An Individual Drug Counseling Approach to Treat Cocaine Addiction

Chapter 5 - The Role of the Addiction Counselor

Patient-Counselor Relationship

The role of the counselor in addiction treatment is to provide support, education, and nonjudgmental confrontation. The counselor must establish good rapport with the patient. The patient recovering from chemical addiction deserves to feel understood and that he or she has an ally. The counselor wants to convey to the patient that he or she appreciates the difficulty of this struggle and the need for support through the recovery process.

The metaphor of the hiker and the guide is useful for conceptualizing the counselor-patient relationship. The counselor guides the patient through at least the early stages of recovery, but the recovery process ultimately belongs to the patient. It is the patient alone who is responsible and accountable for his or her recovery. The counselor must emphasize this point to facilitate personal responsibility. Confronting the patient may be useful to emphasize personal responsibility. However, when confrontation is necessary, the counselor should convey a supportive rather than a punitive attitude.

The counselor must find a balance between being directive and allowing the patient to be self-directed. This process is facilitated if the counselor imposes a structure on the session that includes giving the patient feedback about the most recent urine drug screens and about the patient's progress in recovery and evaluatively processing any episodes of use or near use. The counselor identifies the relevant topic for discussion, based on what the patient seems to need, and introduces that topic. At times, the counselor may directly pressure the patient to change certain behaviors, perhaps, as an example, to start attending 12-step meetings.

However, the patient also is encouraged to be self-directed. For example, within the framework of a particular topic, perhaps coping with "social pressure to use," the patient may explore how to manage this problem best, and the counselor will respond to the patient's direction. If the patient seems unable to change some aspect of addictive behavior - for example, being around dangerous situations - the counselor should accept where the patient is and assist the patient to explore those perceptions or situations in a way that might allow himself or herself to do it differently, i.e., in a better way, the next time. However, the counselor should discourage regressive or other movements that lead back toward addiction. A balance needs to be struck so there is respect for the patient and acceptance of where he or she is and continual, ongoing pressure in the direction of abstinence and recovery.

Therapeutic Alliance

The counselor should create a sense of participating in a collaboration and partnership. This goal is best accomplished through three main avenues of approach. First, the counselor should possess a thorough knowledge of addiction and the lifestyles of addicts. Second, no matter how expert the counselor is, he or she must acknowledge that the patient is the true expert in discussing his or her own life. The counselor must listen accurately, empathize effectively, and avoid passing judgment. Third, the counselor should convey to the patient that he or she has an ally in the difficult progress toward recovery. Each of these approaches should help strengthen the therapeutic alliance and make the relationship a collaborative one.

Generally, the interventions that are most helpful in fostering a strong therapeutic alliance are those that involve the counselor's active listening and those that emphasize collaboration (Luborsky et al. 1997). For example, after the patient reports a relapse, the counselor might say, "Let us examine what happened and together develop a plan to help you avoid using next time." Such language highlights the combined effort in the relationship.

If the therapeutic relationship initially seems weak, the counselor might use the following simple strategy to address the problem: Ask the patient what is not working in the relationship or what the patient thinks is causing it not to work. Often the patient knows full well what might improve the therapeutic relationship but, for whatever reason, does not feel comfortable enough to mention it until the counselor initiates the topic. For improvement to occur, the counselor should be willing to accept feedback from the patient and possibly change the approach. However, in responding to a patient's request to change, the counselor should not feel pressured to change, or in any way compromise, his or her philosophy of addiction treatment. Rather, the counselor may adjust his or her interpersonal style to improve the working alliance.

Behaviors That Should Not Be Done

The counselor should not be harshly judgmental of the patient's addictive behaviors. After all, if the patient did not suffer from addiction, he or she would not need drug counseling, so blaming the patient for exhibiting these symptoms is useless. Also, patients often feel a great deal of shame associated with their addictive behaviors. In order to help resolve those feelings of shame and guilt, the counselor should encourage the patient to speak honestly about drug use and other addictive behaviors and be accepting of what is said.

The counselor should be respectful of the patient. The counselor should always be professional, including not being late for appointments and never treating or talking to the patient in a derogatory or disrespectful manner. Moreover, the counselor should avoid too much self-disclosure. While occasional appropriate self-disclosure can help the patient to open up or motivate the patient by providing a role model, too much self-disclosure removes the focus from the patient's own recovery. A good rule for when to self-disclose, if the counselor is indeed so inclined, is for the counselor first to have a clear purpose or goal for the intervention and then to analyze why he or she is choosing to self-disclose at this particular time. If any doubt results from this analysis, it probably should lead to a more conservative, nondisclosure position.

Lastly, counselors need to be aware of when their own issues are stimulated by a patient's problems and refrain from responding from the context of their own personal issues. For example, consider the case where a counselor in recovery feels that it was extremely important for him or her to break ties with addicted peers. Now this counselor is working with a particular patient who has an addicted spouse or partner and does not want to break these relationship ties. It is imperative that the counselor be flexible and respond creatively to the patient's own perception of the problem. In this case, the counselor must not rigidly adhere to the notion of insisting that breaking ties with *all* addicts is the *only* acceptable path to recovery. In general, the reflexive, noncritical projection of the counselor's own needs or experiences onto that of the patient's situation can be damaging or, at least, counterproductive.