A Differential Counselor Role Model for the Treatment of Drug Addicts

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FEW SOCIAL, psychological, or medical problems contain so many intertwined and interacting factors as drug addiction. Addiction is not a single, distinct entity. It affects a great many persons of widely varying backgrounds, physiques, psyches, ages, economic resources, and other characteristics, who abuse a variety of drugs in differing patterns, amounts, and degrees of purity and with differing consequences. When drug abusers come to treatment, it is for different reasons and to different agencies, where different modes of treatment are used.

Treatment or even amelioration, as far as possible, must therefore be individually tailored, and a multi-modality approach is the sensible one. To mention only two factors among many—Cuskey and associates found that addicts with more education and those who were unmarried when treatment started tended to stay in treatment longer than the relatively uneducated or those who were married (*1*). Educated persons are likely to have a greater familiarity with and understanding of treatment modalities, and single persons have different responsibilities and pressures than married people. It is also clear that the prosperous white physician who takes opiates to get through his busy but productive day should not receive the same treatment as the black prostitute in the slums who takes heroin to get through life because her procurer wants to keep her hooked.

The history of addiction treatment, however, does not show that differences in patients' responses to therapy and counseling have been recognized. American physicians have treated addiction since the turn of the century and have failed to discover a procedure which consistently cures an addict's compulsion to consume narcotics or successfully returns him to the social fabric of the community.

Treatment Alternatives

Since the 1920s, anti-addiction measures in the United States have meant, with few exceptions, institutionalization and detoxification from the drug, usually on an involuntary basis—in other words, jail and cold turkey. This is still the most common approach in the United States.

With the passage of the Narcotic Rehabilitation Act of 1966, providing assistance and support to "States and municipalities in developing treatment, programs and facilities," the Federal Government's general demeanor toward addicts and treatment possibilities changed, and the Government has since given grant support to new methods and even new philosophies of treatment. Currently, four principal modalities are employed in the treatment of heroin addiction in this country—abstinence and detoxification, antagonists, therapeutic community, and methadone maintenance.

Treatment modalities generally can be divided

into those that use medication and those that do not. An obvious use of drugs is as antagonists, much as Antabuse is to alcohol, to kill the craving for heroin and possibly make it distasteful for the addict. The two most commonly used antagonists are cyclazocine and naloxone.

Most widespread among the medication programs are those dispensing oral methadone, a synthetic, longer lasting, and cheaper narcotic that replaces heroin. One dose, taken in the morning dissolved in fruit juice, can last an addict 24 hours and free him from the continuing necessity to arrange and finance frequent fixes. Because it is legal and cheap, the addict supposedly does not have to steal and go to the black market to buy it; its mere possession and use does not automatically define him as a criminal.

Among the newer, more popular, and more controversial approaches are those of the so-called drug-free therapeutic communities such as Gaudenzia House, Daytop Village, and Phoenix House. Therapeutic communities are usually manned and often directed by ex-addicts with messianic zeal but little formal training. Ex-addicts rely heavily on faith, exhortation, and on newcomers to the group being remade from the inside out.

The entire therapeutic process need not be carried out in an inpatient facility. Detoxification of addicts from narcotics has been achieved in both institutional and outpatient settings. Controversy about the relative efficacy of these two approaches has yet to be resolved, however. Advocates of the techniques used with inpatients point to the high incidence of concurrent psychiatric illness and the adverse social influences surrounding addicts as necessitating hospitalization (*2*). Writers such as Berliner, however, point out that institutions have too often been used as a "dumping ground" for social deviants and "undesirables" and that use of inpatient facilities for the treatment of addiction can represent disengagement by the community at the time of hospitalization and by the hospital staff at the time of discharge (*3*).

A major argument favoring the outpatient treatment modalities is that they are much less expensive to operate than inpatient units. Properly organized outpatient clinics, with proportionately fewer professional and support staff than required in an inpatient unit, have the capability of dispensing medication, providing counseling, and giving medical, vocational, and educational services to a larger number of patients on a daily basis. Employment of ex-addicts and counselors with less than graduate level training can result in additional savings.

Role Differential Counseling Model

The model using counselors in differential roles to treat drug addiction that we will describe has not, to our knowledge, been used to any great extent. It has not been demonstrated or proved in practice and, despite its logic and the validity of some of its tenets in areas other than drug addiction, it is a suggested experimental model. However, it is characteristic of the entire problem of drug addiction that, despite the millions of people and the billions of dollars that are and have been involved, there is very little in drug treatment modalities that is not experimental and unproved. (For example, even methadone is still classified by the Food and Drug Administration as an "investigational" drug.) Our model appears to be a reasonable approach.

