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# First Hours of Treatment



## The First Hours

The first thing that clients need when they come into treatment is a warm welcome. Most clients entering treatment feel demoralized and ashamed. They feel like the scum of the earth. These people need you to show them encouragement, support, and praise. You must show them that they are persons of worth, that they are important, and that they matter to others. Nothing gives this feeling better than a warm welcome. A warm welcome helps them to understand that they are entering a caring environment. They do not need to be afraid.



## How to Greet Clients

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You need to convey to clients that you understand how they feel and that you will do everything in your power to help them. When greeting a new client, it is as if you are welcoming a long-lost brother or sister back into your family. This person is not different from you; this person is you. Treat the person the same way in which you would want to be treated yourself. The more the client senses your goodwill and unconditional positive regard, the less alienated and frightened the client will feel.

If you feel as though you can shake a client's hand, then do this. Make it a warm handshake. As you do these things, you are developing your therapeutic alliance, and you are giving your clients the most important thing that they need—acceptance.

The initial words you choose are important. Clients remember your words. Clients come back after years and describe their first few hours in treatment. They remember the exact things that people said. Because coming into treatment is a highly emotional experience, they seal these words inside their hearts. You want them to remember the good things. Think of it like this: These people have been living a life full of no love, no light, no beauty, and no truth. You are walking them toward a new life full of love, light, beauty, and truth. Life in the darkness is lonely and painful. As you welcome them home, clients should clearly see that they are entering a new world full of hope.

## Examples

Introduce yourself and say something like the following:

“Welcome. You have made a very good choice. I am proud of you. This is a victory not only for you but for all of the people in the world that you will help recover.”

“This is a new start. Good going.” [*Give the thumbs-up sign.*]

“Please ask us if there is anything you need. We are going to take good care of you.”

“I know this was a difficult decision for you, but you will not be sorry. This is the beginning of a new life you have not even dreamed about.”

“Try everything in your power to stay in treatment. If you feel uncomfortable, tell one of the staff. We are here to give you the best treatment possible. You will feel better every day.”

Notice how each of these statements welcomes the client and enhances the client’s self-esteem. Welcome. You are a good person. You made a good choice. We are going to take good care of you.

Ask whether the client wants anything. How can you help? Nothing shows that you care better than to offer to get the client something small—juice, food, milk, or coffee. This shows that you care and, more importantly, that the client is worth caring for. You are giving the client new ideas. Treatment is not going to hurt. The staff is willing to respond to the client’s needs. “This treatment thing might be okay,” the client begins to think. “I just might be able to do this.”

### How to Handle Family Members

If the client comes into treatment with family members, then make sure to tour the facility with the family as a whole. This helps the client to make the transition between the family at home and the new family in treatment. When you have all the information that you need from the family members, they should be encouraged to leave. To have them linger unnecessarily can be detrimental to the client’s transition. Clients need to focus on themselves and orient to treatment. Family members who cling are rare, but they do exist. These people need to be separated from the client and given reassurance that the client is in a safe place. Someone in the family program might be willing to talk to the family members for a while to encourage them and answer any questions they might have. Remember that you are bonding with the client and the client’s family members. You want them all to see you as someone they trust.

### Beginning the Therapeutic Alliance

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From the first contact, your clients are learning some important things about you. You are friendly. You are on their side. You are not going to hurt, shame, or blame them. This is a disease like cancer, hypertension, asthma, or diabetes. People should not be ashamed for being sick. No one wants to become addicted, just like no one wants to have cancer.

Freely answer any questions about treatment and the treatment center. Take new clients on a tour, and introduce them to other clients. Be honest, and hold nothing back. You provide the information, and the clients make the decisions. They see you as a concerned professional. The clients begin to hope that you can help them. The therapeutic alliance is built from an initial foundation of love, trust, and commitment.

Give new clients the idea that you are going through treatment with them. They do not have to feel alone. Neither of you can do this alone. Both of you are needed in cooperation with each other. Clients know things that you do not know. They have knowledge that you do not have. They know themselves better than they know anybody, and they need to learn how to share themselves with you. Likewise, you know things that they do not know. You know the tools of recovery. You have to share these tools and help the clients to use them. This is a cooperative effort. It is as if you are on a wonderful journey together.

## The Importance of Trust

Your clients must develop trust in you. To establish this trust, you must be consistent. You must prove to the clients, repeatedly, that you are going to be actively involved in their individual growth. When you say that you are going to do something, you do it. When you make a promise, you keep it. You never try to get something from the clients without using the truth. You never manipulate, even to get something good. The first time your clients catch you in a lie—even a small one—your alliance will be weakened.

Clients must understand that you are committed to their recovery but that you cannot recover for them. You cannot do the work by yourself. You must work together cooperatively. You can only teach the tools of recovery. The clients have to use the tools to establish abstinence.

## Dealing With Early Denial

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The first few hours of treatment are a time not for harsh confrontation, but for listening, supporting, and encouraging clients to share what they can share. The great healer in any treatment is love (treating others like you would want them to treat you), and love necessitates action in truth. All clients come into treatment in denial. They have been dishonest with themselves and others. They are lying, and they will lie to you. Your job is to search for ambivalence and inconsistencies in their story that reveal the lies. As gently as possible, reflect the truth. You do not want to hurt the clients or incur their wrath, but you must be dedicated to the truth. This program demands rigorous honesty.

Clients lie to themselves in many ways. They do not want to see the whole truth because the truth makes them feel guilty and anxious. They keep the uncomfortable feelings under control by deceiving themselves. They distort reality just enough to feel reasonably comfortable. They defend themselves against the truth with unconscious lies called defense mechanisms. “As long as we could stop using for a while, we thought we were all right. We looked at the stopping, not the using” (Narcotics Anonymous [NA], 1988, p. 3).

Clients minimize reality by thinking that their problems are not so bad. Then they rationalize by thinking that they have a good reason to use drugs. Then they deny by stubbornly refusing to see their problems at all. Treatment is an endless search for truth.

Those who do not recover are people who cannot or will not completely give themselves to this simple program, usually men and women who are constitutionally incapable of being honest with themselves. There are such unfortunates. They are not at fault. They seem to have been born that way. They are naturally incapable of grasping and developing a manner of living which demands rigorous honesty. (Alcoholics Anonymous [AA], 2001, p. 58)

Your job as an addiction counselor is to help the clients learn the truth, knowing that the truth will set them free from the slavery to the lies.

