraphrasing helps the client to

- realize that the counselor understands what he is saying
- get a sense of direction
- clarify his remarks

It enables the counselor to

- verify her perceptions of the verbal content of the client's statements
- spotlight an issue

Reflection of Feelings

The counselor expresses the essence of the client's feelings, either stated or implied; this is 'reflection of feelings'. Unlike paraphrasing, the focus is primarily on the emotional element of the client's communication. The counselor tries to perceive the emotional state of the client and feed back a response that demonstrates her understanding of the client's state. It lets the client know that the counselor understands what he is experiencing and feeling. This empathy reinforces the client's willingness to express his

feelings more openly. It also gives the client an opportunity to recognize and accept his feelings.

Client – When I go home in the evening, my house is in a mess. My wife returns home from work only at 7.00 p.m. The kids are dirty and making noise all the time. My wife never takes interest in preparing good food. I don't feel like going home at all.

Counselor – You are not satisfied with the way she is running the house; that irritates you.

Through such reflection of feelings, problem areas can be identified without the client feeling pushed. It also helps the client understand that feelings cause certain types of behavior.

Reflection of feelings helps the client to

- realize that the counselor understands what he feels and experiences
- bring to the surface any feelings that may have been expressed only vaguely
- learn that feelings and behavior are connected.

It enables the counselor to

- check whether or not she is accurately reflecting what the client is experiencing
- bring out problem areas without the client being pushed.

Self-Disclosure

Self-disclosure is the act of sharing the counselor's own feelings, attitudes and experiences with the client which helps him in his own growth. The counselor who has been through addiction can especially, share from her past experience to help the client recognize and deal with problems that he may have encountered. The following guidelines should be kept in mind during self-disclosure.

- The disclosure should relate directly to the client's situation.
- The counselor should disclose only experiences that have actually happened to her (personal pronouns such as 'I', 'me', 'my', or 'myself' can give a clear message that it is her own experience).

- The counselor should guard against any self-disclosure that is likely to shift the focus of the interaction away from the client to the counselor. Self disclosure should be of therapeutic value to the client and not to the counselor. It is neither an opportunity for the counselor to talk a lot about herself and find relief in sharing nor boast about her growth and receive appreciation for her efforts.
- The appropriateness of the issue and the timing are of crucial importance. If the counselor who is a recovering addict, talks about her relapse which happened immediately after treatment, she will only be upsetting a client in the early part of recovery. However, the same issue may be meaningful to a client who has made a lot of progress. He will be able to see the fact that in spite of his initial relapse, with consistent efforts he was able to make progress.
- The counselor should guard against disclosing anything about herself that the client may ignore, deny or ridicule. If the client's perception of the counselor changes negatively because of an inappropriate self-disclosure, the relationship will be disrupted.

Self-disclosure helps the client to

- build a sense of trust and rapport with the counselor
- reduce his feelings that he is alone in the situation he is experiencing (he comes to realize that his counselor also had problems and made mistakes)
- create an atmosphere in which he feels free to express feelings and share information that he had previously avoided.

Self-disclosure is important to the counselor because

- it enables the relationship to move to deeper levels by fostering a feeling of empathy.

Summarizing

Summarizing is the tying together by the counselor of the main points discussed in a counseling session. Summarizing can focus on both feelings and content (information), and is appropriate after discussion of a particular topic within the session or as a review, at the end of the session, of the

principle issues discussed. In either case, the summary should be brief, to the point, and without new or added meanings.

Counselor – We discussed your relationship with your wife. You said that there were conflicts right from the start. The conflicts related to the way money was handled and that she often felt you gave more importance to your friends. Yet on the whole, things did go on well and you were quite happy until 3 years ago. Then the conflicts became more frequent and more intense so much so that she even left you twice and talked of divorce too. This was also the time when your drinking was at its peak. Have I understood the situation properly?

Summarizing clarifies the client's meaning by pulling his scattered thoughts and feelings together. It can terminate a session in a logical way through a review of the major issues discussed in the entire session and also help link one session to the next.

“We were talking about your drug use pattern during our last session. You mentioned that you have been using brown sugar regularly and ganja occasionally quite heavily for the past 5 years. Today, let us talk about how your family reacted to it.

Summarizing helps the client to

- clarify meaning
- realize that the counselor understands what he is saying and feeling
- have a sense of movement and progress.

It enables the counselor to

- ensure continuity in the direction of the session by providing focus
- verify her perceptions of the content and feelings discussed
- terminate a session in a logical way
- focus on one issue while acknowledging the existence of other concerns.

PROCESSING

This takes place within the counselor, between her listening and responding to the client. This includes the counselor's ability in mentally cataloguing data - the client's beliefs, knowledge, attitudes and expectations and thereafter categorizing factors influencing the client's judgement and performance.

For example, after a few sessions, the counselor may make the following observations.

The client started drinking before his marriage. It was a joint family and according to his mother, his father and brothers were running the family. The client's contribution was minimal. As he was the youngest in the family, they did not make any demands on him. After the marriage, the couple set up an independent establishment. According to the wife, he was contributing initially but over a period of time, this less. Since the wife was employed and they had no children, they were able to carry on. Once in a while, he would spend money and buy things like a vacuum cleaner or a cooking range. He would always justify that he is contributing for the family. From various interactions, it was clear that the client had no financial discipline. As part of the counseling session, the client was made to understand the need to plan a budget and make a commitment towards contributing to the family.

The information given by the client and his family in bits and pieces is put together using the counselor's own judgement and observations. She then understands the situation in its totality. Based on this processing, the counselor helps the client develop a meaningful plan for the future.

RESPONDING

Probing

Probing is the counselor's use of a question or statement to direct the client's attention inward to explore his situation in greater depth. A probing question should be open-ended, requiring more than a one-word answer ('yes' or 'no') from the client. Probing helps to focus the client's attention on a feeling or content area. It may encourage the client to elaborate, clarify or illustrate what he has been saying. It sometimes enhances the client's awareness and understanding of his situation and feelings. Probing directs the client's attention to areas that, according to the counselor, need attention.

Client – I was always known to be a good worker. I even received an award for excellence four years back. It is only the past 2 years, that I have been having problems at the work. Anyway, I will get it all right when I go back.

Counselor – Tell me about the problems you have been having at the work place?

The counselor should use her judgment to identify the subject or feelings touched upon by the client that need further exploration. It is important that the counselor uses the technique of 'probing' only after 'attending' to the client.

Probing helps the client to

- focus his attention on a feeling or content area
- become aware of and understand his situation or feelings
- focus his attention on areas the counselor thinks need attention.

It enables the counselor to

- better understand what the client is describing.

Interpreting

Effective interpreting has three components – determining and restating basic messages; adding counselor’s ideas for a new frame of reference; and checking out these ideas with the client.

It is very important that the counselor uses the skills of attending, paraphrasing, reflection of feelings and summarizing prior to and in conjunction with interpreting. The first step in interpreting is to determine the basic messages the client has expressed or displayed, and restate them. As the counselor is restating them, she will have some idea about alternative ways of viewing the client’s situation, or may begin to see connections, relationships or patterns in the events the client describes. When these ideas are included in the material being restated to the client, the counselor adds her ideas to offer the client a new frame of reference from which to view his situation.

Counselor – You say you had difficulty in getting along with your parents. Once you mentioned that sometimes you simply broke the rules for the sake of breaking them. You have given up three jobs. Each time you said it was because of the negative behavior of the boss. You feel you are unable to relate to the warden here in the treatment center. Can there be a possibility that you find it difficult to accept authority?

Because the counselor is offering alternative viewpoints, it is very important to phrase them tentatively or to check the client his reaction to the new point of view. Tentative phrases like ‘The way I see it ...’ or ‘I wonder if ...’ are appropriate ways to begin an interpretation. Then there is a better chance that the client will see the offered interpretation as a possibility rather than as a judgment. He is thus more likely to react to an interpretation openly if it is offered tentatively.

Interpreting helps the client to

- realize that there are more ways than one to look at most situations, problems and solutions
- become more flexible and to explore new points of view
- understand his problems more clearly.

Interpreting enables the counselor to

- share a new perspective for the client to consider
- open out new coping strategies to deal with the issues.

Confronting

Confrontation is the deliberate use of a question or statement by the counselor to induce the client to face what the counselor thinks the client is avoiding. The counselor may, for example, point out discrepancies between the client's verbal and non-verbal behaviors, between two of the client's statements, or between the client's past behavior and his behavior in the counseling sessions.

In confrontation, the counselor identifies contradictions that are outside the client's frame of reference, whereas paraphrasing, reflection of feelings and summarizing involve responding within the client's frame of reference. In using confrontation, the counselor gives honest feedback about what she perceives is actually happening with the client. Confrontation should not include accusations, evaluations or solutions to problems.

Sometimes the counselor may not know what to do after she attempts a confrontation. The following guidelines may be of help.

- If the client accepts the confrontation and agrees with the discrepancy pointed out, the counselor can use the opportunity to reinforce positive behavior.

*'I am happy that you are able to see the problem from this angle.
Let us plan what we can do about it.'*

- If the client denies the confrontation, the counselor should return to an empathetic response.

'You are finding it difficult to see the problem the way your family members and I perceive it. It seems to be bothering you. Think about it. Let us talk about it later.'

- The client may not be ready at that point of time to deal with the discrepancy and it would not be helpful to persist in the confrontations. It can however, be dealt with at the appropriate point in time.
- The client may simply act confused or ambivalent after confrontation. In that case, the counselor should focus on the current feeling.

'You seem to feel confused by my statement. Let me make myself clearer.'

An effective confrontation breaks down the defenses that he has consciously or unconsciously put up. It will enrich the condition of empathy in the counseling relationship if the client perceives the confrontation as stemming from the care and concern of the counselor.

Confrontation helps the client to

- become more congruent (what he says corresponds with how he behaves)
- break down necessary defenses which the client has consciously or unconsciously put up
- focus on problems on which the client might take action or change his behavior.

Confrontation enables the counselor to

- establish herself as a role model in using direct, honest and open communication.

Silence

Silence can be very powerful. It can be a time when things really 'sink in', and feelings are strongly felt and recognized. When combined with 'attending cues', it can serve to encourage the client to continue sharing. Silence can allow the client to experience the power of his own words.

Through commitment and experience, the counselor acquires skills to help the client in the process of achieving an addiction free, qualitatively better life.

SKILLS SHARPENING TOOLS

COUNSELORS' BURNOUT

Professionals working in the field of addiction treatment are prone to stress. When this stress is not managed properly, it becomes an overload and leads to 'burnout', making the job tedious, draining and frustrating. It results in the counselor feeling exhausted and worn out. She feels physically and emotionally drained. From an attitude of helpfulness, care and concern for her patients, her condition turns to one of frustration and apathy.

Why does burnout happen?

Repeated unresolved problems in work situations lead to stress. Totally uncooperative, highly demanding and manipulative clients, repeated violation of rules by patients and frequency of relapses are some of the factors that contribute to counselor's burnout. Family problems, stress at home, and lowered stamina of the counselor due to physical illness also have a bearing on her ability to cope. Interpersonal conflicts and problems in relationships among members of staff activate stress. Lack of clarity of roles, leading to overload of work on one counselor and a non-supportive working environment can also result in a counselor's burnout.

The resultant burnout manifests itself physically as fatigue, headache, insomnia and backache. The body literally breaks down and is no longer able to manage. The mind also switches off. The counselor experiences depression, anxiety, feelings of frustration and anger. The syndrome also includes apathy, weariness, lack of personal involvement and a lack of enthusiasm for the patient's rehabilitation.

Burnout is an inevitable consequence of ineffective identification and management of stress. Since burnout is not an uncommon condition in the field of addiction management, counselors should be forewarned and prepared to take a variety of coping actions, all of which will lessen stress on themselves, their work, their relationship with clients and their communication with their fellow workers. By identifying stress contributors and by developing strategies to deal with them, a counselor may be able to avoid 'burnout' before it becomes a problem. If this problem is not handled properly, it will not only make the individual ineffective, but also bring down the staff morale.

Dealing with burnout

- Addiction treatment is a team effort. Medical management is handled by the doctor and the nurses. Counselors share the responsibility of conducting group therapy, educative sessions and providing counseling. Treating the addict is a shared responsibility of the team. Good interpersonal relationship, along with honest and open communication among team members, leads to a healthy, supportive environment which will lower the incidence of stress.
- Senior counselors can teach newcomers what to expect from troublesome clients and how to handle their own emotions.
- If one counselor is not able to stand the stress and tackle a particular patient, sharing the burden with other counselors will definitely lighten her strain. When she is pent-up at times, it is therapeutic to share the problem with someone and arrive at a reasonable solution together.
- When a counselor is under stress, she can reduce the number of hours dedicated for counseling for the time being. She can relax by taking up other activities like writing letters to treated patients, filling up case files and reading professional journals.
- The counselor should understand that relapse is an integral part of the recovery process. She need not feel guilty or frustrated if a patient relapses in spite of her honest efforts. The professional can, at best, only help the patient to deal with his relapse, if it does take place. However, if repeated relapses occur, the counselor can discuss the case with senior counselors and ensure that her plan of action and anticipatory guidance are proceeding in the right direction.
- Counselors should be encouraged to periodically attend self-development programs which will enhance their creativity and also help them in strengthening their self-esteem.
- Recovered addicts may be encouraged to celebrate their birthdays at the treatment center. This will bring about a sense of gratification to the counselor, while at the same time, it will provide incentive and hope to recovering patients.

- Occasional outing or picnics can be organized for staff members.
- Small things like not taking one's work home, getting sufficient rest, talking about work problems while at work, developing variety in one's work and reducing the repetitive, routine aspects wherever possible, will definitely help in reducing or preventing counselors' burnout.

INTERNALISING TOOLS

CASELETS

Instruction : Divide the trainees into smaller groups and request them to identify the feelings behind each statement (in question I) and name the communication skills used by the counselor (in question II).

I. Identify the feelings behind these statements:

1. *Client:* Are these two medications enough? I can buy some more from the shop, if you give me a prescription.
2. *Father of a client:* I did the right things for my children. I wonder how this happened. I should have been more careful.
3. *Client:* What is the use in taking the medicines? The damage is done.
4. *Spouse of a client:* He had promised to be back by six. But he came back only at 8.00 p.m. I sat by the gate praying all the time.

II. Identify the communication skills being used by the counselor in each case:

A. Patient was talking in detail about his long standing drinking friends and the strong association he had with them. He went on to recount what happened to his closest friend–

Client: He was fine, Madam. We used to meet everyday and drink together. Then I got a call last week that he was admitted in a hospital. He was highly sedated when I visited him, but I thought he would become better. He was only 40 after all. But yesterday, I got a call that he died and that it was because of his drinking. I could not even sleep last night. I went through the funeral in a daze.

Counselor: It must have been shocking for you.

B. In an ongoing session focusing on his marital relationships–

Client: *It is not that I don't have affection for my wife.*

Counselor: *The issue is not whether you have affection for her, but how you have been communicating it.*

Client: *I will make an effort in the future.*

Counselor: *Let us talk about what you would like to do in this regard.*

C. In a session with the client's spouse–

Client's spouse: *Please give a lot of advice to my husband, Madam. I have told him enough and many times not to drink – but he does not listen to me. What does he expect from me? I have shown love and affection. I have scolded and shouted at him. I have tried to advise him. At that moment, he seems to understand and says, 'I will not drink again', but inevitably comes back drunk.*

Counselor: *Over the years you have tried several ways of getting him to give up but nothing worked.*

THE PROCESS OF ADDICTION COUNSELING

For obvious reasons addiction has been termed a baffling illness. Helping the addict overcome this illness calls for an appropriately planned and skillfully managed counseling process. In addiction treatment, counseling offers personal support and guidance to work towards the goal of abstinence from all mood-changing chemicals, and to achieve qualitative lifestyle changes.

The process revolves primarily around the relationship between the counselor and the client. It is this relationship that leads to growth and change. The counselor works 'with' the client, and a sense of partnership and collaboration prevails. In essence, the counselor functions as an ally or guide who helps the client change himself, rather than as an expert who 'fixes' all the client's problems.

The primary goal is to assist the addict in achieving and maintaining abstinence from addictive chemicals and behaviors. The secondary goal is to help the client recover from the damage addiction has caused in his life. That is, the patient is encouraged to achieve and maintain abstinence and then to develop the necessary psychosocial skills to continue recovery as a lifelong process.

Counseling is a process that starts off by building a relationship characterized by rapport and trust with the client. On the basis of this meaningful relationship, the client is helped to explore problem areas at the levels of both thought and feeling, and identify goals of therapy. Planning, implementing strategies to overcome problems, evaluation and follow-up are the other aspects of the process that follow.

The process of counseling moves through five stages from initiation of the counseling relationship to its termination.

STAGE 1 - DEVELOPING A THERAPEUTIC RELATIONSHIP WITH THE CLIENT

The success of any treatment effort, irrespective of the treatment model followed, basically depends on developing a deeply meaningful relationship with the client.

Being able to empathize with the client and perceive his life situation from his perspective without being judgmental is extremely crucial. Demonstrating care and concern for the client and treating him as a human being worthy of respect helps strengthen the counselor-client relationship. It is on the basis of this relationship that further progress is made and nothing can be achieved without it.

Due to the nature of the illness, one is more likely to encounter a resistant, or even a hostile client who is grappling with low self-esteem, low frustration tolerance and confusion about where he is and where he wants to go. Working with this client calls for a lot of patience and forbearance.

The first session or two are usually spent on collecting information, and progress in sessions depends on the pace set by the client. Asking too many questions too soon can be threatening to the client and it is important for the counselor to be sensitive to this.

It is a good practice to use the first session to explain the agency's programs, treatment goals and how individual counseling sessions will help. The client can be encouraged to express concerns about the treatment. Doubts may need to be clarified, fears set to rest, and his motivation and involvement in treatment heightened.

The client usually uses the first few sessions to size up the counselor. 'Can she really understand me? How can I tell this stranger all about myself. What if she does not approve of me?' These are just a few unsaid questions that he may bring with him. By being a good listener and by offering appropriate support, the counselor is gradually accepted by the client as a knowledgeable yet caring and non-critical individual.