Treatment center personnel usually include physicians, psychiatrists, pharmacists, nurses, counselors, and administrators. We will discuss only the counselors in this paper. Although not the most highly paid or highly trained staff, the counselors play the crucial roles in the treatment cycle. If the nurses are the ears and eyes of the treatment center, the counselors certainly are its heart and brain.

If an addict is to be helped to become self-functioning by the end of his treatment, good counseling at every stage is essential. Counselors are important during all three phases of treatment—crisis intervention, progressive treatment, and social re-entry—as well as during the post-discharge period. They may be variously perceived as trusted friend, helpful guide, or as an unyielding representative of the administration who enforces rules and regulations.

Of all staff, the counselor has unique advantages in day-to-day treatment and operations. His experience and skill impinges most directly on the everyday but nevertheless vital facts of the life of the addict. The counselor is extremely familiar with the need to adapt his role and skills to the needs of his client. Finally, it is usually easier for an addict to relate to, and work with, a counselor than with the other professionals who may treat him. A psychiatrist's native habitat

is his own turf—an office, university, or hospital. A counselor may work in the agency, the home, or the street. In the words of Davis, "I don't think the psychiatrist is nearly as effective as a young girl with long hair and glasses that is a graduate sociologist with whom they can relate" (*4*). For many addicts, the counselor, social worker or not, is his link to hope.

Economics of Counseling

A major virtue of matching the skills and training of counselors to need and function is the lower cost of treatment programs. Ex-addicts receive less pay than college-educated workers, yet they can perform some special functions better than degree-holders. Savings are also great because a large percentage of addicts drop out of programs early in the treatment process. Use of masters of social work or other professionals in the first two phases can lead to considerable and unrecoverable waste. Ex-addicts or junior counselors may be employed extensively during the crisis intervention and treatment phases, saving graduate-trained psychologists and social workers for the social re-entry phase and for advanced and specialized work that only they can do.

A study by Cuskey and associates of addicts at the Methadone Clinic of the West Philadelphia Community Mental Health Center showed that almost 69 percent dropped out against medical advice before finishing treatment (*1*). Generally, treatment continued about 10 months before detoxification from methadone. The frequency of dropouts, expressed in number of visits before termination, follows:

Visits before termination	*Number of addicts*	*Cumulative frequency (percent)*
0–20	12	12
21–40	11	23
41–60	5	28
61–80	5	33
81–100	14	47
101–120	15	62
121–140	11	73
141–160	6	79
161–180	9	88
181–200	5	93
201–220	2	95
221–240	5	100
Total	100	.....

NOTE: Mean time before dropping out = 104 visits.

The mean number of visits for patients at this clinic was reported in another study to be three per week. Hence, the mean time before dropping out $= \frac{104}{3} \times \frac{12}{52}$ months $= 8$ months (unpublished study "Management Study of a Methadone Maintenance Drug Rehabilitation Program" by Walter R. Cuskey and T. Premkumar).

If an ex-addict counselor rather than a graduate social worker counsels the addict in the first 8 months, the annual saving can be estimated as follows:

The average caseload of a counselor is about 40.

Let the average annual salary of an ex-addict counselor be \$7,000 and that of a graduate social worker, about \$13,000. The total savings in wages has two components:

1. Savings in treatment of those who remain in the program: $= (1-0.686)\frac{8\,(13{,}000-7{,}000)}{12 \qquad 40} = 0.314\,\frac{4{,}000}{40}$ = \$31.40 per addict per year

2. Savings in treatment of those who drop out before detoxification: $= 0.686\,\frac{8\,(13{,}000-7{,}000)}{12 \qquad 40} =$ \$68.60 per addict per year

Hence, the net savings per year per addict is \$100.

A medium-sized treatment center with a total caseload capacity of about 1,000 addicts could save up to \$100,000 annually if ex-addict counselors rather than counselors with graduate training were employed to work with addicts during their first 8 months in the program.

Addicts' Needs During Treatment

Crisis intervention phase. Generally, addicts seek treatment when conditions preclude alternatives acceptable to them. The conditions include a medical emergency precipitated by excessive and continued use of narcotics or, when the law catches up with the addict, seeking treatment as a far more attractive prospect than jail. A few come voluntarily, under pressure from family or because they are convinced that they cannot go on and that treatment is preferable to continuing as before.

All, except those who are unconscious when they are brought in, are apprehensive, and they fear what treatment and exposure might involve. Their usual primary need at this entry stage is for immediate medical relief and help, followed by understanding and direction. They need to have confidence, self-regard, and hope restored. These needs are seldom answered by incarceration and threats of legal prosecution; if they can feel free of such threats, and assured that they will be treated fairly and helped, they are more

likely to respond to treatment and to have confidence in treatment personnel and therapy.

Progressive treatment phase. The treatment phase extends over varying time spans that involve different procedures and stages. It should be modified according to the addict's needs.