## Example of an Initial Contact

Approach the client. Reach out and take the client’s hand. “Hi, Ralph.” Use the client’s first name. “I am \_\_\_\_\_ [your name]. I am going to be your counselor. How are you doing?”

The client looks at the floor and then at the wall.

You know the importance of silence and wait.

The client finally looks up. "I am okay, I guess."

"The first few days are going to be the hardest. After that, it is going to be a lot better. This is the beginning of recovery. Is there anything I can do for you right now to make you feel more comfortable?"

"I don't think so," Ralph says, looking relieved.

"If you feel uncomfortable, I want you to tell the nurse or one of the staff, okay? If you cannot find anyone else, come and see me. My door is always open to you. We want you to feel calm and tranquil through withdrawal, not anxious or tense. Do not try to get through this by yourself. Let us help you. How you feel is important to us."

*The therapeutic alliance is being established.*

The client might never have experienced unconditional positive regard before. It might seem strange to the client. To many clients, it is unbelievable. They come into treatment with preconceived ideas about how treatment is going to go. Many think that they are going to be punished. When they are greeted with love and affection, it comes as a great surprise. Your words of support and concern are as soothing as a warm bath.

All chemically dependent clients, at some level, want to punish themselves. They feel guilty about what they have done, and they are waiting for the executioner. They expect to be treated poorly. When you treat them with respect, they ask themselves why people are treating them so nicely. *Could it be that I am worth it?*

Tell your clients that they are important. The staff cares about how they feel and what they want. You are here to help. You want to help. You are going to respond to the clients' needs. It might be tough for a while, but things are going to get better.

## How to Check for Organic Brain Dysfunction

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Clients need to be checked for medical problems, particularly organic brain syndrome, as quickly as possible. Some clients coming into treatment are organically compromised and need immediate medical treatment to prevent further damage. Clients may be intoxicated, may be in withdrawal, or may have a serious vitamin deficiency called Wernicke's encephalopathy. They might need 100 milligrams of intramuscular thiamine to stop the death of brain cells. The physician will order the medications determined to be appropriate.

You should be familiar with how to check a client for these cognitive problems. The Cognitive Capacity Screening Examination (CCSE) and the Mini-Mental State Examination (MMSE) can be used, but the professional has to pay for each use. The CCSE is an excellent way of screening for organic brain problems (Jacobs et al., 1977), and the MMSE is a similar assessment test (Folstein et al., 1975). Either of these tests is a brief 10-minute assessment of how the brain is functioning. The test is simple and comes up with a score. If the client falls below the cutoff score, then inform medical professionals of the possible organic problems. If you notice anything unusual about how the client moves, acts, or speaks, then tell a physician or nurse. Always count on your medical staff or the client's family physician. They are more skilled at these examinations than you are.

## The Initial Assessment

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During the first few hours, you must determine whether clients fit into your program. Do they have a problem with chemicals? What is their level of motivation? Do they have the resources necessary for treatment? Are they well enough to move through your program? The criteria for admission are different for different facilities. For the most part, you will start by asking yourself certain basic questions about a client. Does this person have a problem with addiction? Does the client need treatment? Is this person motivated? What kind of treatment does the client need?

## Referral

The counselor will need to establish and maintain relationships with civic groups, agencies, other professionals, governmental entities, and the general recovery community to ensure appropriate referrals, identify service gaps, and help address unmet needs. You will need to network and communicate with a large community resource base. You need to have knowledge and understand the functioning of these agencies:

Civic groups and neighborhood organizations

Health care systems

Employment and vocational opportunities

Rehabilitation services

Faith-based organizations

Governmental entities

Criminal justice systems

Child welfare agencies

Housing administrations

Childcare facilities

Crisis intervention programs

Mutual and self-help groups

Advocacy groups

The counselor needs to have knowledge about community demographics, political and cultural systems, and criteria for receiving community services, access to funding opportunities, state and federal legislative mandates and regulation, confidentiality rules and regulations, effective communication styles, and community resources for both affected children and other household members. If you decide to refer, you must advocate for the client by working with others in the community as a team. You need to respect interdisciplinary service delivery, respect the clients and the agency's services, collaborate and cooperate with respect, and appreciate strength-based principles that emphasize client autonomy and skills development (Substance Abuse and Mental Health Services Administration [SAMHSA], 2006).



Source: Andrea Morini/Thinkstock.

Two quick screening tests for alcoholism have been developed: the Short Michigan Alcoholism Screening Test (SMAST, presented in Appendix 1) (Selzer et al., 1975) and the CAGE questionnaire (Ewing, 1984).

The Substance Abuse Subtle Screening Inventory (SASSI) was developed to screen clients when they are defensive and in denial. The SASSI measures defensiveness and the subtle attributes that are common in chemically dependent persons. It is a difficult test to fake, unlike the SMAST or the CAGE questionnaire. The SASSI gives clients the opportunity to answer honestly about their problems with chemicals, but it also measures their possible abuse using questions that do not pertain to chemicals (Creager, 1989; Miller, 1985). Clients can complete the SASSI in 10 to 15 minutes, and it takes only 1 or 2 minutes to score. It accurately identifies 98% of clients who need residential treatment, 90% of nonusers, and 87% of early-stage abusers (Miller, 1985).

The Addiction Severity Index (ASI) is a widely used structured interview that is designed to provide important information about what might contribute to a client's alcohol or drug problem. The instrument assesses seven dimensions that typically are of concern in addiction: (1) medical status, (2) employment/support status, (3) drug/alcohol use, (4) legal status, (5) family history, (6) family/social relationships, and (7) psychiatric status. The ASI is administered by a trained technician and takes about 1 hour (McLellan et al., 1980).

The Recovery Attitude and Treatment Evaluator—Clinical Evaluation (RAATE-CE) is a measure of client readiness. It assesses client resistance and impediments to treatment. The instrument is a structured interview that measures five scales: (1) degree of resistance to treatment, (2) degree of resistance to continuing care, (3) acuity of biomedical problems, (4) acuity of psychiatric problems, and (5) extent of social/family/environmental systems that do not support recovery (Mee-Lee, 1985, 1988).

