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Models and Theories of Addiction and the Rehabilitation Counselor

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MODELS AND THEORIES OF ADDICTION AND THE REHABILITATION COUNSELOR

By

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Bachelor of Science – Southern Illinois University, 2007

A Research Paper

Submitted in Partial Fulfillment of the Requirements for the
Master of Science

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in the Graduate School
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Approved by:

Dr. William Crimando

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CHAPTER 1

INTRODUCTION

The models used by alcohol and substance abuse facilities do not provide the activities required to correct the issues of alcohol and substance abuse. Counselors must create a new disease model within the rehabilitation practice that will improve disease prevention and intervention. They need to concentrate in assisting individuals to change their use of drugs and alcohol.

Counselors need to study and develop multi-faceted drug intervention programs that are “drug specific” to the addiction at hand. One size does not fit all. An individual who is addicted to meth should not be treated the same as an individual who is addicted to heroin. The craving or call for the drugs is similar, but the field has to be open minded enough to allow for individual variations within the addiction treatment model.

This paper will identify when a counselor assists individuals in recovery as being more than just overcoming addiction to drugs/alcohol. It will identify that recovery is in all aspects of life, spiritual, employment, relations, communication, lifestyle, social growth, education, etc.

This paper will introduce the suggestion of labeling as a bad influence for people in recovery. When we label a person as an “addict”, we immobilize them to remain in this structure. When a person overcomes their addiction, whatever that might be, they should no longer remain in the realm of an “addict.” When we label a person as a “felon”, we assist them to remain in that realm. When people have served their time in prison for committing a crime (felony), society should not hold them back with the label of “felon.” When they completed their time in prison they moved toward a more successful life. When society labels them a felon only assists them to remain in a prison world even though they are supposedly free.

If counselors are to be a positive and relevant component in this field and assist societies and communities in understanding and managing these problems, we should provide services that produce positive-end results. We require support from all subsequent systems to effectively provide effective services.

This paper will introduce how rehabilitation counselors should interview and obtain the whole story of the client. By listening and being empathetic, the counselor will usually obtain enough information to develop goals for the client that will enhance significant changes in client's positive thinking skills and positive behaviors. Importance of multicultural counseling will be introduced.

This paper will introduce how counselors should analyze how effective their interviewing skills are with clients and how counselors should have competence in their approaches to the interview.

Various models and theories will be introduced and defined according to treatment procedures and effectiveness. This research will identify the various treatments that are available and how they are implemented.

Purpose of paper

This research will identify various models and theories and how effective each one may be. This research will identify what Rehabilitation Counselors are doing now and what they should be doing and why they should be providing additional services. Paper will inform how our systems can enhance the Rehabilitation processes.

CHAPTER 2

REVIEW OF MODELS AND THEORIES

Moral Model

In this model, we discover the defective spirit and the inner choice of conscious. Society views addictions in a myriad of way, none of which is positive. There is the perspective of the addiction as being criminal. There is the moral perspective of it being a sin. This model resembles the spiritual and medical model. We usually discover the person's character defects. We emphasize that pride should overcome humility and acceptance should overcome resentment.

Weakness and character defects are the result of addiction according to the moral model. This model contains very little sympathy for people that have chronic addictions. Individual choices are the main theme of this model.

According to the moral model, a person that possesses moral strength would have the required strength to stop the addiction. Religion is required in order to be ethical and moral. This is why this model is similar to the spiritual model.

Without the spiritual belief, Alcohol Anonymous (AA) believes that the will of the individual will not be strong enough to overcome or recover from the addiction. We do not consider this model to be a therapeutic model. (Marino, N., 2006)

Temperance Model

Historically, this model has been confused with the approach of the moral model. This particular therapeutic regimen began in the 1840s and continued through the late 19th century. Benjamin Rush created the temperance model. The thesis of this model is that the substance has the power of addiction and destruction; that the individual is powerless against the addiction; abstinence is the only salvation. The "mantra" is that an individual's will is diseased, and

therefore they lack the control or power to resist. Rush believed that people with addictions should terminate their use of the substance quickly and completely. Their mantra was to “Taste not, handle not, and touch not.” Every bottle of medicine in the people’s homes had this message written on it. People had to do this in order to recover from the addiction of temperance.