A major need in the first stage of progressive treatment is simply information and orientation—knowledge about what to expect. The addict needs to learn the rules and regulations, what is expected of him, what treatment seems most appropriate for him, and why. From time to time, he wants to know how he is progressing—something he should be able to determine to some extent for himself from available indicators, the experiences of others, and good counseling.

In the middle stage of this phase, the addict's specific problems are carefully studied by those who work with him, especially the counselors. This study includes not only the effects of withdrawal, but the whole constellation of background causes that may have helped lead him to drugs and those that might keep him addicted or lead him anew to drug abuse once discharged. He needs understanding and an attentive and sympathetic ear.

In the last stage of the progressive treatment phase, the human being begins to become distinct from the addict. He gains confidence in himself and in the life he might be able to live without drugs. He should work toward shoring up that self-identity and facing his problems apart from drugs. He should be able to communicate with his counselors as an individual, rather than as a junkie dominated by a habit.

Social re-entry phase. Any large-scale therapeutic process that is aimed at bringing about major change in lifestyle and personality adjustment, as do drug treatment centers, acquires a womb-like quality. The time must come when the newly born, or reborn, goes into the world and learns to cope with it, and use of the umbilical cord diminishes or stops completely. The figure of speech is not completely inappropriate; most addicts are dependent, passive personalities who in the past could not cope and sought the artificial womb of drugs. To expect the addict, or former addict, to contend with that world without continued assistance is to expect a great deal. He must, in effect, become a more mature and complete person on discharge than he ever was, even if still on maintenance doses.

Counselor Roles

Each category of counselor has unique skills and attributes which can profitably be employed to assist the addict in his treatment. These are discussed in detail subsequently.

Ex-addict counselor. Few such workers have formal training, but we include them in this model because of their ability to relate to the addicts and their familiarity with an addict's problems and milieu. The value of the indigenous worker and of the person "who has gone the route himself" has been proved many times—most notably in ghetto work, in the therapeutic communities, and in the work of Alcoholics Anonymous. The therapeutic communities rely almost entirely on such help.

Ex-addicts obviously will be most effective in the first phase and at the beginning of the second, when the highest priority is to reach the addict, gain his confidence, alleviate the immediate crisis, get him into treatment, and help him over the first and toughest hurdles. The addict can relate to the ex-addict most easily, and can see in him a model of success to follow (*5*).

Also, ex-addict counselors are probably shrewder than the professionals in such matters as determining whether a patient is really progressing and how much and in detecting signs of cheating. This ability is important because most dropouts and most cheating occur early in treatment.

The ex-addict counselor knows the neighborhoods, the people and their problems, and the addict's ways. He knows the pressures the addict faces and the dodges he uses. He is best suited to bridge the gap between the lower class addict and the middle class professional. Usually he shares an ethnic origin, religion, group identity, and point of view with the poor and the addicted. He is in the best position to help prevent the suspicion, distrust, or obsequiousness addicts inevitably feel or display toward professionals and to guide the addict toward a counselor he can identify with and trust.

Further, the ex-addicts who are graduates of the facility where they work know the procedures, why these are necessary, and where they are faulty. The ex-addict can explain them and use personal examples to drive points home. They are often very hard workers, dedicated to helping the

addict, and they have a strong sense of loyalty to the institution that helped them. Finally, an ex-addict who remains with the facility is much less likely to relapse; this tie becomes a form of insurance and aftercare for him and often for clients with whom he works.

While his contributions are valuable and often unique, he cannot replace the professional in performing some functions. The lengthy experience of AA in this regard—using recovered alcoholics to help alcoholics in treatment—sheds light on this point. Aharan (*6*) stated: "A recovered alcoholic in AA is an expert *on his own* experience and on his own way of working the program . . . [He] can be knowledgeable and skilled in helping; . . . but [the recovered alcoholic's] opinions [about the nature of alcoholism] are often irrelevant in terms of developing effective helping relationships."

Employing ex-addicts also has some drawbacks for drug treatment centers. Although a few have the ability to be leaders, the majority are ill equipped for more than marginal roles, even if they have succeeded in solving their own problems. They often lack objectivity, and frequently they over-identify with the professionals. The tendency to emulate the manner and approach of the professional may decrease the counselor's effectiveness; it can lead to conflict with professionals and result in inappropriate service to clients. And, as noted previously, there is an ever-present threat of possible relapse. The effect of a relapse on patients who have come to look upon the ex-addict as a model can be disastrous. Generally, however, the advantages outweigh the disadvantages of employing ex-addicts, and supervision by and consultation with professionals can make up for many of their faults.