As the counselor, you need to constantly ask yourself about clients' stage of motivation and introduce appropriate motivating strategies to move the clients up to the next level. This manual will give you thousands of ways of doing this. No two clients are alike, so you must be creative in helping the clients to see the inaccuracies in their thinking and move them toward the truth. The *precontemplation* stage is where the individuals are not intending to take action with regard to their substance abuse problem in the near future. *Contemplation* is where the individuals intend to take action within the next 6 months. *Preparation* is where the persons intend to take action within the next month. *Action* is where the persons have made overt attempts to modify their lifestyles. *Maintenance* is where the individuals are working a recovery plan and attempting to prevent relapse. If you can move the clients up to the next stage, then you can be sure that treatment is working (Prochaska, 2019; Prochaska & DiClemente, 1983; Prochaska et al., 1992; Prochaska et al., 1994).

Clients at different stages of motivation will need different motivating strategies. In the precontemplation stage, clients underestimate the benefits of change and overestimate its cost. They remember the good things about addiction and forget the bad. They are not aware that they are making these mistakes in judgment and believe that they are right. Environmental events can trigger persons to move up to the contemplation stage. An arrest, a spouse threatening to leave, or an intervention each can increase motivation to change.

Clients in the preparation stage have a plan of action to cut down or quit their addictive behavior. These clients are ready for input from their doctors, counselors, or self-help books and should be recruited and motivated for action. Action is where the clients are changing their behavior to cut down or quit the addiction. These clients have entered early recovery and are actively involved in treatment.

In the maintenance stage, clients are still changing their behavior to be better and are working to prevent relapse. People who relapse are not well prepared for the prolonged effort needed to stay clean and sober. All clients need to be followed in continuing care

because they need encouragement and support to stay in recovery. Addicts typically do not have the skills needed to work a program in early recovery. This takes time, commitment, and discipline.

As the counselor, you constantly try to raise your clients' awareness about the causes, consequences, and possible treatments for a particular problem. Interventions that can increase awareness include observation, confrontation, interpretation, feedback, and education. You point out the need to reevaluate the environment and how to change behavior. Encourage the clients to reevaluate their self-images and how they are negatively affected by the addictive behavior. Encourage the clients to learn the new skills of honesty, helping others, and seeking relationships with a higher power (Prochaska, 2019; Prochaska & DiClemente, 1983; Prochaska et al., 1992; Prochaska et al., 1994).

Laboratory tests can be used to corroborate suspicions about excessive alcohol use that have been generated by the history and physical. None of the tests alone or in combination can diagnose alcoholism, but they add to the certainty of the diagnosis and warn clients of physical complications. High serum levels of liver enzymes can represent alcohol-induced hepatic injury. Ethyl glucuronide (EtG) testing is the newest way to test for alcohol consumption and can detect alcohol use up to 80 hours after drinking ([www.redwoodtoxicology.com](http://www.redwoodtoxicology.com)). The problem is the test is too sensitive. It will pick up any alcohol use, including using common products such as hand sanitizers or aftershave. Therefore, this is not a good stand-alone biomarker to test for relapse. Gamma-glutamyl transferase (GGT) is elevated in two-thirds of alcoholics. There are many sources for an elevated GGT, and GGT only elevates with heavy drinking. Aspartate aminotransferase (AST) and alanine aminotransferase (ALT) are elevated in about one-half of alcoholics. Alteration of fat metabolism causes elevated serum triglycerides in about one-fourth of alcoholics. Alkaline phosphatase is elevated in about one-sixth of alcoholics. Total bilirubin is elevated in about one-seventh of alcoholics. Mean corpuscular volume (MCV) is elevated in about one-fourth of alcoholics. Uric acid is elevated in about one-tenth of alcoholics. A newer biomarker is carbohydrate-deficient transferrin (CDT) and is now widely available. It has moderate sensitivity and picks up drinking at least five drinks a day for 2 weeks. This biomarker has been shown to be a good measure to identify relapse. The advantage of CDT over GGT is that fewer things can cause elevation. However, CDT is not as sensitive to heavy alcohol use, resulting in false positives. The best biomarkers for monitoring abstinence are using a combination of urine alcohol and EtG. A follow-up test of CDT could be used to confirm heavy alcohol use (Brostoff, 1994; DuPont, 1994; SAMHSA, 2009; Wallach, 1992).

## How to Conduct a Crisis Intervention

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Clients who are severely dependent and unwilling or unable to see the severity of their addiction need a crisis intervention. Crisis intervention is a confrontation by a group of concerned family and friends. This confrontation must be gentle and supportive, and it is best to use a trained interventionist to help you develop the intervention strategy. If you want to do the intervention yourself, first read the books *Love First: A New Approach to Intervention for Alcoholism and Drug Addiction* by Jeff and Debra Jay (2008) and *No More Letting Go: The Spirituality of Taking Action Against Alcoholism and Drug Addiction* by Debra Jay (2006). These excellent texts carefully discuss the intervention techniques. Basically, an intervention has to be carefully organized, rehearsed, and choreographed. Each member of the group should be a caring significant other and not an addict. Group members each write a letter stating exactly how the client's addiction has negatively affected their life (see Figure 2.1 for an example). In this letter, they share their love and concern for the client and ask that the client enter treatment. They say it is not the client that is the problem but the illness. It is a lethal



Figure 2.1 Example of an Intervention Letter

Barbara, you are my closest friend, and I cannot tell you how much your friendship has meant to me. We have grown up together. Our kids love to play ball together, and you and I enjoy being close friends. There is no one in my life who has had a more positive effect on my life than you. Thank you for all of the years you have stood by me. When I made mistakes, you were always there to comfort me and give me good advice like a sister. Now comes the hard part of this letter, and I might not handle this very well so bear with me.

Lately, I have been concerned with your drinking. I see you driving the car with the children after you have had too much to drink. In fact, after the Halloween party on Saturday, you were so drunk you could hardly walk, yet you insisted on driving your children home. We all tried to stop you, but you would not listen to anyone. Barbara, addiction is a disease, just like the alcoholism that killed your father. It is genetic and life threatening. I am here to ask you to get the treatment that you need to get well. It hurts me too much to see you suffer. You and I know you cannot drink in a healthy way anymore. These problems have happened too much. My own kids do not want to come over here anymore, and I avoid you myself. This hurts me too much for it to go on. Please help yourself and your family, and get the help you need. The counselor has set up treatment for you today at a great treatment center, and we would all be incredibly proud of you if you would go for help. I love you very much. Please do this for all of the people who love you.