The client usually discusses non-threatening and non-controversial issues first. He will probably be willing to talk about his job, family members, childhood etc. He will provide a lot of facts but desist from discussing the

emotional issues involved. He may slowly progress and begin to discuss his drinking or drug taking in a superficial manner.

All the while, however, he is alert to non-verbal and verbal cues from the counselor. When the counselor is perceived as a trustworthy, caring individual the client will discuss more and more personal and sensitive issues.

By the end of the first stage, the client feels accepted and comfortable and is willing to reveal more about himself.

STAGE 2 - EXPLORING PROBLEM AREAS

Addiction affects almost all areas of life – health, education, occupation, financial status, family relationships. Yet, the addict can be surprisingly ignorant of these issues. He usually refrains from self-contemplation as it can trigger a lot of unpleasant feelings.

During counseling sessions, the client is gradually led to discuss each of these areas. Details about these areas and the impact of drugs on them have to be focused on. What, when, where, with whom, how long as well as how intense the problem is, are questions that need to be dealt with. The picture that emerges will definitely be complicated, for if it were not, the client would have coped with it long ago.

Talking about these issues in a ‘safe’ environment is often cathartic for the client who finds relief in doing so. By getting the counselor to understand him, the client understands his own problems in a clearer manner. The more he discusses his life situations, the clearer the picture becomes – both to the client as well as to the counselor. At times, it will be helpful to get the permission of the client to talk to significant people in his life to explore problem areas. This would give the counselor greater clarity about the areas she has to work on.

In addition to being an empathetic listener, the counselor needs to make use of her skills at this stage:

- The counselor needs to be sensitive not just to the thoughts that are expressed but also to those that are not expressed. She must help the

client focus on them and thus draw him out. Probing statements may be required to help him express himself more clearly. These statements / questions can move the therapy process to a meaningful state. –*‘You talked a lot about your father but rarely mentioned about your mother’s reactions. Can we discuss this?’*

- Discussions need to help him express his feelings and not just facts. His feelings about the situation and how they are affecting him need to be clarified. Helping the client get in touch with his feelings is an important part of his recovery that helps him understand himself.

Talking about his debts may provide details about his financial status. But helping him express his fears, frustrations, sense of loss as well as his hopes and aspirations take the counseling process to a deeper and more meaningful level.

- Talking about the past, revisiting particular events like marriage, child rearing, illness, conflicts with parents, unleashes a lot of feelings. The counselor needs to be able to stay with the client in this process and deal with it rather than just reopen the past, listen to it and leave it in the open.
- Confrontation is a technique that needs to be used sparingly, judiciously and carefully. Confrontation needs to be made in a caring manner when there is a discrepancy between what the client says and what the counselor perceives, or when there is a difference between what he said earlier and what he says now.

‘You perceive your parents as not being supportive. With great difficulty they have paid the capitation fee and also paid for the training course which you discontinued. They have brought you for treatment and I can see that they visit you daily. Your mother is close to tears whenever she speaks of you. There seems to be a difference between how you see it and what is actually happening.’

- Denial is a part of the disease of addiction. Justification, rationalization and blaming are all part of denial. As therapy progresses, denial is slowly resolved easily in some areas and with resistance in others. Flexibility to progress with the client is important. Counselors need to work with the less problematic areas first before starting to work on other issues.

- The client may discuss problem areas with clarity but may not link them directly/ indirectly to the problem of addiction. The counselor's role lies in helping him establish these links and see the whole picture rather than view it in fragments. His psychological problems, poor job performance, social isolation – he may not see the picture as a whole and understand that addiction has contributed to the deterioration in a big way.

'You said you had beaten your wife under the influence of alcohol. You did not support your wife at the time of your child's illness. For the past few months, you had not given money for running the household. Is there a possibility that these incidents could have led to the separation?'

- Involving family members in this stage is important. Family members can not only support the client in recovery, but can also provide details about the impact of addiction with clarity. Moreover, just knowing that his family is also actively participating in treatment will keep his denial level low.

Family members may also be as dysfunctional as the client. Hence, it is meaningful to involve them in counseling as the client will return to the family on completing treatment. Helping the family view the client positively and provide support is an essential part of treatment.

The client who is largely alienated from the family may resist the involvement of his family. Attempts to reintegrate may not be easy. These situations have to be handled judiciously. In the absence of family members, identifying other support people is essential.

During the second stage, the tendency to blame others for his problems is minimized and the client is helped to see it as 'his' problem. Only when this shift is made, does meaningful problem solving becomes possible.

By the end of the second stage, the patient has a fairly realistic assessment of his problem areas. He accepts addiction as 'his' problem and is motivated to work on it.

STAGE 3 GOAL SETTING

Clients often repeat generalized statements like, ‘I’ll fix everything. I’ll sort it out. I am going to be drug free and everything will be alright.’ Soon after they experience relief from the withdrawals and experience a sense of well-being, many clients are over optimistic and see the future as a bed of roses. To other clients, life seems bleak and giving up drugs can make life seem more complicated. No matter what his expectation of the future, goal setting is the next logical step in the sequence of events.

Goals need to be specific, realistic and appropriate. For example, just saying ‘I’ll pay back the loans’ will not work. The client needs to work out a budget based on his present income, estimated expenditure, and amount available to pay back the loans. Which debtor he will pay first, how much and when, are details that need to be worked out. Impulsiveness, grandiosity and indiscipline are traits that can make this task difficult.

Setting goals gives clients a clear sense of purpose and instills a sense of drive and enthusiasm about the future. Goals also help evaluate one’s progress or lack of it.

Most of the issues are interrelated and some are more pressing than the others. Plans need to be made for each area – health, family, finances, use of leisure time, work as well as faith in a higher power.

Plans to maintain abstinence are often the priority. The main issues that need to be covered include

- Having a routine
- Identifying high risk places, situations and people where relapse is a possibility
- Coping strategies to deal with each of them
- Methods to handle craving
- Continued support from counselor and self-help groups.

The counselor and the client are active participants in the process. The counselor may need to summarize or highlight issues discussed earlier. –

‘When discussing the past, we saw that there were short periods in which you pursued difficult goals vigorously, after a while just lost

steam, and let them die down. Right now you are full of plans of what you will do. You are planning to work full time as well as do an evening course. I am worried that it may be stressful to you. I would rather that you start off with small manageable activities only and let the other issues wait till your sobriety is established.'

Establishing a few short-term and long-term goals is important. While going to work regularly may be part of short-term goals, getting a promotion may be the related long-term goal.

The counselor needs to brainstorm with the client about all possible options. Discussions about his future career may include being a sales man, businessman, teacher or even a computer professional. The client needs to evaluate the different options and weighing the pros and cons needs to be done primarily by the client, with active prodding and stimulation from the counselor. For example, the patient who is contemplating a shift in his job may need to consider the work environment, familiarity with the job, the challenges involved, drinking and drug use in the work environment, and not just the increase in the salary.

It must be remembered that the client is the expert about his recovery. It is his plan for his future rather than the counselor's. Objectivity, experience and knowledge are the counselor's strengths that are offered to assist the client in his effort, but the counselor's role in the plan ends there.

Exercises of these sorts help develop problem-solving skills in the client. Thus slowly he moves through the processes of effective decision-making and learns self-reliance.

STAGE 4

MAINTAINING CHANGE

The initial period of abstinence is usually euphoric. Plans that are made in the safety of the center may not be as easy to implement in the real world. Hence, follow-up visits need to be planned at frequent intervals, depending on the need and accessibility of the treatment center to facilitate the change process. During follow-up visits, adherence to the action plans and progress achieved need to be discussed. His routine –eating and sleeping habits, efforts to maintain sobriety, mood-status – may need to be discussed. These sessions are often used to look back and evaluate recovery.

The counselor is often the only cheerleader in the initial recovery period. She needs to be sensitive to progress made and appreciate the client for the efforts he has made. This strengthens his self-esteem and helps him view the future optimistically.

Two months of work without absenteeism, no further loans taken, the child awaiting his arrival, involvement in the family function – these need to be considered as signs of recovery and recognized.

Changes may need to be made if plans don't work well enough. The decision not to do overtime may have to be relaxed for a week if there is shortage of staff at work. He may be therefore able to attend only 3 N.A. (Narcotics Anonymous) meetings a week rather than one daily. Such contingencies need to be taken into account.

The family members also need to be helped to accommodate changes in the client. High expectations, casual remarks about the painful past and a controlling attitude by the family need to be altered.

Clients need help to identify relapse indicators at thought, feeling and behavior levels. Bringing these to the client's notice and helping him strengthen his coping mechanism are important.

'When you met drug using friends earlier, you would just smile, wave and move on. Now, you seem to participate in short conversations. You have also been missing out on your gym visits over the past two weeks. You mentioned just now, that life is just moving along and isn't interesting. Let us discuss what is happening.'

Handling relapses is an important issue. Counselors cannot view the patient's relapses as a sign of their own failure. The anger and frustration that grows out of it will limit the counselor's ability to help the client. The main issue is to arrest the relapse and initiate abstinence as soon as possible. Talking to the client or the family, making home visits, offering medical help or motivating him to receive help from the self-help groups are some ways of doing this.

Relapse cannot be seen as the client's complete failure either. Rather it indicates that there are areas that need to be changed and that further effort is

called for. Being critical and using 'I told you so' statements are not helpful. These only instigate the patient to be defensive. Instead the counselor should transform his guilt and remorse in a constructive manner. Later, after the relapse is under control, the relapse process, the issues that led to the relapse, and ways to prevent it in the future need to be discussed.

At this stage, the counselor helps the client stay on track, maintain his focus on goals, nudge him on to grow; and she actively intervenes when he is heading in the wrong direction. When there is a relapse, the counselor helps the client by providing hope and enthusiasm for recovery.

STAGE 5 - TERMINATION

All through the preceding stages the counselor is preparing the client to grow so that he is not totally dependent on the counselor any more. When the counselor has repeatedly walked him through the process of problem identification, goal setting and changing, the client learns these skills and can use them himself without the help of the counselor.

Over a period of time, the client's social network gets strengthened and he is well integrated into society. The counselor actively encourages the client to handle issues on his own and gradually withdraws involvement and support.

Termination is the logical conclusion to the process of counseling. The success of a counseling does not end with resolution of his problems symptoms but should also ensure personality growth so that the client emerges as a stronger and more capable of handling his problems. When a client is totally drug free for about two years and made progress in his life functioning in the areas of physical well being, family relationship, occupational and financial functioning, social reintegration, his sobriety can be considered as being stable. This counts as recovery.

Keeping in mind the chronic nature of the disease, it is necessary to assure the client that help is available whenever he needs it. It is not uncommon to receive clients even after four to five years of recovery. They may come just to keep in touch, review progress, or sometimes hasten to take help fearing a relapse.

All through the five stages, the counselor's skill is the primary force that keeps the client actively involved in therapy. In practice, however the client may not specifically progress from one stage to the other in a clear-cut manner as outlined above. Instead, one stage merges into the other and the client may move back and forth on certain issues. The strength of the counselor lies in staying with the client, helping him stabilize and move forward. This process can be emotionally gratifying and professionally satisfying, but it can also be frustrating. The counselor's emotional maturity in dealing with setbacks by using the support of the treatment team members is of crucial importance.

Counseling calls for a lot of skill and much depends on the counselor's own personality style. To be effective, the counselor needs to be able to strike a balance between being stable and mature as well as being spontaneous. Commitment is expected, but with professional detachment. The suffering addict who carries a low sense of self worth needs compassion, but he also needs the steadying hand of firmness and discipline to help him progress.

To play this role well with a fine sense of balance the counselor needs to be aware of her own potential as well as limitations. Counselors need to update their knowledge and fine tune their skills. Feedback from clients and other counselors should be received in the right perspective and changes need to be made. Self evaluation is also necessary. Asking oneself 'How did I handle this client during this session? Could I have done better?' are questions that counselors should ask themselves on a regular basis. With experience and willingness to evaluate oneself honestly, the counselor can develop skills of a high order.

TASKS IN COUNSELING

There are a series of tasks that are involved in the process of counseling. Based on the therapeutic relationship with the client, the counselor works through these tasks at the client's own pace.

A.

<i>Initiation into treatment</i>	<ul style="list-style-type: none"> ⇒ strengthening motivation to participate in treatment ⇒ eliciting client's concerns about problems and solutions. ⇒ understanding client's expectations ⇒ explaining the goals, structure and process of treatment
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B

<i>Assessment of addiction and related problems</i>	<ul style="list-style-type: none"> ⇒ details of current and past drug / alcohol use pattern ⇒ consequences of substance abuse in terms of physical health, emotional well being, family relationships, work performance, financial status and legal issues ⇒ information about major medical problems in the past and present health status ⇒ co-existing psychiatric disorders
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C.

<i>Identifying needs and resources</i>	<ul style="list-style-type: none"> ⇒ identify, focus on and prioritize problems ⇒ identify social support available ⇒ identify and enhance the skills, strengths and resources available to the client. ⇒ teach the client methods to capitalize on his personal strengths ⇒ assess further needs of the client and if need be refer to other centers (for example,
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	vocational training) ⇒ making referrals for critical needs that have been identified but can not be met within the treatment setting (for example, treatment for neurological problems)
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D.

<i>Develop recovery plan</i>	⇒ help client accept the chronic, relapsing nature of substance abuse disorder ⇒ develop recovery plans to address, identify with client's active participation ⇒ help client identify relapse triggers and high risk situations as well as develop coping strategies. ⇒ Develop a plan for future support in the form of self-help groups, family support and community support
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E.

<i>Ending treatment</i>	⇒ elicit commitment from the client to follow through recovery plans on what has been learnt or achieved ⇒ review possible problems the client may encounter ⇒ review positive outcomes the client can expect ⇒ clarify follow up pattern ⇒ leave the door open for possible future sessions for dealing with the client's other problems
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F.

<p><i>Follow-up efforts</i></p>	<ul style="list-style-type: none">⇒ Monitor changes to check whether the accomplishments are consistent with the recovery plan and the client's expectations⇒ Reinforce positive changes and instill optimism for continued growth⇒ Continue to watch out for relapse indicators⇒ Provide help to deal with set backs in implementing recovery plan.
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SKILL SHARPENING TOOLS

EFFECTIVE APPROACHES IN COUNSELING

Counseling includes methods that are sensitive to individual client characteristics and to the influence of significant others, as well as the client's cultural and social context. Competence in counseling is built upon an understanding of, appreciation of, and ability to appropriately use the contributions of various addiction counseling models as they apply to modalities of care for individuals, groups, families, couples, and significant others.

Establish a helping relationship with the client characterized by warmth, respect, genuineness, concreteness, and empathy.

Knowledge

- ❑ Approaches to counseling that have demonstrated effectiveness with substance use disorders
- ❑ Definitions of warmth, respect, genuineness, concreteness, and empathy
- ❑ Role of the counselor
- ❑ Therapeutic uses of power and authority
- ❑ Transference, counter-transference, and projective identification

Skills

- ❑ Active listening, including paraphrasing, reflecting, and summarizing
- ❑ Conveying warmth, respect, and genuineness in a culturally appropriate manner
- ❑ Demonstrating empathetic understanding
- ❑ Using power and authority appropriately in support of treatment goals

Attitudes

- ❑ Respect for the client
- ❑ Recognition of the importance of cooperation and collaboration with the client
- ❑ Professional objectivity

Facilitate the client's participation in the treatment and recovery process.

Knowledge

- ❑ Theories and methods for motivating clients in a culturally appropriate manner
- ❑ Counseling strategies that promote and support successful client participation

Skills

- ❑ Implementing appropriate interviewing approaches
- ❑ Assessing client's readiness for change
- ❑ Using culturally appropriate counseling strategies
- ❑ Assessing the client's responses to therapeutic interventions

Attitudes

- ❑ Respect for the client's frame of reference

Work with the client to establish realistic, achievable goals consistent with achieving and maintaining recovery.

Knowledge

- ❑ Assessment and treatment planning
- ❑ Stages of change and recovery

Skills

- ❑ Formulating and documenting concise, descriptive, and measurable treatment outcome statements
- ❑ Teaching the client to identify goals and formulate action plans

Attitudes

- ❑ Appreciation for the client's resources and preferences
- ❑ Appreciation for individual differences in the treatment and recovery process

Promote client knowledge, skills, and attitudes that contribute to a positive change in substance use behaviors.

Knowledge

- ❑ The information, skills, and attitudes consistent with recovery
- ❑ Client's goals, treatment plan, prognosis, and motivational level
- ❑ Assessment methods to measure progress towards positive change

Skills

- ❑ Motivational techniques
- ❑ Recognizing client's strengths
- ❑ Assessing and providing feedback on client's progress towards treatment goals
- ❑ Assessing life and basic skills and comprehension levels of client and all significant others associated with the treatment plan
- ❑ Identification and documentation of change
- ❑ Mentoring and teaching
- ❑ Recognizing and addressing ambivalence and resistance

Attitudes

- ❑ Genuine care and concern for client, family, and significant others
- ❑ Appreciation for incremental change
- ❑ Patience and perseverance

Encourage and reinforce client actions determined to be beneficial in progressing towards treatment goals.

Knowledge

- ❑ Relapse prevention theories and practices
- ❑ Behaviors and cognition consistent with the development, maintenance, and attainment of treatment goals
- ❑ Counseling methods that support positive client behaviors consistent with recovery

Skills

- ❑ Using behavioral and cognitive methods that reinforce positive client's behaviors
- ❑ Using objective observation and documentation
- ❑ Assessing and re-assessing client behaviors

Attitudes

- ❑ Therapeutic optimism
- ❑ Patience and perseverance
- ❑ Appreciation for incremental changes

Work appropriately with the client to recognize and discourage all behaviors inconsistent with progress towards treatment goals.