Condescendingly, this model of addiction pitied, instead of empathized with the addictions of individuals. Consequently, it should be no surprise that a person with an addiction to alcohol had the label, “Drunkard.” Jellinek argued that the people who supported the temperance model’s idea of a disease made the temperance model weak. In this model, if the person with an addiction believed in a higher power they would possess the strength to resist use of alcohol.

According to the Temperance Model, an addiction was an involuntary disease. They believed that alcohol is the addiction source and because alcohol is so easily obtainable, there was no resistance to drink. Addiction was the end-result. The tenet of this model is; a person who drinks moderately is no less guilty than a person who drinks heavily. They considered a person who drinks in moderation worse than a person who drinks heavily (drunkard). The temperance model sympathizes with the person who drinks heavily and rejects the person who drinks moderately. The temperance model feels that supporting the assistance of the person with the addiction is very important.

The largest temperance membership organization in the history of America was “The Independent Order of Good Templar.” They worried that they might be viewed as persons with addictions because their involvement was so strong in reforming individuals with addictions. They were successful in assisting individuals with addiction to recover.

The Good Templar was much like the sponsors of today's Alcoholics Anonymous (AA).

In order to hold an official position in assisting individuals with addictions, sponsors had to be capable of being abstinent for a certain period. AA originated in the 19th century.

Consequently, it resembled the temperance model. (Marino, N., 2006)

Disease Model

Some Americans began admitting being addicted to alcohol in the late 18th century and early 19th century. They openly admitted their inability to resist the desire for alcohol. They considered the addiction of alcohol a disease that struck randomly and lasted indeterminably depending on the individual. (Benn, P., 2007)

This model definition is alcoholism is a medical disorder. There is something that is uncharacteristic which leads to behavioral impairment. The individual is unable to control their craving for alcohol. There is a progression of deterioration in all functions until the individual has nowhere else to go but up and applies for treatment or some type of positive support.

After the 1935 repeal of Prohibition in the United States, we required a different theory to work with Alcohol or Drug Abuse (AODA), so Bill W. and Dr. Bob started Alcohol Anonymous (AA). Since the belief is, AODA is an original, progressive irreversible disease.

The American Disease Model is born. This theory contends that an individual is not cured even if they are able to stop an alcohol addiction. According to the disease model, substance addiction affects both behavior and the brain. The neurochemical and behavioral processes are impaired during the development of the disease. They utilize this model in therapeutic settings. This model believes the cause of behavioral dysfunctions is from being dependent due to a mental or physical affliction.

The evidence researched by The American Society of Addiction Medicine, states that labeling an addiction, as a disease is incorrect. The Disease model postulates that the biologic

and environmental sources are the genesis of a lifelong disease. There is a social or psychological phenomenon for drinking excessively. A discovery that one group might drink excessively for years and remain in control, while another group lost control was revelatory. Any group was considered to be “alcohol addicts” if they lost control. When a person had an abnormality that caused discomfort and became dysfunctional, they would consider this abnormality a traditional medical model of disease.

They adhere to the concept that addiction is genetic. They feel that the addiction might be due to an environmental occurrence. The people who do not believe in the disease model, especially the belief of the lifelong addiction process, argue that there are no scientific principles and that this model invokes negative effects in society. They argue that the model of disease does not identify addictive behavior due to having no biological involvement. They believe that labeling people as addicts inhibits them from developing self-control and stigmatizes them.

Noted substance abuse researcher, “William Miller” said in 1993 that the disease model we are now utilizing is inefficient in clarifying or explaining the great amount of problems related to AODA.

Miller stated we required a more modern disease theory with a public health procedure for prevention of disease and arbitration of such. This would introduce the different types and strengths of AODA.