Love,  
Nancy



Source: iStock/NoSystem  
images.

problem, and it needs treatment. Each person reads a letter of concern and love for the client and asks the client to go into treatment that day. The treatment setting has been arranged, and the client's bags are packed. The intervention needs to be held at a neutral location when the client is clean and sober, not in the client's home or office where the client may feel more comfortable. It is difficult for the wall of denial to hold up under all of this love, and most of the time, the client agrees to go into treatment. If the client refuses, the truth has still come out, and this often leads to treatment later. Participants are each encouraged to exhibit the following behaviors:

- Show positive regard for the client and negative regard for the addiction.
- Give specific situations where the addiction negatively affected them.
- Validate that addiction is a disease, and it is not the client's fault.

Save the best letter for last. This is written by someone very tender and special to the client. It might be the client's child, a friend, or another family member. It is someone whose letter breaks your heart. It is very difficult for denial to work in this atmosphere of love and truth. Most clients agree and go to treatment. Remember that no intervention is a failure. Even if the client refuses to get treatment, the truth has come out, and that is always a victory.

Interventions and treatment are going to take time. If you are a primary care physician, emergency room doctor, cardiologist, or surgeon, you might not have the time to struggle with this problem. All addiction treatment is a long journey toward the truth, and this journey is slow and painful. Clients have to face the demons they have hidden from for years. They need to walk into the dark forest of fear and need a trustworthy guide. They need someone with time, energy, patience, and love, a person who has been on this journey many times and come out alive. At some point, you need to decide if you are going to take on this

problem yourself or refer the client to an addiction professional. Remember that addiction is a chronic relapsing brain disease. It is only at the 5-year sobriety point that the relapse rate drops to around zero (Vaillant, 2003).

Therefore, if you take this battle on, it is going to be a long one. If you look at addiction programs around the country, you will see that about half of the clients who leave treatment stay sober for the next year. Ninety percent of clients who work the program stay clean and sober. Therefore, if you want to take on this job, remember that you are in a 5-year fight for the client's life. You must do everything in your power to make sure that the client works the program. Because of protracted withdrawal, dual diagnoses, organic brain syndrome, and many other factors, about half of all addicts are not able to work their program on their own. They do not have the spiritual, mental, or physical skills necessary to work a self-directed program of recovery. These clients may need years in a structured facility or a highly structured continuing care program.

Sometimes you will want to refer an addict to an addiction professional. There are excellent alcohol and drug counselors and physicians who specialize in addiction. They are used to the battle, and they have specialized training to deal with the special problems of addiction. A treatment facility locator can be found at <http://findtreatment.samhsa.gov>. Other times, you will want to try to help the client yourself, but remember you are in for a 5-year battle. Never forget that you are the healer, and you will do everything in your power to keep your client sober.

Once the diagnosis of addiction has been made, you will need to decide what level of care the client needs to get the best help possible in the least restrictive environment. This is why the American Society of Addiction Medicine (ASAM) developed the client placement criteria.

## American Society of Addiction Medicine Patient Placement Criteria

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All clients need to be assessed constantly in the following six dimensions:

1. Acute intoxication and/or withdrawal complications
2. Biomedical conditions and complications
3. Emotional, behavioral, or cognitive conditions and complications
4. Readiness to change
5. Relapse, continued use, or continued problem potential
6. Recovery environment

These are the areas of assessment that have been developed by the ASAM and are included in *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions* (3rd ed., Mee-Lee et al., 2013). All counselors need to have a copy of this document and use these criteria in deciding which level of care clients need. The manual details specific criteria for admission, continued stay, and discharge for all levels of treatment, adult and adolescent.

For brevity, the present book concentrates on the criteria for admission and discharge of adult and adolescent outpatient and inpatient treatment. These are the criteria that you, as the counselor, will use most often. The criteria are as objective and measurable as possible, but some clinical interpretation is involved. Psychoactive disorders are no different from any other medical evaluation. Assessment and treatment are a mix of objectively measured criteria and professional judgment. The six dimensions that need to be assessed are as follows:

1. Acute intoxication and/or withdrawal complications
  - a. What risk is associated with the client's current level of intoxication?
  - b. Is there significant risk of severe withdrawal symptoms based on the client's previous withdrawal history and amount, frequency, and recency of discontinuation of chemical use?
  - c. Is the client currently in withdrawal? To measure withdrawal, use the Clinical Institute Withdrawal Assessment–Alcohol (CIWA-A) (see Appendix 6), the Clinical Institute Withdrawal Assessment–Benzodiazepines (CIWA-B) (Busto et al., 1989), or the Clinical Opiate Withdrawal Scale (COWS) (see Appendix 7).
  - d. Does the client have the supports necessary to assist in ambulatory detoxification (or “detox”) if medically safe?
2. Biomedical conditions and complications
  - a. Are there current physical illnesses, other than withdrawal, that may need to be addressed or may complicate treatment?
  - b. Are there chronic conditions that may affect treatment?
3. Emotional, behavioral, or cognitive conditions and complications
  - a. Are there current psychiatric illnesses or psychological, emotional, cognitive, or behavioral problems that need treatment or may complicate treatment?
  - b. Are there chronic psychiatric problems that affect treatment?
4. Readiness to change
  - a. Is the client objecting to treatment?
  - b. Does the client feel coerced into coming to treatment?
  - c. Does the client appear to be complying with treatment only to avoid a negative consequence, or does the client appear to be self-motivated?
5. Relapse, continued use, or continued problem potential
  - a. Is the client in immediate danger of continued use?
  - b. Does the client have any recognition of, understanding of, or skills for coping with the addiction problems to prevent continued use?
  - c. What problems will potentially continue to distress the client if the client is not successfully engaged in treatment at this time?
  - d. How aware is the client of relapse triggers, ways of coping with cravings, and skills at controlling impulses to continue use?
6. Recovery/living environment
  - a. Are there any dangerous family members, significant others, living situations, or school/working situations that pose a threat to treatment success?
  - b. Does the client have supportive friendships, financial resources, or educational/vocational resources that can increase the likelihood of treatment success?
  - c. Are there legal, vocational, social service agency, or criminal justice mandates that may enhance the client's motivation for treatment?

Clients must be able to understand treatment. They must be intellectually capable of absorbing the material. They must be physically and emotionally stable enough to go through the treatment process. They cannot be actively harmful to themselves or to others. They cannot be overtly psychotic. They cannot have such a serious medical or psychiatric problem that they cannot learn.

## Diagnostic and Statistical Manual

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### Criteria for Diagnosis

To make a diagnosis, use the criteria listed in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* published by the American Psychiatric Association (APA). A new edition comes out every few years, so there will be changes in the criteria from time to time. The criteria (APA, 2013) are listed in Appendix 8.