Knowledge

- ❑ Client history and treatment plan
- ❑ Client behaviors and cognition that are inconsistent with recovery process
- ❑ Behavioral and cognitive therapy literature relevant to substance use disorders.
- ❑ Cognitive, behavioral, and pharmacological interventions appropriate for relapse prevention

Skills

- ❑ Monitoring the client's behavior for consistency with preferred treatment outcomes
- ❑ Presenting inconsistencies between client's behaviors and goals
- ❑ Re-framing and redirecting negative behaviors

- ❑ Conflict resolution, decision-making, and problem solving skills
- ❑ Recognizing and addressing underlying client issues that may impede treatment progress

Attitudes

- ❑ Patience and perseverance during periods of treatment difficulty
- ❑ Accepting relapse as an opportunity for positive change
- ❑ Recognizing the value of a constructive helping relationship

Recognize how, when, and why to involve the clients significant others in enhancing or supporting the treatment plan.

Knowledge

- ❑ Research literature which demonstrates the importance of family and significant others' involvement in treatment process
- ❑ How to apply appropriate confidentiality regulations

Skills

- ❑ Identifying the client's family and social systems
- ❑ Recognizing the impact of the client's family and social systems on the treatment process
- ❑ Engaging significant others in the treatment process

Attitudes

- ❑ Appreciation for the need of significant others to be involved in the client's treatment plan, within the bounds of confidentiality
- ❑ Respect for the contribution of significant others to the treatment process

Promote client's knowledge, skills, and attitudes consistent with the maintenance of health and prevention of HIV / AIDS,

tuberculosis, sexually transmitted diseases, and other infectious diseases.

Knowledge

- How infectious diseases are transmitted and prevented
- The relationship between substance-abusing lifestyles and the transmission of infectious diseases
- Harm reduction concepts and methods

Skills

- Using a repertoire of techniques that, based on an assessment of various client and system characteristics, will promote and reinforce health-enhancing activities
- Mentoring and teaching techniques relative to the promotion and maintenance of health
- Demonstrating cultural competence in discussing sexuality

Attitudes

- Openness to discussions about health issues, lifestyle, and sexuality
- Recognition of the counselor's potential to model a healthy life-style

Facilitate the development of life skills associated with recovery.

Knowledge

- Life skills associated with recovery
- Theory, research, and practice literature that examines the relationship of life skills to the attainment of positive treatment outcomes
- Tools used to determine levels of life skills

Skills

- Applying assessment tools to determine the client's level of life skills
- Teaching life skills appropriate to the client's situation and skill level
- Communicating how life skills relate to treatment outcomes

Attitudes

- ❑ Recognizing that recovery involves a broader life context than the elimination of symptoms
- ❑ Accepting relapse as an opportunity for learning and/or skills acquisition

Apply crisis management skills.

Knowledge

- ❑ Differences between crisis intervention and other kinds of therapeutic intervention
- ❑ Characteristics of a serious crisis and typical reactions
- ❑ Post-traumatic stress and other relevant psychiatric disorders
- ❑ Roles played by family and significant others in the crisis development and/or reaction
- ❑ Relationship of crisis to client's stage of change
- ❑ Client's usual coping strategies
- ❑ Steps to aid in crisis resolution, including determination of what client can do on his own and what must be done by counselor, family, or significant others in client system

Skills

- ❑ Carrying out steps in crisis resolution
- ❑ Assessing strengths and resources of client and client's support system
- ❑ Assessing immediate concerns regarding safety and any potential for harm to others
- ❑ Making appropriate referrals as necessary
- ❑ Assessing and acting upon issues of confidentiality that may be part of crisis response
- ❑ Assisting the client to ventilate emotions and normalize feelings

Attitudes

- ❑ Recognize crisis as an opportunity for change
- ❑ Confidence in the midst of crisis
- ❑ Recognize personal and professional limitations

Facilitate the client's identification, selection, and practice of strategies that help sustain the knowledge, skills, and attitudes needed for maintaining treatment progress and preventing relapse.

Knowledge

- How the client and client's family, significant others, mutual-help support groups, and other systems can enhance and maintain treatment progress, relapse prevention, and continuing care
- Relapse prevention strategies
- Skill-training methods

Skills

- Using behavioral techniques to reinforce positive client behaviors
- Teaching coping strategies to prevent relapses
- Motivating the client towards involvement in mutual-help support groups

Attitudes

- Recognize that clients must assume responsibility for their own recovery

INTERNALISING TOOLS

CASE ANALYSIS

Instructions: Trainees are divided into smaller groups and are requested to note down the inappropriateness in each of the following statements made by the counselor. Appropriate responses have to be discussed.

- 1) *Counselor:* Come in. Sit down. Tell me your name. Where are you from?
Are you married? Has somebody from your family come with you?
- 2) *Client :* All the years of married life I have been most unhappy.
I hope this treatment will work.

Counselor: Don't worry. Everything will be all right. Just bring him here.
- 3) *Counselor:* Your daughter-in-law told us that you are not willing to get your son treated for addiction. What is wrong with you?
- 4) *Counselor :* It is one month since you rejoined your husband. Are you happy?

Client : Yes Ma'am.
- 5) *Client :* Please advise my wife. She fights with me all the time. After a day of hard work, I cannot relax. Sometimes I feel I am going mad.

Counselor : How many years has it been since you got married?
- 6) *Client :* My father still treats me like a kid.

Counselor : He is treating you just the way his father treated him. That's all.
- 7) *Client :* I became terribly angry.

Counselor : Come on! Don't tell me you were angry just for a 10 minutes delay.
- 8) *Client :* I have been waiting for two hours to see you.

Counselor : I can't help it. I was not just sitting here.
- 9) *Counselor:* This is the third time you have had a relapse. Why can't you

understand? Can't you think properly?

10) *Client* : That's it, Madam. I have told you the entire story. Now, you tell me what I should do. Shall I leave my husband or continue to stay with him?

Counselor :

- a) You have been married for six years. Why don't you try and patch up the marriage?
- b) Sounds like you have two kinds of feelings. There are a few reasons why you should leave and a few to continue in the marriage.
- c) Your children may be affected if you break up. Shouldn't you think of them? Your parents may not like it if you get separated from your husband.

11) *Client* : Taking medications regularly for a whole year is a big bore.

Counselor :

- a) There is no short-cut to that.
- b) Shall I take the medicines instead of you then?
- c) A year will go by quickly. Don't worry.
- d) If you can't spend even one minute to take it, you are just lazy.

SPECIAL ISSUES IN ADDICTION COUNSELING

Addiction is a complex disease that affects people in various degrees. Each client's strengths/resources as well as weaknesses and limitations vary widely, making each one's problem unique. This makes the counselor's role challenging and demanding.

Theoretical understanding of the disease, maturity to present an appropriate professional attitude and a repertoire of skills are required to carry out this professional task of counseling in an effective manner.

During the process of counseling, the client needs to re-visit his past, assess the damage due to addiction, decide to abstain and make a meaningful plan for the future. Though counseling is largely within this basic framework, there are many specific clients and their specific situations that need to be addressed. Some of these are listed here. Under each head, the issues that the counselor needs to keep in mind and the focus of counseling are discussed.

(1) THE FEMALE SUBSTANCE ABUSER

The stigma that surrounds addiction is much stronger in the case of the female user. This often leads her to delay reaching out for help. By the time she shows up at the treatment center, she has lost her support system and usually has had to deal with severe physical problems as well.

Handling the woman addict calls for an understanding of her childhood relationship with her parents, the stressful events in her life and the manner in which she has reacted to these stressors.

Assessment of her shame, guilt, anxiety and depression is extremely important. Helping her to develop healthy coping patterns to deal with these negative emotions is necessary. Helping her talk about her behavior with and without chemicals provides valuable insight to help her recover. Women are more likely to have suffered sexual abuse in childhood and counselor should be sensitive to this issue. Health related issues have to be handled and possible psychiatric problems need to be assessed.

Extra efforts are often called for to make this patient feel more comfortable amidst the largely male patient population. Her hesitation to attend self-help groups, poor social support and her health problems call for intensive intervention and follow-up measures.

(2) **THE ADOLESCENT ABUSER**

In the case of this client, abuse has set in even before his adult, mature personality style has been established. He is forced to deal with both his addiction as well as the stormy transition stage of adolescence at the same time. It is not surprising that this client is often a challenge to the counselor.

The adolescent is a demanding client who needs a lot of time before he can relate well to the counselor. Denial is most often present as he is unable to view himself as an addict at that young age. The financial dependence and available family support buffer the impact of addiction, making him all the more resistant to treatment.

His family and his peers are the two major influences which need to be discussed in detail. He often needs help to sort out the inconsistent messages from the environment and requires life skills training both at the interpersonal and intra-personal levels. Learning to deal with depression and anger is another major issue.

The counselor needs to be seen as a person who is flexible, open, non-stigmatizing and easy to relate to. The counselor needs an extra dose of tolerance and patience while dealing with this client. The adolescent often needs a lot of time before he can express his fears and aspirations about the future, and the pain and frustration of the past. Labeling and strongly expressed directives to change may be counter-productive as he will react with defiance and rebellion.

(3) **ALCOHOLIC COUPLE**

More often than not, one partner's addiction would have spurred on or aided the other to drug abuse. Concurrent treatment for both partners to support each other in recovery works best. When this does not work, extra efforts to strengthen social support and intensive follow-up measures are needed.

Understanding the pattern of interaction between them is essential. Identifying high-risk situations and planning to deal with these can help prevent relapses. Children, if any, will be in a very painful situation and their needs also have to be considered.

Separation moves may have to be initiated if the presence of the actively drinking / drug taking spouse continues to interfere with recovery.

(4) **SEPARATED PATIENT**

The duration of marriage and separation, the severity of the marital problem, the patient's present life situation and future plans are important variables to consider. If a legal separation has not been ordered, it is worthwhile to establish contact with the spouse even if it is only to get information about the client. Most spouses react favorably to the effort at treatment and may consider rejoining the addict though with a few conditions.

If the separation or divorce is a recent one, the client may discuss these issues more than the addiction. Permitting the client to address this area and gradually but firmly turning the focus on to addiction is a task that needs a lot of sensitivity and flexibility on the part of the counselor.

If the spouse joins the client after a few months, marital therapy has to be planned when reconciliation takes place, irrespective of whether the client is in the early or progressed stage of recovery.

(5) **ADULT CHILDREN OF ADDICTED PARENTS**

Children whose parents abuse alcohol / drugs undergo a lot of trauma. The faulty role modeling, the lack of emotional support, need to deal with a variety of crises (due to the parents addiction) all these make the child's life difficult from his early years. When this child grows up and develops addiction, issues related to his childhood and his coping strategies take on added significance during treatment.

An understanding of the childhood history and the coping mechanism he adopted, provide the counselor an insight into the problem areas and the manner in which they can be resolved. Some patients are likely to defy authority and in these cases, the tendency to take risks will be high, and

compliance with treatment can be poor. On the other hand, the client who never made demands or hid behind a facade will need a lot of probing before he can express himself openly and honestly.

(6) **ANGRY CLIENT**

During treatment, many addicts get in touch with their painful past; this can and usually does unleash a lot of feelings. The future too may look bleak, only increasing the emotional trauma. Angry outbursts can stem from feelings of helplessness and frustration.

Being just as angry and authoritative as the client does not help. Being able to empathize and at the same time, to set clear limits for unacceptable behavior is important. ‘What makes him do this? What is he trying to say through this?’, are questions that one needs to ask oneself to sift through his defenses and understand the client.

Uncontrollable, excessive outbursts of anger also warrant a detailed mental status examination to rule out underlying psychosis.

(7) **RESISTANT CLIENT**

Inadequate motivation, fears about treatment, anger towards family or the enabling mechanism within the family are common reasons for resistance. Inflexible dos and don'ts only alienate this client further. Handling him requires empathetic listening, patience and tolerance which will help him lower his defenses. In-depth psychiatric assessment is called for if the counselor is unable to break through his defenses even after a lot of efforts.

(8) **CLIENT IN DENIAL**

Denial can take many forms. The client may totally deny that he has a problem. He may justify or minimize the problem or blame extraneous situations for his addiction. Listening, summarizing and probing for the unexpressed links lead to development of insight and breaking of denial.

Denial needs to be addressed carefully – the facts he denies, the need to do so, the intensity of denial and the strength of the therapeutic relationship all need to be considered. Collecting information from the family about the damage caused by his addiction and presenting it in a non-judgmental

manner help in breaking the denial. Spending time to understand the client and helping him understand the disease are needed before confrontation can be initiated. Premature and authoritative, critical confrontations more often harm the client than help in his recovery.

(9) CLIENT WITH DUAL DIAGNOSIS

Psychiatric problems can be present along with addiction. Depression, paranoia, affective disorders or even schizophrenia may be present. Addiction can cause or exaggerate these problems. Both the issues need to be dealt with during treatment as each can influence the recovery from the other.

Clients with personality disorders may need to be watched more carefully and they profit more from long-term care.

Detailed history with adequate information collected from collateral resources is needed to make a diagnosis. Basic training in psychiatric diagnosis is needed for assessment. Knowledge about the medications prescribed and their possible effects is necessary. Explaining the issues to the family, stressing the need for medication and making them aware of probable signs of remission are important. During follow-up, the Counselor needs to evaluate this patient carefully to ensure smooth recovery both from addiction as well as from the psychiatric problem.

(10) CLIENT WITH SEVERE PHYSICAL PROBLEMS

Keeping the patient informed about the nature of the problem without making him feel hopeless about the situation is important.

Simple facts about how the body works and the damage that drugs / alcohol cause need to be explained to the client. A regimen of adequate food intake, and simple exercises with adherence to medications has to be stressed.

Counselors need to restrain themselves from making confident assurances about the duration of time required to recover completely. Overly emphasizing the sickness of the client can also do a lot of harm to him and his concern over his illness will cloud everything else including his understanding of addiction.

These patients usually need a lot of time with the counselor as physical deterioration usually brings with it cognitive deficits that limit the gains from other forms of therapy.

During follow-up, the counselor needs to focus on small gains made during therapy to increase the confidence and hope of recovery.

(11) HIV POSITIVE CLIENT

Clients with high-risk behavior of IV (intravenous) use or multiple sexual partners need to be informed about HIV testing and encouraged to take the test. Pre-test counseling and consent for testing are of course a must. Following this, post-test counseling is also needed. If the client tests positive, dealing with the shock, remorse and guilt are foremost issues. Unless this is dealt with, one cannot engage the client in working towards abstinence. Using the 'here and now' focus to strengthen his motivation to recover is important. Helping him to identify one or two supportive individuals and networking with an agency to provide ongoing support for his future medical needs are necessary.

(12) OVER DEPENDENT CLIENTS

The client's pre-morbid personality of being dependent coupled with the social ostracism that addiction brings can make the client over dependent on the counselor. He cannot make even simple decisions without help from the counselor. This not only means a drain on the counselor's time but the unnecessary dependence prevents the client from growing.

Making extra efforts to strengthen the social-network, identifying leisure activities/ hobbies and encouraging the use of self-help groups can help this client. As these measures become comfortable for him, over dependence usually reduces on its own. Planning follow-up sessions at less frequent intervals, focusing on specific major issues alone and helping him see his own ability to handle problems in recovery, also help.

The counselor may at times unconsciously encourage the dependence to meet her own needs and this is unhealthy for both the client and the counselor.

(13) CLIENT FROM LOWER SOCIO-ECONOMIC BACKGROUND

Addiction magnifies poverty related issues; inability to meet even the basic needs, unemployment or poorly paid jobs and all other issues related to poverty heighten the sense of helplessness. The client may view alcohol / drug abuse as a solution to the problem he faces on a daily basis.

These issues need to be discussed during counseling and cannot be overlooked. Focusing only on recovery from addiction and hoping that all the rest will settle on its own does not help.

Active counselor involvement in helping him identify resources and setting small reachable goals is necessary. Mobilizing community resources and vocational rehabilitation without giving the impression that it is our responsibility to 'fix it all' on his behalf may be needed.

(14) CLIENTS WHO RELAPSE FREQUENTLY

Even while understanding that relapses are part of recovery it cannot be denied that they can be frustrating for both the client and the counselor. While the client can take a stand of helplessness about the relapses, counselors may tend to give up. The frustration of the counselor often projects itself as anger towards the client. Family members are often equally distraught and critical, and condemn the client.

Maintaining an objective view of the situation and being able to help the addict assume the onus of responsibility for his recovery is necessary.

Detailed information about the relapses – the dates and duration – recapitulating events, thoughts or feelings prior to the relapse and methods to break the cycle of abuse is crucial to help this client. This will help him to identify the relapse triggers and lacunae in the recovery plan. With empathy and firmness, the therapist needs to provide a sense of optimism and encouragement to the client to continue with treatment.

A detailed psychiatric assessment, ferreting out problems not expressed during the primary treatment and referral to an extended program also need to be considered.

(15) **TRANSFERENCE**

The client may consciously or unconsciously cast the counselor in the role of a parent or sibling in an effort to establish emotionally close ties, and to feel recognized and worthy of attention, in order to enhance self-esteem. In many cases transference can enhance the benefits of therapy. Being sensitive to transference issues and making it work therapeutically is the best course of action. Transference can be intensive, with a great deal of dependence coupled with hostile manipulative and testing behavior. When it progresses beyond an acceptable level and the client replays the conflicts and power struggles of his other relationships in the present counseling relationship, it can become unhealthy. Discussing these issues specifically and openly helps.

When it grows in an unhealthy direction especially with sexual connotations, transference interferes with therapy and it is best to transfer the client to another therapist.

(16) **COUNTER TRANSFERENCE**

Counter transference can grow out of conscious or unconscious thought processes of the counselor. The counselor may project her own feelings or conflicts to the client and lose the professional objectivity that is necessary. Being sensitive to one's own feelings and behavior helps one become sensitive to the issue. Talking about it with the senior counselor helps. Being able to ask oneself why, and deal with it helps the counselor grow professionally. However, if the counter transference is intensive, it would be best to terminate the relationship with the client.

There are scores of other special issues like the aforementioned that confront the counselor. Being aware of the specific issues that interfere with therapy, being open to new learning inputs from the team and senior counselors, help one deal with these problems. The depth of care one really feels for the client along with the professionalism that one brings into practice is what sets apart an effective and successful counselor from the rest of the crowd.