There are too many terms for the AODA problem such as alcohol/drug dependence, abuse/addiction/problems, chemical dependency, substance abuse/misuse, disease, illness, sickness, malady, condition, habit, etc. The first definition should correspond with disease. We should consider an AODA problem a process, not a thing. This would give meaning to the word disease. The new disease theory will stop the victimization of clients with AODA.

This new theory will also include other personal and social problems such as, fetal drug exposure, driving while drug-impaired, criminal activity and violent behavior due to drug use, underage drinking and binge drinking.

The new disease model will identify the intervention and prevention techniques that we should apply to each problem. This model will include the communities' differences and utilize a greater choice of treatment goals and techniques in these different communities.

The new disease theory will officially proclaim as its essence that (a) genetic or biological factors are not the cause of addiction, and (b) there are several factors causing addiction, including other diseases.

Like most chronic diseases, addictions are not progressive; some addictions will remain stable while others will deteriorate. Impulsive remission and maturation exist in addiction as in other habitual diseases.

We must implement varied treatment modalities in this new disease concept. Education will assist clients to manage their health, identify triggers that cause the AODA, and obtain management skills in order to cope with the AODA and obtain lasting recovery. The new disease concept will extend remission periods, reduce the fierceness and length of relapse episodes, and decrease the cost associated to the individual and society.

Psychological or Character Logical Model

This model of addiction concentrates on what takes place in order for a person to start using substances. This model emphasizes that biology does not cause a person to take that first drink or line of cocaine. It must be psychologically motivated. This construct views everyone as being vulnerable to addiction. According to this theory, a character defect and a learned behavior is addiction. An abnormal character or personality trait is what causes a person to

become dependent on chemicals. There are degrees of personal and psychological defects that pre-dispose an individual to these “addictive personality” traits. Poor impulse control, ineffectual coping mechanism to stress, being manipulative, portraying a big ego, and having to be in complete control, but feeling powerless and hopeless, are traits of an “addictive personality”. Assisting in changing the personality of these individuals is the treatment of choice for (AODA).

Modeling influences are when an individual is in a stressful situation, for an example, a marriage separation, or work problem, this individual attends a party. He is expecting to rest and relax with his friends. The friends have been drinking and having a good time. This individual will usually be influenced by the cues of his previous association with drinking and his confidence in his self. The stress this individual is under and history of managing his drinking will determine his management of alcohol use. (Simos, G., 2009)

Behavior and psychological therapies are the treatments for persons with addictions due to learning, emotional, and psychological deficiencies. The reason for substance abuse is if a person is unable to maintain their inner life and external behavior. A person will be able to have control externally, if there is treatment provided in obtaining an inner strength. The change will be the result of External, (behavioral, interpersonal), taking the place of internal, (intra-psychic). The amount, quality, and intensity of triggers identified in behavioral psychology, may be the learned behavior of substance abuse. An addiction is if we give people reinforcement every time for an addictive behavior. The effect on the central nervous system could be a positive reinforcement. (Bentley, R., 2007)

Corroboration is the acceptance by peers. The elimination of withdrawal symptoms and less anxiety could be negative reinforcement. If we replace negative consequences and punishers

with reinforcements, a positive change may take place.

Educating the client on how to develop coping strategies for substance use is required. Dr. Richard Solomon introduced an Opponent-process theory in 1980, which is a psychological model for addictive behavior. This theory stipulated that emotions come in pairs. If we experience one emotion in a pair, we suppress one emotion. His theory, based on the study that a person who started skydiving had more fear than a person who skydived many times, but would have less pleasure when they landed. His theory considers fear and pleasure a pair of emotions. In the opponent process model, pleasure suppresses fear.

Drug addiction is the result of a pair of emotions such as an emotion of symptoms of withdrawal and an emotion of pleasure in the opponent-process theory. In the beginning, there was a great amount of pleasure and very little withdrawal. As time passed, there were lower levels of pleasure from using the drug and higher levels of withdrawal symptoms from not taking more of the drug. This enhanced the use of the drug even though there was less emotion of pleasure.