### Diagnosis: Substance Use Disorder

- A. A maladaptive pattern of psychoactive substance use leads to clinically significant impairment or distress indicated by one or more of the following occurring within a 12-month period:
  - 1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)
  - 2. Recurrent use in situations where use is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)
  - 3. Recurrent substance-related legal problems
  - 4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or made by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)
- B. The symptoms never met the criteria for psychoactive substance dependence for this class of substance.

### Questions for You to Ask the Client

- 1. What are your drinking and drug habits?
- 2. Was there ever a period in your life when you drank or used drugs too much?
- 3. Have drugs or alcohol ever caused problems for you?
- 4. Has anyone ever objected to your drinking or drug use?

If you are unable to diagnose abuse, then check with the family. The client may be in denial, and you might get more of the truth from someone else. A family member, particularly a spouse or a parent, might give you a more accurate clinical picture of the problems.

If you diagnose abuse, then move on to the dependency questions.

## Diagnosis: Substance Use Disorder

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A maladaptive pattern of substance use leads to clinically significant impairment or distress, as manifested by three or more of the following, occurring at any time during the same 12-month period:

1. Tolerance, as defined by either of the following:
  - a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect
  - b. Markedly diminished effect with continued use of the same amount of the substance
2. Withdrawal, as manifested by either of the following:
  - a. The characteristic withdrawal syndrome for the substance
  - b. The same (or a closely related) substance taken to relieve or avoid withdrawal symptoms
3. The substance is often taken in larger amounts or over a longer period of time than was intended.
4. There is a persistent desire or one or more unsuccessful efforts to cut down on or control substance use.
5. A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors, driving long distances), to use the substance (e.g., chain smoking), or to recover from its effects.
6. Important social, occupational, and/or recreational activities are given up or reduced because of substance use.
7. The substance use is continued despite knowledge of having a persistent or recurrent psychological or physical problem that is likely to have caused or been made worse by the use of the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

*Specify if:*

*With physiological dependence:* Evidence of tolerance or withdrawal

*Without physiological dependence:* No evidence of tolerance or withdrawal

Explain to your clients that the diagnosis is your best professional judgment. It is important that clients make up their own mind. Clients need to collect the evidence for themselves and to get accurate in their thinking. Do they have a problem or not? This is a good time to explain about denial and how it keeps clients from seeing the truth.

## Gambling Disorder

### Diagnostic Criteria for 312.31 Gambling Disorder

- A. Persistent and recurrent problematic gambling behavior leading to clinically significant impairment or distress, as indicated by the individual exhibiting four (or more) of the following in a 12-month period:

- a. Needs to gamble with increasing amounts of money in order to achieve the desired excitement
  - b. Is restless or irritable when attempting to cut down on or stop gambling
  - c. Has made repeated unsuccessful efforts to control, cut back on, or stop gambling
  - d. Is often preoccupied with gambling (e.g., having persistent thoughts of reliving past gambling experiences, handicapping or planning the next venture, thinking of ways to get money with which to gamble)
  - e. Often gambles when feeling distressed (e.g., helpless, guilty, anxious, depressed)
  - f. After losing money gambling, often returns another day to get even (“chasing” one’s losses)
  - g. Lies to conceal the extent of involvement with gambling
  - h. Has jeopardized or lost a significant relationship, job, or educational or career opportunity because of gambling
  - i. Relies on others to provide money to relieve desperate financial situations caused by gambling
- B. The gambling behavior is not better explained by a manic episode.

*Specify if:*

*Episodic:* Meeting diagnostic criteria at more than one time point, with symptoms subsiding between periods of gambling disorder for at least several months

*Persistent:* Experiencing continuous symptoms, to meet diagnostic criteria for multiple years

*Specify if:*

*In early remission:* After full criteria for gambling disorder were previously met, none of the criteria for gambling disorder have been met for at least 3 months but for less than 12 months.

*In sustained remission:* After full criteria for gambling disorder were previously met, none of the criteria for gambling disorder have been met during a period of 12 months or longer.

*Specify current severity:*

*Mild:* 1–3 criteria met

*Moderate:* 4–5 criteria met

*Severe:* 8–9 criteria met

## How to Determine the Level of Care Needed

Once you know that the client has a significant addiction, you must decide the level of care the client needs. There are five levels of care generally offered across the United States:

Level 0.5: *Early intervention.* Early intervention is an organized service delivered in a wide variety of settings. Early intervention explores and addresses problems or

risk factors related to substance use and assists clients in recognizing the harmful consequences of inappropriate substance use. Clients who need early intervention do not meet the diagnostic criteria, but they have significant problems with substances. The rest of the treatment levels include clients who meet the criteria for psychoactive substance abuse or dependency.

Level I: *Outpatient treatment*. Outpatient treatment takes place in a nonresidential facility or in an office run by addiction professionals. Clients come in for individual or group therapy sessions, usually fewer than 9 hours per week.

Level II: *Intensive outpatient/partial hospitalization*.

Level II.1: *Intensive outpatient treatment*. This is a structured day or evening program of 9 or more hours of programming per week. The program has the capacity to refer clients for their medical, psychological, or pharmacological needs.

Level II.5: *Partial hospitalization*. Partial hospitalization generally includes 20 or more hours of intense programming per week. This program has ready access to psychiatric, medical, and laboratory services.

Level III: *Residential/inpatient services*.

Level III.1: *Clinically managed, low-intensity residential services*. This is a halfway house.

Level III.3: *Clinically managed, medium-intensity residential services*. This is an extended care program oriented around long-term management.

Level III.5: *Clinically managed, high-intensity residential services*. This is a therapeutic community designed to maintain recovery.

Level III.7: *Medically monitored intensive inpatient treatment*. This residential facility provides a 24-hour structured treatment. This program is monitored by a physician and is able to manage the psychiatric, physical, and pharmacological needs of its clients.

Level IV: *Medically managed intensive inpatient treatment*. This 24-hour program has the resources of a hospital. Physicians provide daily medical management.

## Criteria for Outpatient Treatment (Adults)

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Adult clients qualify for outpatient treatment if they meet the diagnostic criteria for psychoactive substance use disorder, as defined by the current *DSM*, and all six of the following criteria:

1. The client is not acutely intoxicated and is at minimal risk for suffering severe withdrawal symptoms.
2. All medical conditions are stable and do not require inpatient management.
3. All of the following conditions exist:
  - a. The individual's anxiety, guilt, and/or depression, if present, appear to be related to substance-related problems rather than to a coexisting emotional/cognitive/behavioral condition. If the client has emotional/cognitive/behavioral problems other than those caused by substance use, then the problems are being treated by an appropriate mental health professional.