SKILLS SHARPENING TOOLS

CONFIDENTIALITY

What exactly does the counselor mean when she promises confidentiality? Confidentiality is safeguarding information about an individual that has been obtained by the counselor in the course of counseling. Sometimes, for the sole purpose of helping the patient, the counselor uses her discretion to disclose some information to significant people. When the counselor says she will maintain confidentiality, she assures the client that whatever he tells her, will be used responsibly and will be guarded against misuse.

There are two types of confidentiality – absolute and relative.

Absolute confidentiality

The security of information is absolute when data learned or observed by a counselor stay with her and are never passed on to any one else.

Relative confidentiality

Some of the information given by the client is shared with others in the system in a responsible manner as part of the treatment process.

In an inter-disciplinary setting, exchange of information will occur. Case histories will be discussed with other therapists in order to help clients. For example, a case may be discussed with the Vocational Counselor for rehabilitation. As part of case discussion, information may be given to other counselors. This sharing is done with the intention of giving the client better help by seeking clarification from colleagues. A newly appointed counselor may find it necessary to consult a senior counselor regularly to discuss and receive guidance regarding treatment strategies.

Some Guidelines for Maintaining Confidentiality

The following are some of the most common instances in which violation of confidentiality is likely to take place. Inappropriate disclosures like these have to be guarded against.

The counselor sharing details with her own family and friends

This is one of the most frequent violations. The counselor may rationalize. 'It's okay, as long as I don't use names. Besides, they don't know the people I am talking about. So what is wrong with discussing clients or work situations with my family members?'

The counselor who is tempted to share information, must first ask herself a basic question: 'Is my friend or relative bound by the same rules of confidentiality as I am?' If the answer is 'No', then that person cannot be prevented from passing on the information to a third person.

It is acceptable for counselors to share feelings experienced as a result of daily activities, but here too names and specific details regarding clients and others should not be disclosed. Emotional reactions to confidential material rather than the confidential information itself can be shared. It certainly is permissible to state, 'Oh! I had a frustrating day today – nothing went right', or 'A patient of mine had a relapse and it took everything I had to deal with it', or 'A client I have been working with for months died today and I am really upset.'

Indeed, such release of feelings is essential, as friends and family provide the emotional support and empathy needed from time to time.

Disclosure to the client's family members

The counselor should be aware that certain information revealed by the patient need not be conveyed to his family members (e.g. pre-marital / extra-marital relationship). If the family is not staying with the client or is not involved in the treatment (for example, wife separated from client, not attending treatment program), and they want to know some details about the client, the counselor should assertively say 'Sorry', and the information should not be given out.

Informal discussions with colleagues

A counselor may be grappling with a client's problem when her colleagues join her during lunch or coffee break. There will be a tendency to ventilate feelings and discuss unresolved problems during that break. Sometimes, these indiscreet conversations can be overheard and may lead to problems. Therefore, information should be shared only in privacy and in a professional manner with the purpose of helping the client.

Inappropriate remarks to co-workers and other patients

Every patient should be treated with dignity and any inappropriate remark about him to other patients or co-workers should be avoided. For example,

Hello Mr. Prakash – I am sorry I had to keep you waiting for so long, the other client just went on and on.

Another example is,

Counselor-1: Hello VSG, What is wrong with Mrs. Ravi? Has she fought with her husband again?

Counselor-2: Yes. She has started again... Had a big fight with her husband.

Such discussions should be avoided.

Recognizing the client outside

The counselor may see the client at social functions, in cinema halls, hotels etc. Unless the client acknowledges and talks to the counselor, the counselor should not take the initiative and recognize the client.

Release of information to others

Someone other than the client may seek access to information contained in the records. The principle is that the client's consent should be obtained before any confidential information about him is disclosed. First the client

must be told that there is a request for certain data. He must be made aware of the following details:

- who has asked for the information
- what information they have asked for
- the purpose of the request

He should also be fully informed of any repercussions that might occur.

Common Sources of Requests For Information

A few sources that may ask for or need confidential information from records are listed below.

Family and friends of the client

It is natural to assume that family and friends always have the client's best interests in mind and should therefore be given whatever information they want. This is not always true. Therefore, the client has to be consulted before any information is passed on. A standard response may be 'I'm sorry; I am unable to give you that information. I'll contact the client, and if he gives permission, I will get in touch with you. Or, I'll ask him to contact you directly.'

The caller may insist that he has already obtained the client's permission. This statement should not be taken for granted. A formal written consent from the client should be obtained. Usually, families of chemical dependents would ask for certificates of treatment taken at the center for the purpose of divorce, claiming of child, property, job etc. These certificates **should not** be issued without the client's consent.

Legal authorities

No information should be passed on to legal authorities (court, police etc.) unless they come with a formal request, or send the orders through the proper channel. Even then, the information should be addressed to the source of request or appropriate authority only.

Employer

If the client has been referred for treatment by the employer, limited and relevant information can be passed on to the employer. If the employer has not referred, then no information need be given.

Non-clinical staff

They should not gain access to patients' records.

News media

No information pertaining to clients should be given to the news media and no photographs taken without prior permission.

Others

Information with regard to treatment facilities, charges, duration, availability of beds etc., can be given to the public. On the other hand, the center may get telephone calls asking if a particular person has been admitted, taken treatment earlier etc., for which no information should be given, as the caller could contact the respective family for such information.

Thus, maintaining confidentiality is an integral part of the treatment process, since it lays the foundation for mutual trust and confidence, which is very vital to a positive client-counselor relationship.

INTERNALISING TOOLS

CASELETS

Read each of the caselets and suggest the course of intervention that the counselor should follow or the issues that have to be dealt with in counseling sessions:

1. Joseph was an above average student in his school days. With drug abuse and absenteeism, his academic performance in college had deteriorated. His exams were about 6 months away and he had to clear about 10 papers. Joseph and his parents were very confident of his clearing the examinations.
2. John felt that NA meetings were boring. Every member who came to share in the treatment center had been as 'bad or worse than him', he stated. He did not want to attend the NA meetings after discharge.
3. Anand is now in his 30s, married with a five year old son. He had lost his mother when he was 2 years old and his father remarried when he was 7. He has a brother, a sister and two stepsisters. His relationship with the stepsisters was fine. His sister is close to him as well as to the stepmother. But Anand has not even talked to his stepmother for several years. According to him, his stepmother had never discriminated between the children. Yet, he said that he disliked her for the reason that she had taken the place of his mother. Anand's resentment seemed unjustified as the stepmother seemed to really care about him while he was undergoing treatment.
4. It is a month since Ahmed was discharged. To celebrate the new year, a major music show was to be held in the city. Many of his friends were going and had asked him to join them. Ahmed knew that many in the audience would be using grass. 'But it would be fun too. I am wondering what I should do,' he said Ahmed.
5. Raj has come for his first follow-up after treatment. He complained of tiredness and aches and pains in all his joints. He said his appetite had reduced after discharge from the treatment center. Concentration and memory also seemed to be poor, which made him feel anxious.

6. Rajiv appeared to be uncomfortable and hesitantly told the counselor he had a personal problem to talk about. Slowly, he said he was unhappy about his sexual performance even though it was nearly three months since he gave up drinking.
7. Abdul was jubilant about his recovery. He talked of all the improvements he had made in the six months of sobriety. He had asked his brother for a loan to start a part-time business and his brother had agreed. Abdul was happy that with the money from the business as well as his salary he could buy a house quickly.
8. Prem had got his first job two months ago, which involved marketing home appliances.. Things were fairly okay until the manager expressed displeasure about his inability to meet sales targets. Prem was upset and wanted to give up his job.
9. Jacob was complaining about his mother. He said she was trying to control him all the time and that they had arguments everyday about where he went and how he spent his time and money. He said that she had too many expectations and that the situation was unbearable.
10. Rahim was meeting his counselor after New Year day. This was ten months after treatment and the first major celebration after discharge. He said that he had a craving but he did not try drugs.

ADDICTION ITS IMPACT ON THE FAMILY

Addiction creates a major stress on individual family members and the family system. Families are transactional systems in which all parts affect the greater whole (Wolin, 1980). In the case of families where one member is an addict, that one member becomes the focus of the family and consequently, the family loses the balance. The addiction upsets the normal functioning of the family. When family functioning is altered, all members are affected (Steir, Stanton, Todd, 1982).

Addiction is an economic drain on family resources and can threaten job security. Drinking / drug taking behaviour may interrupt normal family tasks, cause conflict and demand adjustive and adaptive responses from family members who do not know how to do so appropriately. In brief, addiction creates a series of escalating crises in family structure and function, which may bring the family to a system crisis

Deutsch (1982) describes family dynamics as 'remarkably uniform in most addicted homes and significantly different from the conditions which govern most other households'. There are certain specific problems they face.

- The family lives on an emotional roller coaster of embarrassment, guilt, hurt, anger and frustration.
- The addict becomes less predictable, less reliable, financial resources are diverted for alcohol / drugs, hence family becomes insecure.
- Constant demands, growing criticism, provocations, erode the family's self esteem.
- To protect the addict from external condemnation and to protect themselves from further embarrassment, the family may isolate itself from external contacts.

THE FAMILY'S REACTIONS TO THE CHEMICAL DEPENDENT

DENIAL

The family of the *chemical dependent* usually denies the existence of the problem in order to avoid humiliation and embarrassment. What is obvious to others is flatly denied by those who live on intimate terms with the *dependent*. The family becomes quite adept at shielding him, making excuses for his behavior, helping him out of tight spots, covering up for him with his employers and others. The minimizing and rationalizing of family members is often deeply ingrained and truly believed –ingrained and believed in much the same way as the minimizing and rationalizing of the addicted person. As a result, family members protect the person, deny that the relationship is troubled, and deny the addiction of the person to whom they are attached.

PREOCCUPATION

The preoccupation of family members is similar to the addict's obsession for drugs. Their entire thinking usually revolves around the *dependent* and they forget to take care of their needs. Their lives are almost always modified to suit the needs of the *chemical dependent*. Acute stresses drive the wife or parent to some behavior or activity which she compulsively performs.

For example, she may be tracking the movements of the *dependent* all through the day, even though she might be aware that by doing this, she can not control his drug use. Her compulsive preoccupation drives her to waste her energy in unproductive ways, and the result is that she fails to perform her duties like cooking or looking after the children. She finally ends up in a self-destructive trap, controlled and manipulated.

MAKING CHANGES IN ONESELF

Most family members believe that the addict is taking drugs because of certain problems. As a result, the family takes responsibilities to deal with those problems. They try to establish a pleasant atmosphere at home hoping that it will help the addict to stay away from drugs. The family may go out of their way to please the addict and maintain a warm and caring attitude towards him even when the situation is difficult. The mother may say:

You have been repeatedly saying that we did not pay attention to you. Now I have given up my job. Father has stopped spending time at the

club. Now that we have taken these steps, we expect you to stop taking drugs.

She believes that her son's problem is just temporary and that once they have made certain changes in themselves, he will stop using drugs.

BARGAINING

Bargaining also comes into play as the parents / wife try to cope with this crisis that has invaded their home.

I will get you the latest computer, so that you can spend your evenings browsing the internet. You will not feel bored.

The moment you give up drugs, I will set up a business for you.

The goal of bargaining is to offer the chemical dependent something in return for the desired behavior. But such bargaining does not work at all. Instead, it leads to frustration and depression.

BLAMING

Unfortunately, the family members start blaming each other. Very often the *chemical dependent* who is trying to take the focus off himself, uses the situation to his advantage and sets one family member off against another. For example, he may tell his mother that he is using drugs because he is unhappy in his marriage. He may say that his wife nags him continuously and he can't stand it. To his wife, the same person complains bitterly about his domineering mother who never made any effort to understand him as a child and sent him away to a boarding school. This results in more pain and tension in the family because the two women start blaming each other for his addiction. In so doing, the family is kept from coming together and addressing the most important issue of how to help the *chemical dependent* recover from the disease.

CONTROLLING

The family attempts to control his drug taking in the hope of getting him out of this problem. The wife /mother may

- hide, empty the drug packets or break the bottles

- ask the addict to avoid his friends
- extract promises from him
- cry, plead, threaten and shout at him to stop his use of drugs

In spite of these efforts, the addict continues to take drugs. Realizing that her efforts have failed, she requests others – elders in the family, his non-drug-taking peers – to intervene and advise him. He may comply for a short period of time but in the long run, this too does not work.

DISORGANIZATION OF THE FAMILY

The family gives up all attempts to make him stop using drugs because the wife / mother realizes that none of these methods help. When she takes stock of the situation at home, she finds everything in disarray. She has no control over the addict; other children's lives have also been affected; she is unable to exercise control even over her own emotions.

Permitting the crisis

At some point in time the family stops taking any responsibility for the consequences of the addict's behavior. The wife / mother may refuse to bring him home from where ever he lies drunk; refuse to clear his debts; refuse to give excuses to his boss for his absence from work; refuse to take him to the 24-hour clinic whenever he develops withdrawal symptoms.

When the addict is left to face these crises all by himself, he feels helpless and the family members make use of these situations to intervene and motivate the individual to seek help.

FEELINGS EXPERIENCED BY FAMILY MEMBERS

In order to offer help and plan effective treatment, it is essential to understand the feelings suffered by the family and the behavior adopted by them as a method to cope with the enormous problems they are left to face.

GUILT

The emotional response to addictive illness in a family member frequently has its roots in feelings of guilt. Our culture often implies that if a person takes to drugs, someone else is to be blamed.

For you, golf was more important than your son's well being. You never cared to spend time with him.

You had sent him to an ordinary school. If he had studied in a better school, he would not have picked up this habit.

GRIEF

The family has lost all the pleasures of life. Their losses are innumerable – loss of prestige, loss of family and personal dignity, loss of relationships, loss of feelings of love, loss of care and understanding, loss of security, loss of finances – loss in each and every area of their lives. Members of affected families constantly grieve.

ANGER

Initially the family's anger is focused on the addict. As addiction progresses and the problems increase, their anger loses focus and direction. They are angry with the addict – even when he is not taking drugs, angry with themselves, angry with their other children, angry at society, angry at the entire world at large.

The wife / mother at times suppresses her anger. As time passes, her mind becomes a storehouse of pent up memories, hidden resentments, hurt feelings and unresolved conflicts. Eventually, the chronic stress of unresolved emotional hurts becomes manifest in serious health problems – ulcers, hypertension, heart disease, etc.

Sometimes her repressed anger leads to a temper that explodes over trifles, frequent feelings of disappointment with others, and a feeling of being let down. Suppressed anger does not protect, it does not make life run more smoothly. On the other hand, relationships become more difficult to handle. It destroys everything that the family hopes it will protect.

SHAME AND LONELINESS

Most of the painful experiences resulting from *chemical dependence* bring a lot of shame to the family. The inappropriate behavior of the addict in front of relatives and friends makes the family terribly embarrassed. Such shame results in avoidance of all relationships and ends in isolation. Within the family also, there is a breakdown of communication. There might only be telegraphic communication like 'come and eat' or 'go to sleep'. Relevant issues like problems related to the education of the addict or management of finances are rarely discussed. The isolation created by lack of communication leads to bitter loneliness.

FEAR AND HOPELESSNESS

Living in a problematic, distressed family, produces fear – fear of the future, fear of family life, fear of financial matters, fear of relationships, and a persistent fear that nothing is going to become normal. As the family is unable to fully perceive the problem or find solutions, they feel desperate and hopeless.

HURT

The family is deeply hurt. Even though they are prepared to go to any extent to help the user out, none of their efforts are recognized or acknowledged. On the other hand, they are constantly blamed.

DYSFUNCTIONAL COPING BEHAVIOR OF FAMILY MEMBERS

Family members of the *chemical dependent* become preoccupied with trying to sort out his life in a meaningful way. They develop a pattern of living, coping and problem solving created and maintained by a set of dysfunctional patterns within the family system. These patterns interfere with healthy growth and make constructive changes very difficult, if not impossible.

WHAT IS CO-DEPENDENCY?

The normal reaction within any family to pain, to crisis and to the dysfunction of one member of the family is to reduce the pain, ease the crisis

and assist the dysfunctional member in order to protect the family. In the case of addiction, these responses do not make things better. If other members in the family deal with the consequences of addiction, the addict will never realize that he has to give up drugs. The family members will take more and more responsibilities to ease the crisis, but the crisis will continue.

As a result of living in a problematic environment, the family members develop a certain pattern of behavior called 'Co-dependency'.

'Co-dependency is a specific condition that is characterized by preoccupation and extreme emotional dependence on a person. Eventually, this dependence on another person becomes a pathological condition that affects the co-dependent in all other relationships.'

(– Sharon Wegscheider-Cruse)

While the family members try to control the *chemical dependent*, (over whom they have no power), they lose control over their own behavior (over which they have power). Hence their lives become unmanageable.

CO-DEPENDENCY TRAITS

Loss of Daily Structure

Family members have difficulty in following a daily routine. In any normal family, the children will be certain that breakfast will be ready on time. Mother would have packed lunch. Uniforms would have been ironed. In a *chemical dependent's* home, there is no structure or routine. If the son had taken drugs the previous day and created problems, the mother is unable to carry on her responsibilities the next day. She is not able to perform even basic duties like preparing food on time, sending the children to school or going for work on time.

Neglect of Personal Care

Family members slowly start losing interest in looking good and neglect their well being. They do not attend to any of their physical ailments.

One of our patients' wife shared with the counselor during treatment that in the recent years she started having

excessive bleeding, but never bothered to consult a doctor. Later on the problem became very acute and when she went to the doctor, it was too late and her uterus had to be removed.

Physical Problems

The family members feel tired all the time (even when they have not done much work). In addition, they also experience physical problems like ulcer, blood pressure, migraine head ache, pain in the neck / back, inability to sleep, and lack of appetite

Getting Involved in Unproductive Activities

The family members know from experience that some of their responses are unproductive and do not help in controlling the addict. In spite of this, they continue to get involved in these activities. For example, calling his office and checking whether he has come for work; checking his belongings for the presence of drugs.

She is convinced that shouting at him when he is under the influence of drugs does not help and that it only aggravates the situation. In spite of this understanding, she is unable to keep quiet and as soon as he enters home, she starts shouting at him.