The belief is that for every psychological event, (A), there will be an opposite psychological event, (B). When a person finds pleasure from the use of heroin, the opponent process of withdrawal will follow it. This would be similar to a person feeling afraid when they jump from an airplane but rewarded with great amounts of pleasure when the parachute opens. Another example of opponent process when a person looks at the color red and then quickly looks at a gray area, they will see green.

In the nervous system, there are many examples of opponent processes, which include taste, touch, vision, hearing, and mobility. When opponent processing occurs at the sensory level this may lead to an addictive or habit-forming behavior.

The results of research regarding psychological or character logical therapies are positive. Not all individuals will recover as quickly as anticipated. The studies of the brain imaging will be an asset for this model. We require utilizing various behavioral therapies. This model could take less time, be less complex, and more cost efficient as per the group counseling approach. These treatments need to be more accessible.

Social Education Model

Operant conditioning and training are principles in this model. Behavioral and genetic influences are learned behavior in AODA. A requirement in this model is to develop methods of reducing stress factors. This Model believes that environment plays a huge role in certain addiction behaviors. The process of socializing and observing behaviors of role models forms AODA behavior.

Family, work, emotional relationships and social support are social and environmental factors that are the main event in shaping and controlling onset of addiction. An example is the tobacco bans in Europe. These bans will be a most powerful effect of change for many people who may not require treatment. This model belief is a small amount of people seeks professional treatment. Many social and environmental factors intervene in improving compliance and help people to take fewer substances. Improvement of social responsibility and community support will probably improve a person's motivation to abuse substances.

Social Learning Theory

This model was developed by Albert Bandura in the 1970s. Social Learning Theory, (SLT), describes the effect of thought process on goal-oriented behavior. It considers the capability of an individual to learn within a social environment through study and verbal interaction.

This model forms basis for remedial intercessions such as coping skills training and prompt exposure therapy. A key element of SLT is reinforcement. An individual will copy any behavior that they are rewarded for. Some examples of positive reinforcement are when an individual feels the pleasure and rush of using cocaine or their anxiety and stress they are feeling seem to diminish while drinking alcohol.

In SLT, the more substance or alcohol is used the more of a habit it becomes. Of course, the affects of using cocaine and alcohol are different in each individual and want they want and need. The affects are based on what personality they may have, their history, and what type of lifestyle they are living. If an individual is using to overcome personal problems, they will have different problems in trying to stop than an individual that is using to be social with their friends.

When individuals use alcohol or drugs they expect the experience they will have when they use again. Many people do not know their experience is based on dose of substance or amount of alcohol, personality and environment. The way they are feeling and the environment they are in. In time the individual who is using will realize these factors will influence the effects compared to what they expect. The effects that an individual expects will determine how much of a problem their use will be.

The SLT plays a big part on peer roles and others who are more significant in their lives. If they have learned to drink in a social culture when they were growing up, this will determine their behaviors and what they expect when they drink. This is considered to be modeling.

Modeling, in accordance to research, is a big theory. Modeling techniques are used in therapy in skills training for teaching certain substance coping skills.

An effect that is important of peer and parental modeling is the growth of internal expectations for alcohol/substance effects. When a young person see their parents drink a few

glasses of wine to ease their stress regarding work or socializing at a party, their development can be reinforced and generalized when watching alcohol-related scenes on television. They tend to see plenty of drinking in soap operas. A relationship that adapts between an individual and a stressed environment is stress. It is the result of unevenness between environmental stress and an individual's means.

Another important constituent of SLT is self-efficacy, the individual's amount of self-assurance in their capabilities to systematize and finish measures that lead to specific objectives.

An individual's self-assurance influences the objectives that they attempt, the amount of energy used to complete those objectives, and the length the individual will last while encountering barriers while attempting to complete those objectives. The amount of self-assurance plays a huge role in the objective being completed.

The amount of self-assurance an individual has will be controlled by the accomplishment or disappointment that the individual has encountered attempting to complete that specific objective.