- b. Mental status does not preclude the client from comprehending and understanding the program or from participating in the treatment process.
  - c. The client is not at risk for harming oneself or others.
4. Both of the following conditions exist:
- a. The client expresses a willingness to cooperate with the program and to attend all scheduled activities.
  - b. The client may admit to having a problem with alcohol or drugs, but the client requires monitoring and motivating strategies. The client does not need a more structured program.
5. The client can remain abstinent only with support and can do so between appointments.
6. One of the following conditions exists:
- a. The environment is sufficiently supportive to make outpatient treatment feasible. Family or significant others are supportive of recovery.
  - b. The client does not have the ideal support system in the current environment, but the client is willing to obtain such support.
  - c. Family or significant others are supportive, but they need professional interventions to improve chances of success.

## Criteria for Inpatient Treatment (Adults)

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Adult clients need inpatient treatment if they meet the *DSM* diagnostic criteria for substance use disorder and at least two of the following criteria:

1. The client presents a risk of severe withdrawal or has had past failures at entering treatment after detox.
2. The client has medical conditions that present imminent danger of damaging health if use resumes, or concurrent medical illness needs medical monitoring.
3. One of the following conditions exists:
  - a. Emotional/cognitive/behavioral problems interfere with abstinence and stability to the degree that there is a need for a structured 24-hour environment.
  - b. There is a moderate risk of behaviors endangering self or others. There are current suicidal/homicidal thoughts with no action plan and a history of suicidal gestures or homicidal threats.
  - c. The client is manifesting stress behaviors related to losses or anticipated losses that significantly impair daily living. A 24-hour facility is necessary to address the addiction.
  - d. There is a history or presence of violent or disruptive behavior during intoxication with imminent danger to self or others.
  - e. Concomitant personality disorders are of such severity that the accompanying dysfunctional behaviors require continuous boundary-setting interventions.



4. Despite consequences, the client does not accept the severity of the problem and needs intensive motivating strategies available in a 24-hour structured setting.
5. One of the following conditions exists:
  - a. Despite active participation at a less intensive level of care or in a self-help fellowship, the client is experiencing an acute crisis with an intensification of addiction symptoms. Without 24-hour supervision, the client will continue to use.
  - b. The client cannot control the use so long as alcohol or drugs are present in the environment.
  - c. The treatments necessary for the client require this level of care.
6. One of the following conditions exists:
  - a. The client lives in an environment where treatment is unlikely to succeed (e.g., chaotic, rife with interpersonal conflict that undermines the client's efforts to change, nonexistent family, other environmental conditions, significant others living with the client who manifest current substance use and are likely to undermine the client's recovery).
  - b. Treatment accessibility prevents participation in a less intensive level of care.
  - c. There is a danger of physical, sexual, or emotional abuse in the current environment.
  - d. The client is engaged in an occupation where continued use constitutes a substantial imminent risk to personal or public safety.

### Criteria for Outpatient Treatment (Adolescents)

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Adolescent clients qualify for outpatient treatment if they meet current *DSM* criteria for substance use disorder and the following dimensions:

1. The client is not intoxicated and presents no risk of withdrawal.
2. The client has no biomedical conditions that would interfere with outpatient treatment.
3. The client's problem behaviors, moods, feelings, and attitudes are related to addiction rather than to a mental disorder, or the client is being treated by an appropriate mental health professional. The client's mental status is stable. The client is not at risk for self-harm or harming others.
4. The client is willing to cooperate and attend all scheduled outpatient activities. The client is responsive to parents, school authorities, and staff.
5. The client is willing to consider maintaining abstinence and recovery goals.
6. A sufficiently supportive recovery environment exists to make outpatient treatment feasible:
  - a. Parents or significant others are supportive of treatment, and the program is accessible.

- b. The client currently does not have a supportive recovery environment but is willing to obtain such support.
- c. The family or significant others are supportive but require professional intervention to improve chances of success.

## Criteria for Inpatient Treatment (Adolescents)

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To qualify for inpatient treatment, adolescents must meet the current *DSM* criteria for substance use disorder, all of the dimensions for outpatient treatment, and at least two of the following dimensions:

1. The risk of withdrawal is present.
2. Continued use places the client at imminent risk of serious damage to health, or a biomedical condition requires medical management.
3. History reflects cognitive development of at least 11 years of age and significant impairment in social, interpersonal, occupational, or educational functioning, as evidenced by one of the following:
  - a. There is a current inability to maintain behavioral stability for more than a 48-hour period.
  - b. There is a mild to moderate risk to self or others. There are current suicidal/homicidal thoughts with no active plan and a history of suicidal/homicidal gestures.
  - c. Behaviors are sufficiently chronic and/or disruptive to require separation from the current environment.
4. The client is having difficulty in acknowledging an alcohol or drug problem and is not able to follow through with treatment in a less intense environment.
5. The client is experiencing an intensification of addiction symptoms despite interventions in a less intense level of care; the client has been unable to control use so long as alcohol or drugs are present in the environment; or the client, if abstinent, is in crisis and appears to be in imminent danger of using alcohol or drugs.
6. One of the following conditions exists:
  - a. The environment is not conducive to successful treatment at a less intense level of care.
  - b. The parents or legal guardians are unable to provide consistent participation necessary to support treatment at a less intense level of care.
  - c. Accessibility to treatment precludes participation at a less intense level of care.
  - d. There is a danger of physical, sexual, or emotional abuse in the client's current environment.

## The Client's Reaction to Intoxication

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Clients in these acute organic brain syndrome states can seem to be relatively normal or extremely bizarre. They can be actively psychotic, relaxed and comfortable, or in a panic. They can experience intense flashbacks. High doses of amphetamines, cocaine, or



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phencyclidine (PCP) may produce organic delirium. Disorganized thinking characterizes delirium in the ability to maintain attention. The client will not be able to follow a conversation. The disorganized thinking is manifested by rambling, irrelevant, or incoherent speech. This delirium usually is brief (less than 6 hours) after amphetamine or cocaine use, but it can last for up to a week after PCP use (Schuckit, 1984; Spitzer, 1987).