The ‘Whatever I do is right’ Attitude

She is convinced that nobody will understand her problems and maintains that whatever she is doing is the right thing. She neither discusses her problems nor is prepared to listen to others.

For instance, she believes that separating her son from his drug-taking friends will solve the issue and decides to go to her parents’ village. When others point out that this will affect the education of her other children, she is not willing to listen and adamantly proceeds with her decision. Since she is not open to suggestions, relationships get strained and she becomes isolated.

The wife of a client would beat her 8 year old child for some silly reason. If her mother-in-law intervened, she would say ‘If I don't beat him, he will also become irresponsible like his father.’

Blaming Others

Members of the family start blaming each other and hold the *chemical dependent* responsible for everything that happens at home.

The mother will not carry out her responsibilities, but would blame the *addict*.

- for her inability to cook properly,
- if siblings get low marks or
- if she is not able to keep the house clean

Inability to Plan and Prioritize

As days go by, the responsibilities increase. When there are several responsibilities to complete, prioritizing becomes essential. The family member is unable to plan and prioritize her activities. All her efforts are focused on facing one crisis after another.

For example, in the case of an alcoholic, till the schools reopen after holidays, the wife will not plan how to get money to pay annual fees for her children. She knows very well that her husband will not take responsibilities. In spite of this, she will not plan ahead.

In the case of a drug addict, the mother would send one of her sons to look for the addicted son instead of sending him for tuition.

The Family Should Be Made To Realize That

- ❖ Addiction has affected the family physically and psychologically.
- ❖ Some of their behavior patterns have in the course of time become inappropriate.
- ❖ They need help to cope with the problems brought on by addiction
- ❖ A change in their attitude and behaviour will help in supporting the addict in his recovery.

HELP FOR THE FAMILY

If addiction has been a problem in the family over a long time, it is most likely that all the members of the family will be in need of help in restoring themselves to a state of health and happiness.

During recovery, the family should be made to feel the need to detach themselves from the problem which has for so long been the sole focus of their lives. In due course, it will help both the *dependent* and the family if they start facing the problem by doing the following.

- ❖ Stop telling themselves that ‘if only he decides, he can always give up drugs’. They have to accept that it is a serious problem that requires professional help.
- ❖ Start talking calmly and factually to the *chemical dependent* about his drug use and subsequent behavior when he is drug free. The more open they are, the more uncomfortable they will make him feel about his use of drugs. He should be made to understand that his addiction is causing problems and that he can recover by taking help.
- ❖ Stop protecting him by covering up the consequences of his drug use (giving reasons for the addict’s absence from college, or repaying debts incurred by the addict). He will become aware of the enormity of the problem only when he faces the crisis caused by his drug use.
- ❖ Not feel or give the impression that the addict is doing them a favor by giving up drugs. If they do so, the addict will become manipulative and this will hinder his recovery. For years, families might have patiently put up with the addict’s behavior just to have some peace at home. By continuing to yield to his irrational demands and difficult behavior, they will only complicate recovery.
- ❖ Start communicating honestly and openly to other members in the family about their concerns.
- ❖ Start accepting that they are not alone; they have choices and they need

the support of self-help groups to cope with the problem. Self-help groups will help them find ways of changing and building up their self-esteem.

- ❖ Start looking after their own needs and the needs of other children. They should realize that they have to perform the duties which they have neglected so far.
- ❖ Identify positive methods of diversion like spending time with other children, such as pursuing hobbies, etc. These positive experiences will give them the energy to face problems.
- ❖ Plan one day at a time and start executing their plans.

SKILLS SHARPENING TOOLS

PATTERNS IN CO-DEPENDENCY

The counselor can use this tool to help the family understand their co-dependency patterns and characteristics. This may be particularly helpful to newcomers in family program as they begin to understand co-dependency and may aid those who have been in recovery for a while in determining what traits still need attention and change.

Denial Patterns

I have difficulty in identifying what I am feeling.

I minimize, alter, or deny how I truly feel.

I perceive myself as completely selfless and dedicated to the well being of others.

Low Self-Esteem Patterns

I have difficulty making decisions.

I judge everything (I think, say, or do) harshly, as never 'good enough'.

I am embarrassed to receive recognition and praise or gifts.

I do not ask others to meet my needs or desires.

I value other's approval of my thinking, feelings, and behavior over my own.

I do not perceive myself as a lovable or worthwhile person.

Compliance Patterns

I compromise my own values and integrity to avoid rejection or others' anger.

I am very sensitive to how others are feeling and feel the same.

I am extremely loyal, remaining in harmful situations too long.

I value others' opinions and feelings more than my own and am often afraid to express differing opinions and feelings.

I put aside my own interests and hobbies in order to do what others want.

I accept sex when I want love.

Control Patterns

*I believe that other people are incapable of taking care of themselves.
I attempt to convince others of what they 'should' think and how they
should feel.*

I become resentful when others will not let me help them.

I freely offer others advice and directions without being asked.

I have to be 'needed' in order to have a relationship with others.

INTERNALISING TOOLS

CASE ANALYSIS

Case 1

Vimala had three children – two boys and a girl. Her husband was working in the army and would be home only for two or three months in the year. All the responsibilities of running the family were on her shoulders. Her eldest son, Madhu, had problems with drugs for the past three years. Vimala used to take care of her family extremely well and she was proud that she was a good housekeeper. Of late, there were lots of changes in her. Her close family members felt that she had become impatient and irritable. She often had spells of headache, but was indifferent and did not consult a doctor.

There were two or three incidents that took place last month which made her think about her behavior. One night, Madhu came home under the influence of drugs. On seeing him, she shouted at him, unmindful of disturbing the other children as well as other tenants. As she could not sleep well in the night, she got up very late next morning and could not prepare breakfast for the school-going children. She gave them some money for breakfast. This was becoming a routine practice. She started blaming her son for everything that was happening at home – getting headaches, not being able to get up in the morning, or her inability to take decisions.

Prior to examinations, the daughter felt that she was unable to study and wanted to stay in her grand parents' house. Vimala also felt it was a good idea. But she was very confused. 'Should I send her? Is it right? What will my sister-in-law say...?' She was just not able to take a decision. Vimala was upset that she could not even offer a peaceful atmosphere for her daughter to study at home.

The daughter got high marks in the 12th Standard. Vimala planned to send her to college. She knew that a significant amount of money would be needed. Yet, she did not do anything about it. When the opening of the college was only a week away, she had not made any plans to get money for the college fees. Finally, she borrowed money from a moneylender at high interest.

Due to Madhu's drug problem, Vimala had to pay back some of his debts. One of her friends who was working in a school, wanted to help Vimala by

sending her some students for tuition. Vimala had completed her B.Ed. with excellent marks. She also had the experience of teaching for a few years. However, she declined her friend's suggestion, saying 'I will not be able to teach well; I am inefficient. I don't want to let you down.'

Vimala was dissatisfied with her life. She felt that she was the only person in the family who was suffering and began to curse her fate. She spent most of her time at home, avoiding all social get-togethers and family functions.

What negative traits are visible in Vimala's behavior?

Case 2

Senthil, 18 years old, was studying in a technical education institute. His father, who was working in a factory as a supervisor, was drinking alcohol off and on.

Senthil's drug problem started off with ganja use. After about three months, Senthil was becoming secretive and one day, Senthil's mother saw him smoking ganja on the terrace. She was shocked; but pacified herself, 'He is only smoking cigarettes. He is not drinking like his father. He must have learnt to smoke from his friends. I should not make an issue of this. I should not tell his father.' Instead, she advised him to give up smoking as it causes many illnesses.

But as days went by, she noticed a few more changes in Senthil. Often he would not eat, saying that he was not hungry, but drink tea with lots of sugar. On many occasions Senthil's mother would force him to eat at least a little.

One day, there was a letter from his institute stating that he had not paid his fees. His mother had already given money to Senthil to pay his fees. On seeing this letter she was upset, but did not tell her husband as he would be very angry. She pawned her earrings and paid Senthil's fees. She apologized on behalf of her son to the authorities, saying that the financial situation at home had made it difficult for her to pay on time. On reaching home, she shouted at Senthil. He said that someone had stolen the money from his purse and he had been afraid of telling her. She felt that he might be lying. But, somehow she wanted to believe that he was telling the truth as he went on repeating it.

Some days later, Senthil's mother met one of his friends in the market place. He told her that Senthil spent a lot of time with drug addicts and was irregular for classes. When she confronted Senthil, he convinced her that classes were not being conducted well and so he spent time studying with his friends. He also blamed her that she did not trust him and always made him feel small. She decided not to make an issue of it.

She found out later, that he had not written his final exam, she felt very upset. When she searched his cupboard, she was shocked to find cigarettes, matchboxes and small packets. She collected all of them and threw them into the dustbin. She shouted at him and made him promise that he would not touch drugs again. After that, Senthil looked all right for a few days and his mother was not sure whether he was taking drugs.

One day, Senthil's father received a phone call from the police station that Senthil had brown sugar in his possession and, therefore, was in the police station. On hearing this, Senthil's father paid money for providing bail and brought him home. He was very angry and accused his wife of not being strict enough. In return, Senthil's mother blamed her husband. On bringing back Senthil from the police station, they found he had a runny nose and watery eyes. He was taken to an addiction treatment center by his parents.

Point out the inappropriate coping behavior in Senthil's mother.

FAMILY IN RECOVERY

Acceptance of treatment by the *chemical dependent* brings a great deal of relief to everyone concerned. Family members may hope that life is going to take a turn for the better at once. They may feel that all their tensions will disappear. In a supportive environment, the counselor should make them understand that it would be very unrealistic to expect that everything is going to be wonderful immediately. They should be made aware of the fact that there are certain problems which they may face during the patient's recovery. An understanding of this will help them handle the problems effectively.

PROBLEMS EXPERIENCED DURING RECOVERY

- During recovery, it is possible for family members to experience great relief over his abstinence and yet miss the old, familiar lifestyle. Although it was painful, there had always been some predictability. They knew how he was going to behave, and what situations they would be required to handle. But now the recovering person is likely to be more independent and more demanding. This can leave family members resentful. Earlier, the *chemical dependent* would not have reacted to anything happening at home. Now he may expect his wife to prepare tasty meals, keep the house clean and help the children in their studies. The family may not be able to view his expectations as justified.
- Friends and relatives may have all along admired the tolerance of the wife/mother and praised her for bearing the brunt all alone. When the *chemical dependent* stops taking drugs, the positive comments are likely to be transferred to him. They may even pick on her. 'Now that he has given up drugs, why don't you be more understanding? Why do you unnecessarily get angry and shout like this?' These remarks hurt her and it is very common for close family members to experience extreme bitterness and resentment, especially if they have coped with addiction by suppressing all their feelings.

- Certain actions that would not stir a second thought if displayed by others, may set off alarms when exhibited by the recovering person. It is virtually impossible for the family not to harbor doubts when, for example, they find some cash missing or when they find the recovering person moody, tired or notice him remaining extra long behind a locked door or getting phone calls late in the night.
- Family members may tend to treat the recovering person as a 'brittle doll'. This is the result of a continuing fear and a prolonged belief that anything they might say could cause conflict and make him go back to drugs. To give an example, a recovering *addict* may come home from college in an auto rickshaw. His mother may feel that he need not have spent money so extravagantly, and should have come by the college bus instead. But she will not open her mouth for fear that it might upset her son, and he might get back to drugs. As a result, there is no communication, no clarity of roles and the family works only according to his expectations. There is no chance of mutual trust developing in this kind of relationship because it continues to be dominated by fear. It will only result in more stress for the family.
- After many years of embarrassment and humiliation, the family may have few outside interests or friends. All other adjustment problems will be intensified by the family's lack of social contacts and shared pleasures.
- Family members will find it very difficult to listen to the recovering person or relate to him in a meaningful way. They may expect him to make changes according to their expectations. For instance, they may make plans for his future. They may ask him to go for work in the mornings or attend classes in the evenings, without discussing those issues with him. They are likely to feel that they have the solutions to all his problems.
- Family members may continue to harbor resentment. As a result, even though the *addict* may be making positive changes, they will be reluctant to acknowledge this. On the other hand, repeated remarks about money being wasted will be voiced.
- Members of the family may have conflicting views if it comes to the question of giving recovering person responsibilities. He may be willing

to take up certain responsibilities. But the family members may not be able to trust him with the responsibilities he wants to carry out. They may find it more comfortable to assign him only menial or insignificant jobs and even after assigning jobs, they will be doubtful whether he will complete the tasks properly.

THE NEED FOR FAMILY THERAPY

The interconnected relationships within a family are widely recognized as crucial elements in substance use disorder and its treatment. Family therapy focuses on family change (parenting practices, family environment and problem solving) and takes into account is also aimed to take place psychosocial environment in which the *addict* lives. In one situation, family therapy might refer to an educational session or a discussion of family problems with a substance abuse counselor. In others, it might consist of a few family conferences with members of the treatment team present to explore what family members can do to help the user.

The broad goals of family therapy are

- To provide information about addiction and its effects on the family system – It is essential to provide information about addiction being a disease, its impact on the family system, relapse symptoms and coping methodologies.
- To provide a safe and acceptable environment for the family to discuss their problems – Normally the family's attitude would be 'Once he gives up drugs, all our problems would disappear'. The counselor should focus the family's attention on the problems experienced by them as a result of addiction. Some of the open-ended questions which can help them focus their attention on themselves and see a need to change their attitude and behavior are
 - What would you like to work on?*
 - What kind of help are you looking for?*
 - What kind of changes do you think you should make?*
- To improve interactions among family members – The intervention aims to bring about changes in the way family members relate to each other by examining the underlying causes of dysfunctional interaction and by encouraging new healthier ones.

Therapy helps in revitalizing interpersonal bonds which help family members to change their negative components of interaction.

The counselor helps family members appreciate how the values and perspective of each family member may differ, but those differences do not have to be a source of conflict. Helping family members solve problems together in the therapeutic setting enables them to learn strategies that can be applied with the *addict* in the home environment. Family members learn to listen to one another and solve problems through negotiation and compromise.

Another method of improving communication between family members is to introduce the concept of 'I' statements. 'I' statements focus on the effect of an action on the speaker rather than on the action itself. Instead of saying 'You always give us trouble', a family member would say, 'I feel sad when you behave in this manner'. These statements are often effective because people can disagree about what they do, but it is difficult for them to dispute what someone else says she feels.

- To equip parents with the skills needed to deal with youngsters – Parents of youngsters who use substances typically aggravate small conflicts due to inadequate parenting practices (being permissive, authoritarian or inconsistent). The counselor should guide them towards improving parenting skills – appropriate monitoring (to know their friends, to know how they spend their time), setting limits, rebuilding emotional attachment and taking part in activities with the youngster.
- To provide optimism and a supportive environment – The counselor should help family members realize that the family support system surrounding the recovering person will require some change. They have to be guided to give up their preoccupation and obsession with the *chemical dependent*, and still be caring and help him in his recovery.
- Family can be helped even if the user is unwilling - Even if the chemical dependent does not seek help, it is imperative that family members should seek help. Breaking the silence about what they have been dealing with is the first step, followed by learning about enabling

and co-dependency and methods to cope with addiction. Significant healing can begin to take place for families, even if the user's drug-taking continues.

SKILLS SHARPENING TOOLS

FAMILY THERAPY - THE TTK MODEL

T T Ranganathan Clinical Research Foundation (TTK Hospital) located in Chennai is a pioneer non-governmental organization working in the field of addiction since 1980. This 60 bedded treatment-cum-rehabilitation center offers medical and psychological support to people addicted to alcohol / drugs. The in-patient treatment is for a period of one month. The organization also offers a two week therapy program specially designed for the families of addicted individuals. Attendance to this program is mandatory. .

The goals

The goals of family therapy are

- to provide information about addiction and its effects on the family system
- to provide a safe and acceptable environment for the family to discuss their problems
- to help the family members express their feelings of shame, guilt, fear and hurt
- to help them grow out of their dysfunctional coping behavior
- to help the family to clarify their problems and set realistic goals
- to help them improve their communication, so that they interact in a more constructive and helpful manner
- to guide the family to provide a supportive environment for the recovery of the chemical dependent.

The components

The comprehensive family program includes

- thought for the day – Every day one thought / concept is taken up. The thought is explained through a story.
- re-educative sessions – Specific information is provided about the symptoms of addiction, feelings experienced by family members, handling emotions, problems during recovery and improving quality of life.
- group therapy – In group therapy sessions, the family members are encouraged to share their feelings and the problems they face.
- individual counseling sessions – Specific personal issues are handled. If the user is married, marital counseling is also provided.
- self-help programs – Self-help groups play a significant role in reducing the family's feelings of isolation and helplessness. They provide opportunities to share feelings and experiences and offer practical and concrete suggestions.

Support program

It is important that the chemical dependant has well-wishers or support persons who are willing to assist him in his recovery. Support people are those who have a keen interest in the welfare of the patient. They may be the family members – siblings, uncle, aunt or in-laws; personnel at his office – supervisors, managers, co-workers, family doctors or non-drug-taking friends.

Support people are those

- who do not use alcohol or drugs
- who meet the patient frequently
- whom the patient respects and holds in high regard.

The reasons behind having support people are

- to give additional help and support to the recovering person
- to bring him back for treatment in case he relapses.

The role of support persons:

- When the treatment agency loses contact with the patient and his family members, support persons are contacted to get the necessary information.
- If the patient needs a job or his wife has to be reconciled, the counselor seeks help from the support person.
- In case of a relapse, if the family members find it difficult to bring the patient to the center, the support person is requested to motivate him to take help.

At the TTK Hospital, regular programs are organized for support persons – either on an individual basis or as a group. The counselor conducts the session for one to two hours.

In the session, the following issues are dealt with:

- making them understand that addiction is a disease
- the importance of continued follow-up to sustain sobriety
- the relapse symptoms
- methods to sustain the motivation of the addict to stay abstinent and improve the quality of his life.