Self-assurance can be transmitted to an explicit duty such as attempting to stop using alcohol or self-assurance can be wide-ranging in description. Self-efficacy is connected to alleged restraint with consideration to her or his concepts, emotions, and surroundings, not just an individual's actions. An individual's self-efficacy will be manipulated by existing stress conditions and their history of managing in comparable circumstances.

The individual will focus on positive reinforcing effects of alcohol, (fun, restful, etc.), while he overlooks the negative outcomes, (hangovers, increased anxiety, car accident, etc.)

This individual will have low self-assurance when it comes to relaxing or having fun with their friends without a drink. When drinking is introduced, different reinforcing effects of

alcohol come into play. The individual's expectations of alcohol minimizing his nervous tension and permitting him to obtain more pleasure in the evening will likely be established.

Coping models

Coping is an effort to meet the stress in a way that recovers balance or equilibrium.

There are many different ways an individual can cope with stress.

Coping strategies that are focused on problems are directed primarily at changing or managing a threatening or harmful stressor. Coping that is focused on emotion is directed at alleviating or controlling the emotional influence of a stressor.

A form of strategy that is focused on emotion is intended to change or manage an intimidating or damaging stressor. Since using alcohol is much faster in effectiveness in dealing with events that are stressful, alcohol turns out to be the chosen coping method.

This individual will become more and more dependent on alcohol use to minimize the effects of anxiety in many circumstances. They most assuredly will forget other more advantageous ways of coping with stress. However, the temporary effects of alcohol and feelings of stress will be much stronger when they return the next day after alcohol use due to rebound effect.

When an individual is using alcohol in a certain circumstance, their self-efficacy for different actions may take part in a significant condition. Their self-assurance they can manage in a significant situation, and assessment of the possibilities of accomplishing, will establish the choice and execution of coping behaviors. One of these managing approaches in nerve-racking circumstances can be the ingestion of alcohol.

An individual that has developed an excessive drinking problem when using alcohol during stressful periods has usually been negatively affected. These individuals will usually feel

uneasy about the use of directed approaches when dealing with hectic events.

An individual who is abstaining from alcohol due to problems from drinking should discuss with their counselor in acquiring assistance in triggers that are causing the drinking. The individual should practice different coping techniques and various behaviors that they can use in complicated circumstances. The individual should also discuss with the counselor the function accustomed prompts can take part in the individual's ability to use alternative coping skills.

The individual should be informed of more complicated circumstances. Since this individual has been abstaining from alcohol, they should be increasing their self-efficacy through management skills and staying away from drinking. This individual should be able to relax and have fun at a party where alcohol is served without drinking.

CHAPTER 3

REVIEW OF TREATMENTS

Reasons for various treatments

Many persons who abuse alcohol or drugs are the vulnerable individuals within our society. They tend to be globally disadvantaged: socio-economically, educationally, and vocationally.

Moreover, persons who abuse alcohol/drugs are exposed to discrimination with the accompanying psychological and physical health results due to the alcohol or drug use.

According to statistics from a research report of June of 2007, only small amounts of people actually agree to treatment, even though treatment has been available.

It has also been proven that the costs of alcohol and drug treatment are less than the cost if not treated, for example; sexually transmitted diseases, crime, physical and mental impairments. Some treatments that individuals requested were not available, due to factors such as age, gender, insurance, etc. (Benn, P., 2007)

Outpatient Drug Rehabilitation Treatments

This type of treatment will be successful for some individuals with addictions and not as successful for others. The models of treatments in these facilities are Cognitive-Behavioral Therapy (CBT).

The medications used in this model are Naltrexone, (a relapse preventative for alcohol and heroin abuse), Disulfiram, (a preventative to alcohol abuse; currently being tested in treating cocaine abuse), and Acamprosate, (another preventative to alcohol abuse).