Acute use of amphetamines, cocaine, or PCP may result in a delusional state. Delusions are false beliefs that are intractable to logic. Clients may feel that someone or some group is out to get them. Clients may think that they have strange or unusual powers. These delusions usually are brief, lasting from several hours to several days, but in some clients, they can last for up to a year or more, even in the absence of further drug use. Hallucinogen use can result in the development of delusions (Vardy & Kay, 1983). Brief psychotic states also have been reported following cannabis use (Hollister, 1986).

During acute intoxication and withdrawal, it is not unusual to see clients complaining of hallucinations. These hallucinations usually are visual or tactile and rarely are auditory. Lights may seem too bright, or sounds may seem too loud and startling. This is a transient psychotic state. The clients may see trailing of objects (e.g., when the clients move a hand, they see a brief image extend behind the solid object like a jet contrail). The walls or floor might seem to move, or the clients might see bugs or other things that are not there. The clients may feel something unusual on or under their skin. These hallucinations usually are brief, but the clients will need to be reassured and supported. The clients' brains are chemically correcting. These negative experiences are used to give the clients evidence that they need to stop abusing chemicals.

## What to Do With an Intoxicated Client

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Never argue with intoxicated clients. This will get you nowhere. They probably are not going to remember the conversation anyway. Briefly introduce yourself, let the medical staff examine and treat these clients, and let the clients sleep. Intoxicated clients and clients in withdrawal will mainly be the responsibility of the medical staff. These staff members will be watching the clients carefully and monitoring their vital signs.

There is an old idea that has been floating around the field for years that clients should hurt in withdrawal. The theory goes that this will help clients to learn that they have a problem. To do this would be a medically unsound practice. It is inappropriate to subject clients to severe withdrawal symptoms just to teach them a lesson. Some of them would die. Clients should be medicated to a point where they stay in mild withdrawal. This hurts enough.

Intoxicated clients who want to talk will have to be reassured and educated. They are not bad people. They are sick. If they want to talk a lot, then let some of the other clients do the talking. Join in if you must. The clients will definitely need to trade off. This is very tiring work, but it is beneficial for them to see the intoxicated clients so messed up. It reinforces for the other clients that they never want to go through this again.

Clients need to be educated about withdrawal. What can they expect? The main thing that clients need to hear is that things are going to get better. With every hour that passes, things are going to improve. The staff is not going to let the clients feel too uncomfortable. Things are going to feel uncomfortable sometimes, but the staff is not going to allow the pain to reach intolerable levels.

Many of the clients' thoughts and feelings now are chemically induced. The clients need to understand that they are going to have some wide mood swings in acute withdrawal. Most

clients will be feeling depressed, agitated, irritable, and crabby at various times. They need to have their fears and concerns put to rest. Let them talk. Answer their questions. Listen. These clients need a lot of attention.

## Detoxification

Except for the hallucinogens, PCP, and the inhalants, prolonged drug or alcohol use is accompanied by the development of drug tolerance and physical dependence. In the case of withdrawal from the central nervous system (CNS) depressants (alcohol, barbiturates, and benzodiazepines), tremulousness, sweating, anxiety, and irritability may give way to life-threatening seizures and delirium. Opioid withdrawal is not life threatening, although these clients feel very uncomfortable, like they have a bad case of the flu (Group for the Advancement of Psychiatry Committee on Alcoholism and the Addictions, 1991). Withdrawal from CNS stimulants may be accompanied by a “crash” characterized by depression, fatigue, increased need for sleep, and increased appetite (Gawin & Ellinwood, 1988; Kasser et al., 1998).

Detoxification is the gradual safe elimination of the drug from the body. Some drugs, such as alcohol, are detoxified quickly, usually within a few days, but the benzodiazepines, opioids, and amphetamines may take weeks or months (Burant, 1990; Schuckit, 1984). Many clients are suffering from polysubstance withdrawal, and this can complicate the clinical picture. The drugs most likely to cause serious physical problems are the depressants. These clients can deteriorate rapidly.



Source: ©iStockphoto.com/  
Scrofula.

## How Clients React in Detoxification

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Most any physical or mental symptom can present itself in withdrawal. No heavy confrontation is necessary. These clients are sick and irritable. They are sleeping poorly. They have powerful cravings. This is where many clients walk out of treatment. They feel as though they cannot stand the symptoms anymore. These clients need medication, reassurance, and support. You must be gentle. Keep telling them repeatedly that it will get better. If they stay clean and sober, then they never will have to go through this misery again. The correct detox medication should keep the client in a mild withdrawal that is easily tolerated, but some clients can't seem to stand even mild withdrawal symptoms.

In withdrawal, clients are restless and have strong cravings. This physiological and psychological need for the substance is the primary motivating force behind drug addiction. The clients' bodies are driving them to return to their drugs of choice. The cells are screaming for relief. The clients have been in withdrawal hundreds of times before, but they always have treated it by getting intoxicated again. Now they are going to stick it out, striving for recovery. All of these clients think about leaving treatment, but when they get to feeling a little better, they reach the greatest chance of actually going out the door. You must be on top of this by constantly assessing where the clients are both physically and psychologically.

- The clients need to keep a journal of each day they are in treatment. What happened? What did they learn? What do they need to work on? As they journal, they need to think about their recovery skills and how they need to use them.
- The clients need to rate their cravings and try to uncover the situations, feelings, or thoughts that trigger the craving. Clients need to keep up with their Daily

Craving Record (see Appendix 9) for at least the first 90 days of recovery. Check this record often throughout treatment to see how the client is doing in recovery. Identify situations, thoughts, and feelings that trigger craving, and make a plan to cope with each trigger. Watch for triggers that happen repeatedly because they are driven by inaccurate thoughts. For example, clients may have a trigger that they call feeling angry. “When I get angry, I want to drink.” You know that all anger comes from hurt, so you try to answer the questions of why other people hurt the client so often and why the client feels other people are too aggressive. Once you pull for the thinking that comes before the feeling, you will get more and more data about how to help the client see these situations and cope with each situation appropriately.

Detoxification should be managed in a room that is reduced of excessive stimulation. The area needs to be quiet and without bright lights. Familiar people, pictures, a clock, and clothes are helpful. Soft conversation that reassures clients and keeps them oriented is best. The staff should display a positive attitude of mutual respect. Reassuring touches, such as taking a pulse and putting a hand on a shoulder, are helpful (Baum & Iber, 1980).