SKILLS SHARPENING TOOLS

DEEPER INSIGHT INTO THE FAMILY DYNAMICS

1. *What is meant by 'the enabling behavior' of the families of addicts?*

'Enabling' is a therapeutic term which in this context denotes a destructive form of helping. Any act that helps the addict to continue drug taking without suffering the consequences is considered 'enabling behavior'. The 'enabler' is a person who may be impelled by his own anxiety and guilt to rescue the *addict* from his problems. This role is taken on by family members, friends, supervisors and colleagues at work.

Some examples of enabling behavior are

- paying back the debts incurred by the user
- justifying his use of drugs – 'He takes drugs because of problems at the workplace.'
- calling the manager and giving false reasons for his absence.

2. *What should the family avoid doing?*

- Do not hide alcohol bottles and do not search for drugs.
- Do not argue or quarrel with the person while he is under the influence of drugs. This will only lead to meaningless arguments.
- Do not look for reasons for his drug use. Some may be excuses and some, the consequences of his drug use.
- Do not attempt to punish, threaten, bribe, preach or try emotional appeal with the user.

In the long run, none of these methods work.

3. *What is 'denial' of the family?*

Due to the social stigma attached to addiction, the family members deny the existence of any problem and gives excuses such as 'going through a phase' or 'too much pressure'. The problem of addiction is either totally denied, minimized or rationalized.

4. *What is Al-Anon?*

Al-Anon is a fellowship of family members of chemical dependents. Members of Al-Anon share their problems and feelings with one another. These members work out methods to manage problems and improve the quality of their lives so that even if the *addict* refuses to seek help, their lives will be manageable. Al-Anon meetings are conducted on a regular basis in various cities in India.

Some of the principles followed are ‘easy does it’, ‘let go and let God’, ‘first things first’, ‘live and let live’ and ‘live one day at a time’.

‘Easy does it’ - The purpose of this slogan is to reduce tension and release the user’s family from their abnormal involvement with their problems.

‘Let go and let God’ – The family member has to realize the futility of her behaviour, stop trying to control the uncontrollable and leave everything to God. In doing so, she would have taken the first constructive step towards dealing with her problem.

‘First things first’ - Acquiring the habit of dealing with issues in the order of their importance can make life more meaningful, because less time and energy will be spent on fruitless and destructive actions.

‘Live and let live’ – This slogan touches directly on one’s attitude towards other people. When the family fill their lives with satisfying activities, they will be less tempted to judge and criticize others.

‘Live one day at a time’ - As there is constant uncertainty surrounding the life of the user’s family, she cannot make long-term plans. She has to plan for just one day at a time and execute her plans.

5. *Does a father’s addiction affect his children?*

Yes, a father’s addiction leaves its impact on his children. Constant exposure to this environment leads to a lingering fear, and they are filled with feelings of shame and embarrassment. They see nothing other than fights, guilt, justification and they practically lose their childhood. As a result, they end up with a lot of emotional problems.

HELPING PARENTS ADOPT POSITIVE ROLES

While educating parents about the prevention of addiction, the counselor can offer the following guidelines. These keys will provide parents methods that have been proven to equip children with a sense of well being and security.

Allot Time for Fun

- Your child's self-esteem is greatly influenced by the quality of time you spend with him – not the amount of time that you spend. Make time for activities that the whole family enjoys. Making a list of fun things is a starting point. It might be going for a walk or visiting family / friends, or eating together or going to a movie. Parents and children who take the time to play together bring joy and fun into their relationships, as well as a feeling of warmth and closeness that will help during the more difficult times.

Get Involved

- Don't be afraid to ask where your child is going, who he will be with and what he will be doing. Get to know your child's friends and their parents to ensure that you are familiar with his activities.
- Create a welcome environment in your home where your children can bring their friends and you can ensure their involvement with positive, healthy peers.
- Foster strong family bonds to help counter powerful peer influences. Make your child feel your participation in her activities. Go to school functions with your child whenever you can. Establish or renew family traditions such as celebrating festivals, visiting places of worship, visiting relatives or eating together. If kids have a sense of belonging within their own families, they will be less likely to seek it elsewhere.
- Try to be there after school when your child gets home – the 'danger zone' for drug use is evenings, when no one is around.
- Eat together as often as you can – meals are a great opportunity to talk about the day's events, to unwind, reinforce and bond. Studies show that

kids whose families eat together are less likely to be involved with drugs or alcohol.

Learn to Communicate

Good communication is another quality of effective parenting. Good communication is more than just words. Often the words a child uses do not tell parents how the child is feeling. Parents need to listen ‘deep’ for the feelings and explore them with the child. This is called ‘active listening’. Here is an example: the child says ‘My teacher does not like me’. This statement might be the result of the following feelings – ‘I feel upset because my teacher did not give me high marks in the test’, or ‘My teacher smiles at the other kids but she does not smile at me’. To communicate effectively with the child, the parent must first explore the feeling behind the words; accept the child’s feelings without saying he should not feel that way, and work together on some solutions to the problem.

Another example of effective communication is the use of ‘I’ statements. These statements let the child know what the parent is feeling, thinking, or intending. For instance, the effective parent would say ‘I am feeling tired and need some time to myself right now’, instead of saying ‘You never leave me alone, not even for a minute’; or ‘I want to visit grandma; I need some help in the kitchen’, instead of ‘You never do anything to help me when I am in a hurry’. The more good communication skills are used, the more they become a natural way of communicating.

- Be a good listener – Ask questions and encourage the child to speak. Paraphrase what your child says to you. Ask for his input about family decisions. Your willingness to listen will make your child feel more comfortable about being open with you
- Let your kids know they can talk to you about anything, without harsh judgment or lectures. And be on the lookout for ‘teachable moments’, like when your child raises the subject of alcohol and tobacco (during farewell parties, ‘culturals’ in colleges and schools).
- Be absolutely clear with your children that you don’t want them to use drugs **–ever, any time**. Learn the facts and talk often about the dangers and results of drug and alcohol abuse.

- Expose your children to activities like sports, art, music, reading, or drama, so that they develop other interests. Introducing children to a variety of activities gives them wholesome things to turn to when they have time on their hands. When kids are bored, they are more likely to experiment.
- Teach your child to be assertive whenever appropriate. Encourage your kids to make informed decisions, so that when faced with offers of drugs or alcohol, they can assert themselves and resist pressure.

Help to Develop a Positive Self-Esteem by Appreciation and Encouragement

The most valuable gift that we can give children is a feeling of positive self-esteem. Children need to feel loved, accepted, understood, and appreciated. Positive self-esteem does not come from allowing children to do whatever they want to do. Limits need to be set, but these need to be established in a caring, loving way. Messages like ‘You are a stupid girl. You have thrown the ball into the living room’, or ‘Why can’t you get better marks like your sister?’ do not develop positive feelings about oneself. Phrases like ‘I am worried that the window might get broken when you throw it’, or ‘I am worried about your science marks. What can you and I do to improve them next term?’ help to make children believe that they can solve their own problems with some support from their parents. As children grow, they need to believe in themselves and to know that they have some freedom to make choices and to take responsibility for the decisions they make.

Is there anything that encourages a kid more than his or her parents’ approval? The right word at the right time can strengthen the bond that helps keep the child away from drugs.

- Reward good behavior – consistently and immediately. Expressions of love, appreciation and thanks go a long way. Even kids who think themselves too old for hugs will appreciate a pat on the back or a special treat.

- Accentuate the positive – acknowledge the things your child does right. Restrain the urge to be critical. Affection and respect, making your child feel good about himself, will reinforce good (and change bad) behavior far more successfully than embarrassment or uneasiness.
- Set realistic goals and performance objectives with your children. Encourage and appreciate improvements made.

Be a Role Model

- Be a living, day-to-day example of your value system. Exhibit the compassion, honesty, generosity and openness you want your child to have.
- Examine your own behavior – know that there is no such thing as ‘Do as I say, not as I do’. The child will only see your behavior and may not merely hear your words. Evaluate your own use of tobacco, alcohol, and drugs. If you have a drink or two or light up a cigarette every time you get tense, remember you are conveying to your child inappropriate methods to cope with life and its stresses.
- Teach your child to cope with frustration and stress. When your child is upset, help him or her to learn ways to feel better – like talking about it, taking a walk, or relaxation techniques.

Lay Down Acceptable Principles

- Create rules – and discuss in advance the consequences of breaking them. Make your expectations clear. Don’t make empty threats. Don’t impose harsh punishments.
- Set a time limit for your child to reach home in the evening and enforce it strictly. Be prepared to negotiate for special occasions.
- Listen to your instincts – don’t be afraid to intervene if your gut reaction tells you that something is wrong. Be watchful for visual and verbal signs that your child is experiencing difficulties in school,

having trouble with peers, or suffering bouts of anxiety. Be alert to non-verbal cues.

PARENTS – THEIR PREVENTIVE ROLE

In addition to serving the basic roles as family leaders and nurturers of children's development, parents can play a variety of roles in helping children lead drug free lives.

- Parents should be educators or information resources, enlightening their children about legal and illegal substances, their likely health and social consequences, family health histories regarding alcohol and other drug use. Children should be made aware of the hidden agenda behind the promotion of alcohol in the media by the alcohol industries. This multifaceted educational role requires that parents become knowledgeable so that their children learn to turn to them for alcohol and other drug information.
- Parents should act as family policy makers and rule setters for their children regarding the use of substances. The focus is on arriving at a clear 'no use policy' or rules with clear and enforceable consequences for violation.
- Parents should be supporters in talking to their children about peer pressure and methods to resist it. The focus is on helping children appreciate the power of peer pressure and providing them with resistance techniques.
- Parents should act as simulators of and participants in enjoyable family activities that provide alternatives to social events involving alcohol or other drugs. The focus is on helping children engage in healthy pursuits like sports, cultural activities and religious practices.
- Parents should be observers, being aware of where the children are spending their free time and being reasonably assured of their safety.
- Parents should act as collaborators with other parents in their children's world. This involves being aware of children's activities and their social involvement.

- Parents need to be identifiers and interveners – in case of addiction, being aware of methods to handle children who are dependent on drugs and ways to refer them for treatment.
- Parents need to act as managers of their own feelings about their children's substance abuse. Parents must learn to work through their feelings so that they become productive and provide a conducive environment for the child to recover.

Reference: National Clearing House for Alcohol and Drug Information, 2000.

INTERNALISING TOOLS

FAMILY ENVIRONMENT SCALE

FES is an easy to administer test that helps counselors assess ten aspects of the family environment. One can quickly assess the family's strengths and also identified areas where further work is needed. With some clients, the test is administered independently to the client as well as parent/s to identify discrepancies in the way the family is perceived which need to be addressed during therapy.

Please read the following statements carefully. If the statement describes your family, put a mark for 'True' and if it does not describe your family a mark against 'False'. If you are not sure, given an answer based on how your family is like most of the time. Make sure that you respond to all the statements.

True False

1. Family members really help and support one another
2. Family members often keep their feelings to themselves
3. We fight a lot in our family
4. We don't do things on our own very often in our family
5. We feel it is important to be the best at whatever you do
6. We often talk about political and social problems
7. We spend most weekends and evenings at home
8. Family members go to church / temple / mosque fairly often
9. Activities in our family are pretty carefully planned
10. Family members are rarely ordered around
11. We often seem to be killing time at home
12. We say anything we want to around home
13. Family members rarely become openly angry
14. In our family, we are strongly encouraged to be independent
15. Getting ahead in life is very important in our family
16. We rarely go to lectures, plays or concerts
17. Friends often come over for dinner or to visit
18. We don't say prayers in our family
19. We are generally very neat and orderly
20. There are very few rules to follow in our family

21. We put a lot of energy into what we do at home
22. It is hard to 'blow off steam' at home without upsetting somebody
23. Family members sometimes get so angry they throw things
24. We think for ourselves in our family
25. How much money a person makes is not very important to us
26. Learning about new and different things is very important in our family
27. Nobody in our family is active in sports or other games
28. We often talk about the religious meaning of festivals or other holidays
29. It is often hard to find things when you need them in our household
30. There is one family member who makes most of the decisions
31. There is a feeling of togetherness in our family
32. We tell each other about our personal problems
33. Family members hardly ever lose their tempers
34. We come and go as we want to in our family
35. We believe in competition and 'may the best man win'
36. We are not that interested in cultural activities
37. We often go to movies, sports events, camping, etc.
38. We don't believe in heaven or hell
39. Being on time is very important in our family
40. There are set ways of doing things at home
41. We rarely volunteer when something has to be done at home
42. If we feel like doing something on the spur of the moment we often just pick up and go
43. Family members often criticize each other
44. There is very little privacy in our family
45. We always strive to do things just a little better the next time
46. We rarely have intellectual discussions
47. Everyone in our family has a hobby or two
48. Family members have strict ideas about what is right and wrong
49. People change their minds often in our family
50. There is a strong emphasis on following rules in our family
51. Family members really back each other up
52. Someone usually gets upset if you complain in our family
53. Family members sometimes hit each other
54. Family members almost always rely on themselves when a problem comes up
55. Family members rarely worry about job promotions, school grades, etc.
56. Someone in our family plays a musical instrument
57. Family members are not very involved in recreational activities outside work or school

58. We believe there are some things you just have to take on faith
59. Family members make sure their rooms are neat
60. Everyone has an equal say in family decisions
61. There is very little group spirit in our family
62. Money and paying bills is openly talked about in our family
63. If there is a disagreement in our family, we try hard to smooth things over and keep the peace
64. Family members strongly encourage each other to stand up for their rights
65. In our family, we don't try that hard to succeed
66. Family members often go to the library
67. Family members sometimes attend courses or take lessons for some hobby or interest (outside of school)
68. In our family, each person has different ideas about what is right and wrong
69. Each person's duties are clearly defined in our family
70. We can do whatever we want to in our family
71. We really get along well with each other
72. We are usually careful about what we say to each other
73. Family members often try to one-up or out-do each other
74. It is hard to be by yourself without hurting someone's feelings in our household
75. 'Work before play' is the rule in our family
76. Watching TV is more important than reading in our family
77. Family members go out a lot
78. The religious texts are very important in our home
79. Money is not handled very carefully in our family
80. Rules are pretty inflexible in our household
81. There is plenty of time and attention for everyone in our family
82. There are a lot of spontaneous discussions in our family
83. In our family, we believe we don't ever get anywhere by raising your voice
84. We are not really encouraged to speak up for ourselves in our family
85. Family members are often compared with others as to how well they are doing at work or school
86. Family members really like music, art and literature
87. Our main form of entertainment is watching TV or listening to the radio
88. Family members believe that if you sin you will be punished
89. Dishes are usually done immediately after eating
90. You can't get away with much in our family

SCORING KEY

Assigning a score of '1' to each of the correct answers and totaling the scores on individual statements under each sub-scale, a score is arrived at for each of the 10 sub-scales listed below.

Cohesion 1-T, 11-F, 21-T, 31-T, 41-F, 51-T, 61-F, 71-T, 81-T

Expressiveness 2-F, 12-T, 22-F, 32-T, 42-T, 52-F, 62-T, 72-F, 82-T

Conflict 3-T, 13-F, 23-T, 33-F, 43-T, 53-T, 63-F, 73-T, 83-F

Independence 4-F, 14-T, 24-T, 34-T, 44-F, 54-T, 64-T, 74-F, 84-F

Achievement

Orientation 5-T, 15-T, 25-F, 35-T, 45-T, 55-F, 65-F, 75-T, 85-T

Intellectual-Cultural

Orientation 6-T, 16-F, 26-T, 36-F, 46-F, 56-T, 66-T, 76-F, 86-T

Active-Recreational

Orientation 7-F, 17-T, 27-F, 37-T, 47-T, 57-F, 67-T, 77-T, 87-F

Moral-Religious

Emphasis 8-T, 18-F, 28-T, 38-F, 48-T, 58-T, 68-F, 78-T, 88-T

Organization 9-T, 19-T, 29-F, 29-T, 49-F, 59-T, 69-T, 79-F, 89-T

Control 10-F, 20-F, 30-T, 40-T, 50-T, 60-F, 70-F, 80-T, 90-T

The ten sub-scales of the family environment scale assesses the family on the following way:

1. Cohesion refers to the degree of the commitment, help and support family members provide for one another.
2. Expressiveness refers to the extent to which family members are encouraged to act openly and to express their feelings directly.

3. Conflict refers to the amount of openly expressed anger, aggression and conflict among family members.
4. Independence refers to the extent to which family members are assertive, self-sufficient and make their own decisions.
5. Achievement-Orientation refers to the extent to which such activities are cast into an achievement oriented or competitive framework.
6. Intellectual-Cultural Orientation refers to the degree of interest in political and social issues and intellectual, cultural activities.
7. Active-Recreational Orientation refers to the extent of participation in social and recreational activities.
8. Moral-Religious emphasis refers to the degree of emphasis on ethical and religious issues and values.
9. Organization refers to the degree of importance of clear organization structure in planning family activities and responsibilities.
10. Control refers to the extent to which set rules and procedures are used to run family life.

GROUP THERAPY TECHNIQUES

Group therapy has been acclaimed over the years as by far the most effective method of treatment for addiction. The gains of group therapy are now well established. The following are a few therapeutic gains that are unique to this treatment method:

- Provides an opportunity to share and identify with others who are going through similar problems. Groups help in developing a sense of belonging.
- Spontaneous sharing of older members, of their progress and the changes they have achieved, instills hope in the new skeptical members.
- Helps clients understand their own attitudes about drugs / alcohol abuse and their defenses against giving it up by identifying similar attitudes and defenses in others.
- Verbalization of thoughts and feelings, open feedback from others about positive and negative behavior and being a witness to successful conflict resolution, helps clients develop socialization skills.
- Teaches members interdependence (in contrast to dependence on *chemicals*) and thus build a better social network. This also helps *chemical dependents* to work through isolation.
- Provides a congenial atmosphere to powerfully confront denial, and assess high-risk situations. Members utilize the group as a laboratory for developing new responses and new skills.
- Provides an opportunity to formulate realistic goals and plans.
- Sharing insights, offering suggestions and support gives an individual the pleasant feeling of helping another. This altruism aids in strengthening self-esteem.

These gains prove beyond doubt that group therapy can be effective. The task then for the counselor is to maximize the gains within the available timeframe. The following are a few basic guidelines that contribute to effective group therapy sessions.