Another treatment method is the 12-step program. This well-known program's theory teaches and relies on individuals surrendering themselves to a higher power in order to increase

their success in recovering from their addiction. They teach the 12-steps that lead to recovery. They teach individuals to take one day at a time abstaining from substances, working on the present, letting go of the past and acquiring hope for a better tomorrow. They have sponsors that have abstained from alcohol for a period that are prepared to assist those individuals who are beginning the recovery process.

Motivational Interviewing, problem-solving groups, and talk therapies are part of the treatment modality employed. These outpatient rehabilitation settings offer different types and duration of treatment depending on each individual's requirements.

There are outpatient programs and detoxification centers that use the most modern medications and utilize compassionate care. These types of therapy are useful in stopping the cycle of AODA. The detoxification phase provides services approximately seven to ten days, according to the client's individual needs assessment.

Residential Treatments

These treatments are for the clients with more severe AODA problems. The client will stay in a therapeutic residential environment 29 days to twelve months. There are clients that have serious impaired social functioning, have been involved in criminal activities, or have long histories of AODA, who are eligible for residential treatment stays. These treatments assist the client in functioning in a community free of crime and drugs.

Group Therapy

Clients can see their problems in reality, learn of the negative consequences, and enhance their motivation to remain alcohol and drug free.

Clients can learn effective methods of coping with their personal and emotional problems without the use of alcohol or drugs.

Diagnostic and Statistical Manual of Mental Disorders (DSM)

The six clinical assessments areas included in the DSM are acute intoxication and/or withdrawal potential, biomedical conditions or complications, emotional/behavioral conditions or complications, treatment acceptance/resistance, relapse potential, and recovery environment. The areas that problems might be included in are medical, employment/support, alcohol and other drug use, legal, family/social, and psychiatric. (Felice, A., & Kouimtsidis, C., 2012)

Treatment Modality Matrix

If there were a behavioral pattern of low self-esteem, anxiety, verbal hostility, an intervention of relationship therapy, client centered approach would be used. The goals would be to increase self-esteem, reduce hostility, and anxiety.

A behavioral pattern of defective personal constructs, ignorance of interpersonal means, an intervention of cognitive restructuring including directive and group therapies instituted with a goal of insight. A behavioral pattern of having a focal anxiety such as a fear of crowds would be intervened by utilizing desensitization, which would have a goal of changing response to that same fear. A behavioral pattern of undesirable behaviors, lacking appropriate behaviors would be intervened by utilizing aversive conditioning, operant conditioning, and counter conditioning with a goal of eliminating or replacing behavior. A behavioral pattern of lack of information would require an intervention of providing information with a goal that the client will act using that information.

A behavioral pattern of difficult social circumstances would be intervened by using organizational intervention, environmental manipulation, and family counseling with a goal of removing the cause of social difficulty.

Empirically Supported Therapies (ESTs)

We most assuredly need to implement ESTs in our practice. There should be more education on public health and improve natural recovery, early access to interventions and better compliance, retention and outcome. These types of measures are not only low cost but also simple. We will minimize the encumbrance of substance abuse and improve patient outcome faster and easier than only transferring highly sophisticated ESTs into practice, and should be part of a comprehensive alteration idea.

Selecting therapists when they have just begun their practice or for a particular patient might also improve the treatment outcome at a greater degree than ESTs.

We have collected many treatments as active treatments or controls, and the differences in the reported results have been meta-analyzed by sophisticated data programs. The outcome proves that we now have over a hundred different types of ESTs. We must think of the adversities the therapists will be facing in trying to sustain to ESTs in their practices. We classify therapy as a black box. We have not attempted to sort through the many different therapies thrown together to see which ones are effective for what certain problems, and for which persons.

We need highly selected groups in strictly controlled therapeutic settings, far from the variety and complexity of patients and therapeutic challenges in the real world. The most important question of all is how do they work in the real world?

The Ecological Adaptation Model

The Ecological Adaptation Model perspective in substance abuse assists the client to develop methods that enable him or her to maintain sobriety in difficult circumstances in their chosen environment. Counselors should assist the client in social learning.