Once the acute withdrawal syndrome has passed, clients remain in a protracted abstinence syndrome for weeks or even years. Meth addicts seem unable to feel normal pleasure for two years. Opioid addicts can feel sick and in pain for months. Relapse is higher during this period of physiological adjustment. The protracted abstinence syndrome varies depending on the drug of dependency. Typically, it is a symptom constellation opposite of that which the client was using the drug to produce (e.g., the client who used stimulants to increase energy will experience lethargy) (Geller, 1990).

## The AMA Threat

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Clients in an inpatient or outpatient setting can present an AMA threat (leave treatment *against medical advice*). They usually isolate themselves first from the treatment peers and staff. Addictive thinkers must lie to themselves and believe that the lies are the truth for the illness to work. The addiction cannot exist in the light of the truth. The disease has a much better chance of working in isolation. That is why clients must not be left alone in early treatment until they have stabilized.

The illness cooks a stew of inaccurate information—minimization (“My use is not that bad”), rationalization (“I have a good reason to use”), projection (“It is not my problem; it is their problem”), and denial (a stubborn refusal to see the truth). All of these defenses are used to distort reality.

You may first get wind of an AMA threat as you assess a client, or you may learn of it from another client or from a staff member. Clients may share that they are thinking about leaving treatment. You must intervene when you see this problem developing. As the clients tell more and more lies to themselves, they become convinced that the lies are the truth. Such clients keep collecting information that proves that the illness is right.

For the most part, clients’ reasons will be inaccurate. They are distortions of reality. Clients might not be aware that the real reason they are leaving treatment is to use their drugs of choice. Clients delude themselves. They are craving, but many of them do not know it. They believe the inaccurate thinking.

## Example of an AMA Intervention

The intervention desperately needed here is the truth. Every time clients bring up a reason for leaving treatment, you challenge them with the truth. Be gentle. The truth is on your

side, and a big part of every client wants to know the facts. Do not talk to the illness side of the client. Talk to the side that wants to get well.

- Client:* I have to get out of here. I can quit on my own.
- Counselor:* You have tried that before, and you have always failed.
- Client:* This time I can do it.
- Counselor:* Your meth addiction is worse now than it has ever been. It is not better. It's worse.
- Client:* I will go to meetings. That is all I need. I know how to stay off drugs.
- Counselor:* You may do that for a while, but it is very likely that you will begin using again.
- Client:* I think I can do it this time.
- Counselor:* You have had that thought a hundred times before. Give the disease some credit. It is stronger than you are. The 12-step program says that no human power can remove our addiction. It is unlikely that you will lick this problem on your own.
- Client:* I will go to church.
- Counselor:* I believe you need treatment.
- Client:* I have some marital problems that I need to work out. I cannot do that in here.
- Counselor:* The best thing you can do for your marriage is to stay in treatment and get into a stable recovery. Why don't we call your wife and see if she wants you to leave?
- Client:* I have to get out of here. I do not fit in.
- Counselor:* Why don't you try to help someone else?
- Client:* I am not like these people. Their problems are much worse than mine are. Some of them are criminals.
- Counselor:* Weren't you arrested twice?
- Client:* Yes.
- Counselor:* But you are not like these people?
- Client:* No.

This conversation can go on for quite some time. The longer you expose the lies that clients are telling themselves, the better the chance of keeping these clients in treatment. If you have to, see whether the clients will agree to stay in treatment for one more day or even one more hour. The longer they stay, the more opportunity you have to help them see the truth.

## How to Develop and Use the AMA Team

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The AMA team is a group of three or more treatment peers selected by the staff to help other clients who are at risk of leaving treatment early. Have them share their experiences, strengths, and hopes with the client. Often, this group will be more effective than you are.

It is easier for a client to trust people who are in treatment. In an outpatient setting, if you do not have an AMA group, then maybe one of the clients further along in the program will agree to encourage the client to stay.

If there are any consequences that clients will face if they leave treatment, this is the time to bring these things out. A client may have been court ordered into treatment. The client's employment may be in jeopardy. A spouse or parent may have given the client an ultimatum—get treatment or else. Use every angle you can so long as it is based in the truth. The family may even have to involuntarily commit the client into treatment.

Clients must be gently told the truth until they hear it. There is a healthy side of every client—the side that is sick of this problem and wants to recover. The truth is a very powerful tool. It is even more powerful when delivered in an atmosphere of encouragement and support.

Some counselors believe that they have to hammer away at a client's denial aggressively until they literally “break through it,” but it cannot be like a war. The therapeutic alliance builds on mutual acceptance, trust, and unconditional positive regard. It is impossible to trust someone who is verbally beating on you. This behavior harms your relationship and makes your job even harder than it already is. You will get angry with clients. That is normal; everyone does. Try to treat clients the same way in which you would want to be treated.

## How to Use the In-House Intervention

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If all else fails, then you might have to arrange an in-house intervention. Here you gather the client's family and concerned others together and have them share why they want the client to stay in treatment.

Have each of the participants write a letter stating how the client's addiction has adversely affected the participant. The participants need to give specific examples of how they were hurt. They share how they are feeling now and ask for what they want. They write down exactly what they are going to do if the client does not agree to stay in treatment. A wife could state that she has been humiliated in front of friends. If the client, her husband, does not stay in treatment, then she will divorce him. An employer could say that he is weary of the client calling in sick. If the client does not stay in treatment, then he will be fired. The kids could say that they are embarrassed by the client and want out of the home. Parents could talk about the lies and mistrust in the home and say that they are going to withdraw their financial support.

In an intervention, the family members are going to need a lot of encouragement. You need to help them with their letters and practice the intervention without the client present. Once the group is gathered, bring the client in and have each member share a letter. If the client is still unwilling to stay in treatment, then you can open the group up for discussion. Again, every time the client gives the family a good reason for leaving, you and the family will tell the client the truth.

## How to Respond to Clients Who Leave AMA

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Do everything in your power to keep your clients in treatment, but if they decide to leave early, then wish them well and invite them to come back if they have further problems. Many clients will leave for a time and then return. Whatever happens, remember that when the clients were in treatment, you told them the truth. Clients leaving treatment are no reflection on you or your skills. You did not lose. You planted the seed of the truth that will grow later.

Programs that are more genuinely caring will keep more clients than will programs that are harsh and confrontational. The key balance is to confront the clients in an atmosphere of support. An encouraging and supportive environment is attractive, and everyone wants more. You will know that you have struck the right balance when many of your clients are reluctant to leave treatment at the end of their stays. They have felt so accepted, loved, and supported that they do not want to leave an environment in which they have made major growth.