Size of the Group

Five to ten members in a group is the acceptable range. When there are less than five members, it fails to function as a group; with more than ten, it becomes unwieldy – both making it less effective.

Duration of the Group Meeting

A minimum of one to an hour and a half is needed for the group to settle down and get to work on an issue. However, if a group session stretches beyond 90 minutes, fatigue sets in and diminishing gains are reported.

Frequency Of Meetings

Five group meetings a week is the minimum requirement. After discharge and/or during follow-up, meetings may be held once or twice a week to strengthen changes made and offer support through the recovery process.

Physical Environment

A pleasant quiet room that ensures privacy is a pre-requisite for group therapy meetings. The seats should be similar and placed in a circle conveying that all are equal. Moreover, everybody is visible to the rest of the group; face-to-face interaction is made possible and non-verbal behavior can be easily observed.

Rules and Limit Setting

At the beginning of the session, the counselor has to clearly spell out basic rules like punctuality, regular attendance, staying for the entire session and not leaving midway, not attending under the influence of drugs. The following norms are a requisite as they help members function appropriately.

Confidentiality

Any information gained about another group member in the group therapy setting is to be treated in strict confidence. In short, 'What happens in the group, stays within the group' should be repeatedly stressed.

Listening

Maintaining eye contact, willingness to listen to other person's feelings and words without interrupting, are important. Interruptions are not to be made unless

- the member is repetitious
- the member is rambling without focusing on issues relevant to the topic of discussion
- the listener has not understood and wishes to clarify his thoughts.

Using 'I' Statements

'We' and 'they' statements lead to superficial sharing on generalized issues. 'You' statements usually turn into critical, judgmental ones. 'I' statements, on the other hand, help the member speak only for himself and own responsibility for his feelings, thoughts and behavior. (Example: 'I feel ashamed. I have hurt my parents.')

Open, Honest, Spontaneous Sharing

Group therapy offers an unique opportunity for handling issues. It should be emphasized that to maximize gains, the wholehearted participation of the group is essential. Each member needs to remember that the more he puts into a group, the more he will benefit from the experience.

All participants are considered equal, irrespective of their drinking or drug taking status, number of days they have stayed at the center, or nature of the damage. The counselor, as a facilitator of the group, need not share any details regarding herself.

Feedback

Guidelines for Giving Feedback

Feedback is an essential component of group therapy. Here are a few guidelines to be discussed with clients prior to entry into the group. These guidelines facilitate involvement in the session and help them relate appropriately to other group members.

Members should talk about behavior they can see. The feedback should be specific and relevant.

I notice that you are late by 5-10 minutes everyday. So we are unable to start the group meeting on time.

Feedback should be given caringly and not by hurting or attacking another member. No judgmental statements should be made. For instance, the following should be avoided:

You have been lazy and irresponsible at work. You cannot be upset now with your boss for criticizing you. You just have to take it – you asked for it.

The proper feedback would be to say, ‘you talked about your repeated absences, delay in submitting reports and not meeting sales targets. Your work has definitely suffered due to addiction. You are now upset that your boss has expressed dissatisfaction. Considering your work pattern, this is not surprising and your boss’s reaction seems reasonable.

- Members should avoid sarcasm and condescending remarks while giving feedback. No advice is to be given – only responses.

*You want to repay debts to the tune of one lakh in 6 months?
You must be joking. – Sarcastic remark*

*Listen to me. You cannot handle this. You better ask your wife. –
Advice*

Let us discuss various methods and see how best it can be worked out. – Proper response

- Members should be encouraged to share positive feedback also.

I am touched by your honest sharing.

Guidelines for Receiving Feedback

- Members should spontaneously ask for feedback and receive it openly.
- Excuses should not be given. Members should avoid being defensive.
- Members should learn to acknowledge the value of feedback and express appreciation.

I am glad you have helped me see the positive qualities of my brother.

- Members should think about and build upon the feedback they receive. They should view these responses as a continuing exploration.

THE PROCESS OF GROUP THERAPY

During group therapy sessions, groups gradually move through a process of development. The early phase is the beginning of the group, particularly the first few meetings. The middle phase is the substance of the group, with the clients coming together, interacting, sharing, growing and changing in the counselor's presence. The last phase is when the client completes the program and leaves the group.

STAGES IN GROUP THERAPY

Extensive clinical observations show how the group evolves and moves through four stages of growth. In general, a successful group will flow through them. At times, it may regress to the previous stage, but it will eventually move into the later stages.

Each stage is characterized by its own set of feelings and behavior. Being familiar with these will help the counselor identify which stage the group is

in, so that she can aid its moving successfully through its developmental stages.

THE FIRST MEETING

Group members are usually very anxious about their first meeting. As in any relationship, introductions are needed. The counselor initiates the process by introducing herself, outlining the purpose of the group, and soliciting introductions from the clients. This can be done in several ways, of which the following is one example:

I am glad that every one of you could make it. Lets get started. As you know my name is.... I want to tell you why we are here and what we will be doing in these meetings. Some of you know each other and others do not. One thing that every one has in common is being dependent on alcohol or drugs. This is going to be a time to get to know each other, learn about problems each one is facing, and find new ways to deal with them. At times we will talk about issues which may be sensitive like feeling lonely, depressed, problems at home, etc. Here you will discover that you are not alone with these feelings and when you start sharing them you will definitely find them less painful. Members here will help you minimize your pain.

The introduction sets the tone for the group. In the above example we find the following messages:

- 1) a statement of purpose of the group
- 2) identification of the common factor between members: this aids in developing unity in the group
- 3) disclosure that sensitive issues will be explored: it is vital that clients know such topics will be discussed
- 4) the offer of hope: clients are often overwhelmed by their problems and are disillusioned that no alternatives exist; the group gives them much needed hope.

The introduction of clients can be done in many ways. When the suggestion is open ended, i.e. 'Let's tell each other our names and something about ourselves', the response may be either anxiety-ridden silence, or names rattled off in a rapid fashion with no mention of personal data. Introduction is the patient's first step towards self-disclosure. They can be in a state of

panic and can have a lot of anxiety. To get over this initial barrier, the following methods may be followed. First, the group can be divided into pairs and each client asked to introduce himself to his partner. After this initial contact, they could come back, form a group and introduce the person each one met. This exercise helps the client redirect focus from oneself. The second method is to request senior members to introduce themselves first, thereby setting a role model for the newcomers. After the introduction, the next step is to spell out group guidelines. These group guidelines have been discussed in the earlier part of this chapter.

First Stage: Formative Stage

Hesitant participation with random spurts of energy mark this stage. The participants look at each other with caution, find similarities and differences and attempt to establish the universality of the problem of addiction.

Not sure of how the group will progress, participants display dependency on the counselor. Communication is stereotyped, limited to superficial issues, and directed more to the counselor than to other members. They frequently look to the counselor for approval and appreciation.

Here the counselor should encourage members to relate to the group. By repeatedly calling attention to the need for 'I' messages and descriptive rather than judgmental statements, the counselor sets the stage for smooth progress.

The therapeutic benefits which the client experiences in the early phase are –

- anxiety is reduced
- clients establish relationships which remove loneliness and isolation.

In the early stage, sharing is more on structural details rather than feelings. Members talk about their expectations, about what they want to achieve during their stay at the treatment center, etc. After the initial verbalization, they start sharing their addiction-related damage.

Middle Stage: Developmental Stage

As the group completes its initial tasks, it moves into relating – the heart and soul of group therapy. Initially, the counselor will have to actively facilitate sharing, with clear focus on specific issues. The most important therapeutic task in the middle phase is the handling of defenses. Defenses will be high, and nurturing intervention in the form of support from the counselor and the group is necessary in order to break the patterns. The predominant form of defense is denial. There are at least two levels of denial in a client. The first is denial of the magnitude of the drinking / drug-taking problem. Once the initial denial has been overcome, a second form of denial is encountered – the denial of the need to change. Both these forms of denial can be handled in group therapy.

A general approach to handle denial is direct confrontation. Confrontation will be successful only if the patient is well integrated into the group therapy and has made a strong emotional investment in the group process. This approach is most useful when voiced with concern and accompanied by examples of the behavior being confronted. Confrontation should be descriptive, focusing on what one has observed in a person. It should be based on specific facts and should not be in the form of generalized comments, advice or discussions about something which has not been witnessed by the member or counselor confronting the person. Confrontation is best accomplished by other members of the group.

The other therapeutic task of group therapy in the middle phase is motivation. This should be an issue of concern throughout and must be built progressively. Initially motivation is built by focusing on damage, thereby, giving insight to the client on the need to change. Subsequently motivation is strengthened by focusing on the positive changes each individual has achieved. This leads to growing hope among group members that it is possible to lead a drug free life.

Recognition and identification of feelings is another task here. Now the clients will feel comfortable and will be able to identify their negative and positive feelings. An understanding of the fact that addiction is a disease helps them to talk about and share their feelings of guilt, shame and hurt. Members also learn to respond openly to others' feedback, and spontaneously report their feelings without hiding. The patients discover that it is more helpful to be open than to be right.

The more common negative emotional states like guilt, resentment, low frustration tolerance, shame, fear and anxiety are also dealt with. During the group therapy process, healing also takes place.

The counselor's main task here lies in being alert to changes in the tempo of the group. The counselor should be adept in making significant interventions in case members lose focus. She should help them focus on issues, bring conflicts to the forefront and deal with them appropriately.

Towards the latter part of the second stage, the group weaves its way through conflicts with a little help from the counselor. As the group progresses, they slowly take responsibility for decision making. The counselor makes conscious efforts to this end by refusing to answer questions and encourages group participation in views expressed and decisions made. The group thus learns to look for resources and directions from within itself. The group's attitude turns into one of support and understanding for each other. This is eventually followed by a stage of encouragement, appreciation, closeness and intimacy.

The therapeutic benefits of this stage are

- open sharing and ventilation of feelings are made possible
- defenses are handled in the group itself by the group members
- dependence on the counselor is replaced by dependence on other group members.

Third Stage: Action stage

The stage is now set for bringing in the most productive and satisfying phase of the process. Members find it comfortable to express all feelings and take responsibility for what they wish to achieve in the group. Opposing viewpoints are no longer threatening, and conflicts are resolved constructively. Participation is at its best. Significant issues are discussed, feedback received well and tasks get done at a rapid pace.

Sometimes groups fail to progress especially when conflicts are seen as negative factors. In such a case the counselor's task will be to stay with the group in the second stage, work through conflicts and help them reach this stage where members feel their dependence as well as their independence.

They are able to see their similarities and differences, disagree at times and still feel comfortable.

The counselor's intervention helps sharpen focus on emerging issues and provides useful input to handle complex issues. The group may revisit the same problem areas as in the previous stage but they are now viewed from a different perspective. The counselor stays tuned to the tempo of the group guarding against stagnation on one issue. During this stage the counselor consciously gets ready to bring the group to the stage of completion. The major issues to be focused on are relapse prevention and recovery plans.

The therapeutic benefits of this stage are

- complicated issues are openly discussed and conflicts resolved
- motivation to continue with sobriety becomes their priority
- members feel the significance of independence and interdependence; they understand the importance of A.A./N.A. and After-Care services to maintain abstinence.

Fourth Stage: The Resolution Stage

When the group draws closer to completion or when a few members prepare to leave the group, the situation may be anxiety-provoking for all. For the members who are leaving, having to do without the group's support and encouragement can be unsettling. The rest of the group may also feel bad because they would miss the contribution of the older members. Now the counselor can give them reassurances, and encourage the members who are leaving, to make frequent visits to the center.

ROLE OF THE COUNSELOR

Making group therapy a powerful source for change is an art and a skill. Here, as in an individual counseling relationship, the basic personality of the counselor, her professional training and experience can make a world of difference. The counselor has to maintain a relationship characterized by warmth, empathy, concern, acceptance and genuineness. An effective counselor will be sensitive and flexible to the needs of the group and flow with it, all the while making valuable interventions.

➤ ***Helping members belong***

The group therapy situation may be stressful for the newcomer. Members are strangers to each other and look to the counselor as the unifying force. By using this 'special member' status, the counselor goes on to create one physical entity, 'a group', from a collection of members with different experiences and problems.

Being sensitive, accepting and supportive to all members and displaying this through appropriate verbal and non-verbal behavior, the counselor can create a sense of 'oneness' or togetherness.

Late coming, absenteeism, sub-grouping (two or three members carrying on interactions while actively excluding others) and 'scapegotting' (majority of the group making one member the target of their negative feelings) threaten cohesiveness. The counselor should act early and decisively to counteract these forces.

➤ ***Encouraging 'feeling level' interaction***

Shame, guilt, resentment and fear are the predominant negative emotions. Being able to talk about them in a supportive, caring environment to people who have actually experienced them, is what makes group therapy effective. Handling anger and resentment means coming to grips with the true underlying feelings. Members who are eloquent may find it easy to share on a superficial level. By encouraging and emphasizing 'feeling level' statements, the counselor can help them get in touch with their negative feelings, which they try to run away from. Separating thoughts from feelings and labeling feelings, helps members explore them further and deal with them better. This exercise stands them in good stead in their future communication patterns and problem-solving efforts.

➤ ***Facilitating growth***

The counselor should never forget that her involvement is of prime importance in shaping the group norms. Too exacting behavior or being too passive – both can inhibit members. She needs to play her role with confidence and poise.

Basic rules that are set at the start of the group process may sometimes need further strengthening. The counselor can draw attention to the norms through statements, observations, questions and display of appropriate non-verbal behavior. For example, to encourage member-to-member communication, the following methods can be used:

- asking for other members' reactions
- refusing to answer questions directly

Nodding, smiling, verbal reinforcements and other good attending behavior help shape positive behavior among members. The counselor has to respond to unacceptable behavior like hushed or whispered conversations or late coming. Unhealthy practices like frequent interruptions or excessive criticism can grow quickly and it is the counselor's responsibility to guard against them.

The counselor should encourage feedback. When a member is criticized or confronted, caring questions like 'How do you feel about what was just said?' help that member respond. When many suggestions or comments have been made in response to one member's sharing, asking him 'What did you find most helpful? How did you feel to receive so much?', helps the member give appropriate feedback.

The counselor is a 'model setting participant' in many ways. Good attending behavior displayed by the counselor is quickly copied by the members. By giving support and encouragement, the counselor invites members to follow suit. The counselor's handling of conflicts by permitting expression of negative feelings and working through them rather than suppressing them, helps members learn to do the same even in real life situations.

➤ ***Recognizing the group's power***

The primary therapeutic agent in a group is always the interaction between the members and not the counselor. As an effective counselor, she recognizes that the group's power is more than her own, and makes the group assume responsibility to make the interactions. If the counselor takes the responsibility, the members would sit back and wait for the counselor to make the interventions as if watching a movie.

The counselor needs to resist the urge to quickly intervene with the right answers, and should wait for a discussion to follow and allow it to move slowly to a conclusion. The group values the decisions that they arrive at and does not look for quick fix answers from the counselor even if the solutions are just as, if not more, effective.

➤ **Recording**

The progress or lack of it among each member in the group and the counselor's impressions need to be recorded. This will help the treatment professional to see and clarify the level of progress and plan further directions. In case a different counselor takes over, she will be able to

- assess the progress of each member
- set specific goals for each member
- identify and help him deal with negative factors so that they don't grow stronger and interfere with the recovery process
- use those facts to give appropriate feedback to members.

Recording is thus extremely useful and clearly necessary. But for the 'time-pressed' counselor, if recording needs a lot of time, it can become stressful and poor compliance will result. To prevent this, recording should be structured, and carefully structured recording should not take more than 10 minutes.

If 5 sessions are held in a week, a weekly recording will suffice. If the session is once a week, recording can be done immediately. Changes initiated in group therapy may continue between sessions also. Recording helps the counselor keep tabs on the issues discussed and maintain continuity between sessions.

The ultimate goal of group therapy is to aid self-understanding and initiate change to the maximum level possible in each and every member of the group. Three factors contribute to this outcome.

1. The skill of the counselor
2. The openness of the members who constitute the group
3. The (genuine) interaction between the members

Therefore, the skill of the counselor needs to be sharpened periodically through frequent self-assessment, clinical reviews with peers, openness to new techniques and readiness to explore directions suggested by group therapy research studies. The counselor has some control over the second factor also in the sense that through a display of supportive care and concern, she can facilitate the group to become open and honest in their sharing. This will lead to genuine 'feeling level' interaction and conflict resolution. To put it plainly, the counselor, even though a catalyst, is the key player and her skill is of prime importance.

SKILLS SHARPENING TOOLS

RECORDING OF GROUP THERAPY

A model format for recording progress made by clients during group therapy sessions is presented below. The record is simple and easy to update on a weekly basis. The counselor should handle the group for at least five sessions continuously to be able to assess the progress appropriately

Group Therapy Record

Name of client :

Date	Attendance	Level of sharing	Focus of sharing	Participation / response to others	Comments and signature of therapist
1st Week					
2nd Week					
3rd Week					

ISSUES IN GROUP THERAPY

As mentioned in the previous chapter, group therapy is being increasingly recognized as the most effective form of therapy for addicted individuals. The gains that the individual receives from group therapy depend on how much he gets involved in the group process and the honesty and depth with which he shares.

When the client joins a group, there is a lot of hesitation to share thoughts and feelings, and the sharing is strained and superficial. As he gradually settles into the group, he is able to express himself more and more openly. From being a non-committal observer he goes on to participate in the group's proceedings. He feels comfortable enough to give feedback to others and can even express negative feelings about himself as well as others.

He interacts spontaneously and participates in problem-solving efforts of others too. His identification with the group develops and the level of trust is high. He then uses the strength of the group to work through his confused thoughts, conflicts and feels more and more confident about facing the future without drugs / alcohol.

This growth process can take place only when the group is cohesive, with a moderate to high level of activity. Some factors can however prevent the smooth flow of the group. The counselor needs to recognize signs of distress in the group and help it move on.

SIGNS OF DISTRESS **DULL AND SLOW GROUP TEMPO**

The level of participation is low. Individual members share briefly with a quick recital of events and then lapse into silence. They sit back and watch others share with little or no interest in the group's activity.