CHAPTER 4

THE REHABILITATION COUNSELOR

Counseling is a healing and educational service. The Rehabilitation Counselor determines what the most appropriate treatment modality, individual, group, or family counseling is required for the client.

This decision should be a mutual one between the counselor and the client. The counselor will manage the provision of services received by the client.

The provision of these services must be professional, timely, and in an ethical manner devoid of judgment and prejudice. Moreover, all the needs of the client need addressed in order to increase the probability of success. (Corrigan, P., 2004) The Rehabilitation Counselor must utilize all positive outside sources in order to ensure the client's successful outcome.

The client should develop goals that are attainable to promote success in their recovery. The rehabilitation idea is to assist the client in their entire necessities in order to live productively and independently in society. Counselors should accept each client as an individual by determining his or her different needs and goals. Counselors should assist clients to obtain the goals of communicating effectively and assist them to develop behaviors and skills that will ensure becoming productive and independent in society.

A Rehabilitation Counselor should be able to communicate effectively with the clients, while maintaining the appropriate boundaries in the counselor-client relationship.

The Rehabilitation Counselor should understand the various models and principles of addiction and other issues that might relate to the substance use. They should be able to identify the concepts, applications, rules, and results of the most broadly recognized and scientifically endorsed models of treatment, recovery, relapse prevention, and

continuing care for addiction and other substance-related dilemmas.

The Rehabilitation Counselor should acknowledge the eminence of family, social resources, and community organizations in the treatment and recovery preparation. They should gain knowledge of the kinds of insurance and health support choices available and the importance of helping clients obtain those choices.

Multicultures

The Rehabilitation Counselor should gain knowledge of the various cultures and combine the important needs of the various cultural groups, as well as people with disabilities, into the professional practice. Counselor should transfer these concepts to their own insight and the assessment.

They must be dedicated to all assisting resources and the self-respect and meaning of each individual. We must work on a win/win methodology.

Skills

The Rehabilitation Counselor should gain knowledge of the importance of a disciplined use of complex skills in the addiction treatment. They must have possession of exceeding abilities of being able to function within the required resources of various agencies, agreeing upon plans, involving the resources of those agencies, and promoting protection of the clients. They must be able to find the required resources that will amplify the qualities of life and independence for the clients.

The Rehabilitation Counselor must use efficient management skills in assisting the client in developing goals and objectives using the amount of time that is productive. They must be able to assist the client in developing methods to solve problems that the client is exhibiting. Counselors should possess team-building techniques by building rapport so plans may be

supported and changed if necessary.

The Rehabilitation Counselor must be able to interview, screen, assess, and gather information while laying the groundwork for good fellowship with the clients. They must be able to assist the client in discovering his or her strengths. (Christopher , R., John, B., D., & Simon, C., H., n. d.)

They must be able to identify treatment required in order to assist the client in meeting their distinctive goals.

The Rehabilitation Counselor should be accessing the means to assist the client in utilizing their strengths, acquiring their needs and wants in the assessment process.

Treatment Plan and Goals

A long-term goal is considering the core of the service planning process centered upon the success of the goals. It is not unusual for a long-term goal to be set up for a five-year span. The plans should be encouraging and practical.

The Rehabilitation Counselor should possess skills in empowerment. There are various ways to enhance empowerment: (Benn, P., 2007)

The treatment plan should be easy for the client to read and understand. The client should be interested in and satisfied with the program. The treatment programs should have recovering counselors that have shared in experiences of mental illness or had AODA. This will give the client the ability to build a positive relationship. (Marino, N. 2008)

Services

The counselor should be able to travel to the client's home or community instead of the client coming to the counselor. Clients could go back to school and obtain the required documents in order to provide services.

There is a history of people with AODA and mental illness developing programs to assist individuals. The programs are assisting those individuals who own similar problems. Persons with AODA and mental illness should be equal cohorts in research for better programs.

The Rehabilitation Counselor should be able to assist the client in believing that changing life styles is the key to obtaining successful goals. The client's wish to change is much more important than the type of treatment that we offer.