The lack of interest is contagious, grows quickly and the group comes to a slow grinding halt. Members start giving excuses to absent themselves from the group and even if they are forced to attend, no therapeutic gain is in sight.

- The style of the group counselor can often be the reason behind this phenomenon. The counselor who controls the group too tightly can gradually stifle spontaneous sharing. When the group views the counselor as being critical and authoritative, group members limit their participation.
- If the counselor takes all the responsibilities for keeping the group moving, once again members stop contributing to the group. By making the necessary interventions all by herself, the counselor absolves the group of all responsibility to keep it going. So, each member just delivers his lines and nothing more. Therapists should recognize that it is the group's collective power that makes group therapy effective. By retaining power and control, the therapeutic influence is greatly weakened.
- Encouraging members to give feedback by inviting comments and suggestions helps. Not rushing in to provide the right answers or even to correct a wrong perception, instead prodding the group to handle the issue, increases the level of activity. For example, a group member may make a comment that he is very confident of his sobriety and that he will get actively involved in getting drug-taking friends to also quit drugs. Instead of pointing this out as a high-risk behavior and stress the need to stay away, it is prudent to draw the attention of the group and invite comments. When this is done repeatedly, the group will start playing this role on their own without needing a cue from the therapist. The more the group participates, the closer they feel and the level of interest also increases.
- Talking about the therapist's observations and feelings can also help members into activity. Sharing this openly can mobilize involvement. For example, the counselor may say

This group seems to be moving very slowly. Members sit back after they share and do not react or respond to others' sharing. There is no active involvement. Not surprisingly, I can see many losing interest. Group therapy is useful only if all of us speak honestly as well as get involved in others sharing. A group becomes meaningful depending on what is put into it. Most of you are giving very little to the group. So, the group is dull and uninteresting. I hope all of you will get involved and the group will work dynamically.

DISORDERLY GROUPS

Rules are broken and orderly behavior is absent. Late coming, leaving the group mid-way, absenting oneself without prior notice, talking all at once, interrupting when others are sharing – many issues may arise. The atmosphere is chaotic, members do not take the group seriously and cohesiveness is at a low level. Not surprisingly the therapeutic benefits are low or nil.

- When therapists do not state rules and expectations explicitly, members are not clear about their expected roles and they function as they like. Stating the rules in detail once a week and repeating it at the beginning of every group session is essential.
- If members perceive the counselor as being lenient and not firm enough, members fail to conform. The group's behavior often reflects the functioning of the therapist. When the counselor fails to enforce rules consistently or does so with seeming reluctance, the group breaks limits set.
- Whenever rules are not respected, reminding members of the expectations along with the logic and reasoning behind it helps.
- When rules are repeatedly broken, a firm stand needs to be taken. Members need to be directly confronted and action taken if this fails. By doing so, the counselor sends a clear message that sessions are to be taken seriously. For example, if the members repeatedly report late to the group, the counselor can say

We have already started the group. So, you will not be able to join us today. You can leave now and come back for the next session on time.

GROUPS THAT ARE NOT FOCUSED

Members may deviate from the topic presented for discussion. When members do not restrict themselves to the topic, each member will talk of issues he wants to present and pull the group in different directions.

- When the topic is vaguely presented in general terms, groups tend to wander. If the topic is too vast and includes a wide range of ideas the focus can be lost. For example, if the group topic is presented as the ‘symptoms of addiction’, it may not be clear enough. Listing just 2-3 symptoms with appropriate examples gives clearer directive to the group.
- Reminding members each day to restrict their sharing to the topic is helpful. When someone deviates, reminding him of the topic to be discussed can bring him back to focus.
- Asking the group if sharing is focused and calling for their intervention can also be done.
- Topics need to be chosen according to the level of maturity of the group. Groups which are not yet cohesive and supportive cannot be expected to work with topics which can be emotionally painful. For example, talking of shame and guilt can be beneficial only to a well-developed group but can fail to take off in a group where most members are still new to each other

FORMATION OF SUB-GROUPS

A few members of the group may form coalitions based on age, financial status, educational status or even the choice of drugs abused. Formation of such bonds can negatively influence the group process.

Such members would then exchange looks when others share, come to each other’s rescue, always agree with ideas presented by one of them and refuse to confront each other. When this grows to the point of making fun of others or when they conspire to stay silent, they block individual and group progress.

- Research suggests that negative sub-grouping takes place more when therapists display an authoritarian, restrictive style of leadership. So, such reactions may call for self-assessment by the therapist.
- Individuals with strong needs of intimacy, dependency or dominance often form sub-groups. Recognizing the hidden need of the individual can help the counselor handle them appropriately.
- Calling the attention of other members towards unacceptable behavior and bringing negative behavior into the open can be an effective intervention strategy. For example, the counselor may say

I noticed that both of you smiled when he was sharing. Tell us about it!

- Encouraging the other members to provide feedback can also be effective. For example, the counselor can say

Many group members had something to say about his reluctance to talk in the group. But you were surprisingly silent even though you are very friendly with him. I wonder if others in the group want to comment on it.

- Describing the proceedings in the group and inviting comments also helps.

I can sense some undercurrents in the group. I guess some of you are feeling uncomfortable about what is happening. Let us talk about it.

UNHEALTHY BEHAVIOR OF INDIVIDUAL MEMBERS

1. Poor eye contact

When a group member looks at only the counselor or a few members of the group alone, he excludes others in the group. The others then lose interest in the group's proceedings.

- A new member looks more often at the counselor than others as he sees the counselor as an authority figure who will take care of him among the strange faces in the group. He may actively look for non-

verbal cues to start sharing and encouragement when he does. As he settles down, he looks more often at others. The counselor also helps this change by looking away at others in the group and encouraging him also to do so.

- Reminding the group to look at everybody in the group while they are sharing and listening helps members maintain good eye contact. Not maintaining eye contact conveys an air of disinterest and disrespect but members may not be aware of it. Inviting others to share how they feel when a member does not look at them is another effective strategy to use.

Mr. Ravi does not look at others but instead stares out of the window. I want to know how each of you feel about it.

While a few may say it is okay, most will express their displeasure. This feedback is often sufficient to help him change.

2. Rude language

Group sessions are an excellent situation to help addicts express negative feelings appropriately. While most of them quickly learn to check their language and refrain from using unacceptable language, some may continue to do so.

- When this happens, active counselor intervention is called for. The counselor can call on the patient to stop, rephrase and present his feelings or views in an acceptable manner. For example, the client may react unfavorably to another member's feedback by saying

Don't talk rubbish. Can't you understand what I am trying to say?

The counselor can help him react in a better manner by commenting on his unpleasant language and probably rephrase it to say

Your suggestion will not work. I think you have not understood what I was saying.

- A one-to-one discussion with the member outside the group about his unacceptable behavior can prevent recurrence.

- If a member seems very restless and aggressive, it would be good for him to leave the group. His re-admission can be considered after he is sure of his ability to restrain himself.

3. Breach of confidentiality

- Discussing group issues outside the group setting or reporting parts of it to other patients or family members amounts to breaking confidentiality. Stressing this during the sessions helps members respect the trust with which members confide in the group.
- Explaining the problems it causes and stressing the need for confidentiality in each group session helps.
- When confidentiality is broken, trust level becomes low and the group cannot progress beyond the first stage. If this has happened, it should be seen as a serious issue and must be handled in the group setting.
- Stating the problems it causes and discussing the issue openly is most helpful. Talking about the incident openly and helping members air their views about how they feel will help.

4. Relapsed patients

Patients who are under the influence of drugs or alcohol should not be permitted to attend group therapy sessions. They do not profit from it and may instead upset the proceedings.

- The patient who has had a relapse but does not mention it in the group cannot be allowed to continue with secrecy. The counselor can encourage him to share this with appropriate probing responses. Stressing the need for honesty can help. An individual session with the client can also be planned to emphasize the need for sharing openly.
- If he persists in denying the relapse in the group, the reason for his group participation should be questioned. If he is unwilling or unable to work through his recovery issues in the group, he might as well discontinue attending the group.

- If the group members are aware of it and he persists in staying silent about it, the counselor can help the group voice their feelings. The group may then take over and question him. They may ask why he does not share openly but listens to their sharing and use it for his own recovery. Some members in the group may openly confront him and point out how this only prevents his recovery.

PROBLEM BEHAVIOR OF INDIVIDUAL MEMBERS

Groups have their share of difficult patients. They can prevent the healthy group process. The following are some types of problematic behavior that may be encountered, and methods to handle them.

1. Denial of individual members

Clients can be expected to deny their problems during the early phase of their recovery. As he shares more about himself and listens to others too, denial usually breaks.

- If he continues to deny, confrontation needs to be undertaken. This is best done by the group itself. Calling on the group to focus on specific issues usually works.

Mr. Xavier says that he has been using drugs over the past 5 years. Even while stating that he did not complete college and has been unemployed most of the time – he says not much damage has been caused. Would anybody like to comment on this?.

- Paraphrasing his sharing and re-stating it can also help clients to share more honestly. For example,

So, you feel that if your parents had paid the capitation fees and sent you for higher education in the private college you would have quit drugs much earlier.

Focusing on the relevant issue without the trimmings, forces clients to see incongruent messages.

- The counselor needs to guide such confrontations, balancing firmness with a caring attitude. Scathing remarks of group members may need to be rephrased. The counselor should also ensure that the feedback must be specific rather than general. For example, instead of just saying

You are crazy to do that members need to be encouraged to point out the unacceptable behavior specifically. It would be better to say

To resign straightway when criticized by your boss seems a hasty decision to me.

- During confrontation sessions the counselor needs to be sensitive to the reactions of the other group members especially those who are new to the group. Confrontation sessions can be threatening to other group members even if this is not so far the member who is being confronted . The new member may tell himself

I better watch out. They are ripping this guy apart.

- Closures at the end of these sessions takes on more significance if major confrontations have taken place. Feelings need to be assuaged, caring statements need to be made and gentle reminders that members need to think about these issues too are required. Stressing confidentiality may also be called for.
- Talking about the denial and the way it can hamper his recovery can be done with the patient on a one-to-one basis outside the group to actively encourage him to share in the group sessions.

2. Monopolist

The monopolist talks incessantly, interrupts frequently and attempts to be the center of attention. Ordering him point blank to stay quiet can hurt him and also frighten other members. On the other hand, if left unchecked, others will become bored, and react negatively, leading him to sulk and withdraw.

- His tendency to hold the stage is often an attempt to keep to the superficial level and this prevents him from getting to the real issues. By summarizing when he shares, the counselor can get him to be

precise. Repeated, gentle interventions and feedback will be useful in tackling this difficult member.

- The counselor can tactfully call for responses from other group members while desisting from discounting the monopolist. By highlighting the need for their participation, the other group members can be made responsible for the manner in which the group is progressing. More involvement by the others helps keep this member in check.
- The monopolist often continues his unwelcome behavior, unaware of the negative feelings of others towards him. Helping him become aware of this is important. Saying

Let us now check out on how the group is feeling

can help others give him a feedback to facilitate change. The members may say,

We have only one hour in which ten of us need to share. When you talk for a long time, others do not get sufficient time to share. It would be good you can come directly to the point and share briefly.

3. Patient with difficulty expressing feelings

Some patients seem so emotionally blocked that they do not show any feeling in their sharing. They recite facts and events without the emotive element. Their sharing is brief and remains at a superficial level, keeping their own as well as the others' gains at a low level.

- Helping such a patient get in touch with his feelings and verbalizing them needs to be done. For example, the counselor can say

You described what happened on your child's birthday. Tell us how you felt about it.

- Clients who don't relate at the feeling level can be isolated in the group – be in the group and yet far removed from it. Efforts need to be made to get them involved in the group proceedings. The counselor can encourage such clients to give feedback with emphasis on feelings

when another member shares something significant. This helps them get involved and also gives them an opportunity to talk about their feelings. For example the counselor may say

I saw you listening with rapt attention to what he was saying. Tell us how you felt about his sharing.

4. Silent patient

He willingly stays a passive spectator to the group's proceedings. His silence may arise from

- his discomfort in talking about himself in a group
- his anxiety that if he shares a little, others will force him to share more than he wants to
- his fear that if he starts talking he may cry or breakdown letting everyone see how shattered his life is

- An individual session with the patient prior to the session can help him feel more comfortable in the group. The counselor can use this opportunity to assure him of support and actively encourage him to share. He can be helped to understand the need for sharing and guided to share at least at the minimal level to start with.
- Some information about the patient's history can help the counselor understand the reason behind his silence and handle these issues appropriately. Some clients resist getting involved in the group as they are reluctant to share some issues that they consider to be very sensitive. The counselor then needs to be cautious and alert – noting when and what topics interest him, which ones make him tense – and help him get involved as and when he is ready.
- Even the 'silent' patient is never completely 'silent'. His non-verbal behavior often betrays his feelings. The counselor can call attention to this and ask for his feedback. For example

I saw you lean forward and show concern when he talked about his loss of job. Would you like to talk about it?

- Some prodding and questioning of gradually increasing depth is useful. When the patient does share a little, he needs to be encouraged and appreciated. The counselor can get the silent patient to commit himself by saying

You shared when questioned today. Did you feel pressurized?

When the patient says ‘No’, as he usually will, the counselor can settle the issue by saying

I am happy about that. We can then continue doing this in later sessions too, isn't it?

5. One who believes he is always right

He advises and gives solutions to all the members and sees his ideas as being the most ideal. He feels a compelling need to be seen as being ‘right’ all the time. The underlying message in his sharing is to stress ‘how well I have succeeded in spite of problems’.

This behavior is most enhanced if the patient is older, richer or more educated than the rest of the group. His ‘air of superiority’ leads others to be hostile towards him. Other group members try to isolate him or make sarcastic comments about his ‘know-all attitude’. To maintain the superior air, he does not share openly, limiting his gains from the group. By focusing on others, he is too busy with others’ recovery and not his own.

- With this patient, surprisingly, the key issues are shame, hurt and a low self-esteem. The counselor needs to make special attempts to help him recognize and verbalize the shame and hurt in his relationships. Focusing on this helps him lower his defenses and get help.
- Subtly inviting others to give feedback and underplaying his role in problem solving can also be effective.

6. Boring patient

His sharing is superficial, repetitious and delivered in a flat monotone. When this patient keeps repeating his oft heard statements, group members usually

betray boredom by yawning and display other non-verbal cues that indicate restlessness.

The fear of being rejected can limit this patient's level of sharing. The boredom that he generates helps him isolate himself further from the group.

- The counselor can summarize his sharing and help him share at the feeling level to make his sharing more meaningful.
- At some point, members may tell the patient that he repeats the same issues and that his contribution is not sufficient. The counselor can induce such interventions and help him focus on relevant issues.

7. Help-rejecting complainer

He has a list of things going wrong (including the poor progress of the group) and will present problems as if his is the biggest of all. He frequently asks for suggestions but does not make use of them. Even when he implements them and finds them useful, he will not acknowledge it. This patient's constant complaints may reduce the faith and hope of the group and weaken cohesiveness.

The counselor should guard against becoming resentful of this patient because this is what the patient wishes to happen. He can then use this to 'revalidate' his self-pity and prove to himself that nobody understands or helps him.

The counselor should consciously refrain from offering solutions for they will be rejected. The counselor should help members see the 'yes – but' approach of the patient to suggestions made. The members thus take over and help him see his 'self-defeating behavior'.

8. The questioner

He frequently asks questions and raises doubts, often with a false air of high motivation to get more attention. Questions, when excessive, can draw the counselor off focus and also allow the member to intellectualize on issues.

When the question is not related to the topic of discussion, the counselor can say

I am afraid that by answering this question, we will sidetrack from the present issue. I will be happy to discuss this with you after the group.

However, the counselor needs to be sensitive to genuine requests for information and clarification. When meeting this need, answers are to be kept short, followed by a return to the topic of discussion.

To Sum Up

The effectiveness of group therapy session depends on three major forces – the skill of the counselor, composition of the group and the interaction between the two. As the counselor is largely responsible for the first and the third, effectiveness is largely dependent on her. Maintaining group therapy records, and inviting supervision by an experienced group counselor can help sharpen her skills. With experience and willingness to learn from one's own experience, one can emerge as a skillful group therapist.

INTERNALISING TOOLS

WILL I MAKE A GOOD COUNSELOR?

Ask yourself the following questions:

1. Am I happy with myself?
2. Do I have confidence in my own abilities?
3. Am I happy not dominating or controlling others?
4. Do I take a liking to different types of people easily?
5. Do I feel that everyone can take his own decisions and assume his own responsibilities?
6. Do I find different types of people interesting?
7. Can I listen patiently when someone is talking in detail about his/her problems?
8. Do I have the well being of most people around me in my heart?
9. Am I tolerant towards religious and social beliefs that do not agree with mine?
10. Am I warm and loving towards new people who come in contact with me?
11. Can I talk easily and frankly about myself when the need arises?
12. Can I listen to a tragic circumstance without getting weighed down with sorrow?

If you can truthfully answer 'Yes' or 'I think I do' to most of the questions listed above, then you are the type of person who will make a good counselor. However, if you answer 'no' to a majority of the questions, you will either have to change your outlook, undergo more rigorous training, or accept the fact that you may not make an effective counselor. (Khwaja,2000)

FEED BACK FORM

This field guide had been developed to assist counselors in the area of drug abuse. Your experience of using the guide can help us improve and refine it further. You will be very grateful your comments and suggestions.

Please complete this form and mail it to

National Center for Drug Abuse Prevention
National Institute of Social Defence
Ground Floor, West Block, Wing 7
Ramakrishnapuram
New Delhi 110 066

Please feel free to add any additional comments you would like to share with us.

1. Does the guide contain comprehensive information you found useful in the field? If not why?
2. Is the format and language to your liking? If not why?
3. Is there any area the guide has over looked, or not discussed in sufficient detail?
4. He is the technical data provided in the guide easy to use in your work?
5. How do you rate the guide as a reference hand book?
6. Would you like the manual to carry support tools such as charts, posters etc.
7. Are there other areas of counseling and treatment on which you require further information (field guides) ?

Additional comments and suggestions

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