The Rehabilitation Counselor should be able to offer various methods of change due to some failing efforts. The Rehabilitation Counselor needs to realize that improvement does not happen at once. All improvements should take place one-step at a time, accepted and rewarded.

The Rehabilitation Counselor should be capable of assisting the client to develop life style skills that aid the client in resisting triggers and coping with stress. The Rehabilitation Counselor should possess the knowledge of teaching good communication skills.

State funded programs are providing scientifically proven practices, "Evidence Based Care," which have proven to be cost effective.

The Rehabilitation Counselor should be skilled in performing a comprehensive assessment. They should be able to identify the following stages of change as the Pre-contemplation Stage when the client is not considering any change,

The Contemplation Stage when the client is uncertain about using drugs, the Determination when the client begins to work towards recovery, and the Action that means the client begins to change. In maintenance, the client will become integrated with the successful change.

The Rehabilitation Counselor should implement treatment plans that correspond with the client's physical, psychiatric, psychological, and social requirements.

The Rehabilitation Counselor should be able to provide psycho social treatments that concentrate on behavior change, identifying triggers, client's interests, adaptability methods, cognitive-behavioral therapy, motivational therapy, Alcohol Anonymous 12 steps therapy, and family and partners therapy.

They should be able to discuss the terms of treatment goals with the client in order to find the best treatment available for the client's problems. They should be able to listen with empathy, counteract rebellion, indicate disagreements, ensure the client of their free will, and show the results of taking action compared to not taking action.

The Rehabilitation Counselor should relate the fact that the client should not implement the same behaviors used when they failed in some situations. They should help the client to understand that it is essential to develop different behaviors in order to obtain a successful goal.

The Rehabilitation Counselor should always give clear prospects of their and the client's conditions of treatment such as the length and times of the treatment, how important steady attendance will be. The counselor should inform the client they should call ahead of time if they are going to be absent. There will be urine collected before each session. They should stress that the client should remain abstinent throughout the sessions. (Bently, R. 2007)

The Rehabilitation Counselor should be able to provide continuing feedback regarding their behaviors, good or bad. Counselors should be giving clients responsibilities along with guidance from the counselor. They should provide an honest response to the client regarding the client's good or bad behaviors.

The Rehabilitation Counselor should be able to interpret the client's verbal communication as well as their body language, such as nonverbal images, gestures, and facial expressions. These types of communication could relate important confidential information.

(Riggart, T.F., Maki, Dennis R., 2004)

The Rehabilitation Counselor must ensure the client that they are concerned for that client's well being. They should be able to teach coping skills, enhance positive thinking, confront negativity or poor behavior, and possess accountability in crisis and other situations. The Rehabilitation Counselor should be experienced in the psychodynamic approach to addiction treatment in obtaining successful goals. They should realize that relapse is a process and not a failure of recovery.

The Rehabilitation Counselor will assist in the development of a service plan to meet the client's needs. (Riggart, T. F., Maki, D. R. 2004) This plan should include long-term goals, a narrative of the client's existing position, and needed services along with supports and resources.

The Rehabilitation Counselor must be attending trainings periodically in order to enhance their knowledge of the addiction recovery process.

We have found that many treatments used do not work for many individuals. We have determined treatments that do work. We know that Rehabilitation Counselors should be implementing changes that match research results and the practice provided. They need to stop practicing methods that are not working and implement the changes that we desperately require.

Counselors do not need to help clients trade their dependence on alcohol or substances to a dependence on a program. (Fletcher, A.M, 2013). That is not an acceptable goal. Most importantly, all agencies, private and public, should be consistent in their treatment methods.

The Rehabilitation Counselor should not be initiating empirically supported treatments because academic researchers say they should. They should only implement these treatments if the patients' outcome is going to be improved.

The Rehabilitation Counselor should be instituting support for motivating and producing

changes in practice. Inductive research may produce the practice-based evidence that help to acquire the goal of evidence-based practice.

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