Junior counselor. Once the addict has been brought to treatment, convinced of its necessity, and is physically on the mend, he must come to an understanding of the basic causes that led him to drugs. The junior, professionally trained counselor is best qualified and prepared to help bring these changes about in phase 2. He can give practical help in daily tasks and supply supportive therapy. For example, he can assist in preparing family budgets and help the addict keep his appointments and look for a job. The junior counselor can help him with agencies that can provide other services—public assistance, medical care, training, and the like. At this stage, the mutual trust established earlier should be consolidated, and the addict now undergoes a period of readjustment and self-assessment. A counselor with a bachelor's degree is ideally suited to a patient who is on the threshold of understanding his problem and requires helpful guidance in addition to empathy.

Senior counselor. By the end of the treatment phase, the patient needs deeper and more sophisticated therapy and support, and the senior worker with advanced training makes his contribution at this point. The addict should have gained insight into what drove him to drugs; he must now, in effect, construct a new identity and develop new confidence that will enable him to face the world without crutches—and despite the extra handicaps that being an ex-addict will inflict on him.

The senior level social counselor, in addition, is more involved in management and administration of the total program, and he needs to be able to view the process as a whole and to cope with administration and supervision that go along with the higher responsibilities.

If he has not dropped out before phase 3, the social re-entry phase, the patient should have reached a fairly high level of maturity and understanding about his problem. He may not be completely drug free, but he is committed to continuing improvement. He needs help in getting back into the stream of everyday life and all that that might entail. If he has been treated while in residence, he may belatedly need help getting a job, housing, and education, finding friends, and eventually, if desired, a suitable spouse, and in staying away from the old neighborhoods and pressures that might put him back on drugs. His counselor may have to check to see that he keeps appointments and should be available when the ex-addict needs him. As in the first stage for nonresidents, the treatment staff must be effective social lubricants in this transitional interface.

The post-treatment phase is a trying period for most ex-addicts. Constant social and situational pressures, peer group influences, real and perceived problems, along with the social stigma associated with ex-addicts, and ever-present temptations to relapse, make the immediate post-treatment life difficult. Occasional contacts with the ex-addict and his family by the treatment staff and the assurance of accessibility to treat-

ment personnel and facilities help reduce stress. The importance of post-treatment contact with the ex-addict cannot be over-emphasized.

Benefits From Role Delineation

The preceding discussion of the total process of treatment and of staff roles implies clearly defined roles for counselors. Delineation of specific roles has several advantages, in addition to strictly economic ones.

First, available skills of the staff are matched with the addicts' needs, and this alignment increases the effectiveness of a program's manpower resources.

Second, such assignments can partially justify wide differences in wage scales. Complaints about different wages for counselors performing apparently similar tasks are common. Staff members are of optimum value to a program only when they function at the top of their potentials and capacities, not when they work at tasks which can be done as well by workers with less training.

Third, if the differing roles of counselors are clear, the patient will know how well he is doing according to the type of counselor who is helping him. Going upward in the scale of counselors constitutes a visible promotion. This advance can constitute encouragement and reward, or if he stays too long at the same level with the same type of counselor, it can be a silent warning.

Fourth, each addict will relate differently to each counselor, depending on the addict's educational, cultural, economic, and social background. The sequential therapy provides an opportunity for an addict to interact with persons of varying skills, and perhaps it will enable him to find the needed emotional and psychological support from the counselor who most nearly matches his own personality.

Finally, clear definitions of roles can give counselors a feeling of belonging, teamwork, and an understanding of the total treatment process. This feeling can foster cooperation and team spirit. Each counselor needs to know how he fits into the framework of the program, but the framework should also allow for some overlap among counselors or their stepping across boundaries to help each other when necessary.

REFERENCES

(1) Cuskey, W. R., Chambers, C. D., and Wieland, W. F.: Predicting attrition during the outpatient detoxification of narcotic addicts. Med Care 9: 108–116 (1971).

(2) Hekimian, L. J., and Gershon, S.: Characteristics of drug abusers admitted to a psychiatric hospital. JAMA 205: 125–130, July 15, 1968.

(3) Berliner, A. K.: Bridging the gap between institution and community in the treatment of narcotic addicts. Ment Hyg 52: 263–271 (1968).

(4) Davis, E. P.: The man alive program. Int J Addict 5: 421–430 (1970).

(5) Proctor, M.: Addiction, the counter-culture. Nation 212: 623–627, May 17, 1971.

(6) Aharan, C.: AA and other treatment programs: problems in cooperation. Addictions 17: 25–32, winter 1970.

CUSKEY, WALTER R.: (University of Pennsylvania), and PREMKUMAR, T.: *A differential counselor role model for the treatment of drug addicts. Health Services Reports, Vol. 88, August–September 1973, pp. 663–668.*

Differences in the social and psychological makeup of each person addicted to drugs, coupled with the innumerable and unpredictable causes of that addiction, have brought into focus the need for an individually tailored approach to the treatment of drug addiction. Historically, treatment approaches in the United States have not taken cognizance of patients' differing needs and responses to therapy and in the counseling they receive.

In this paper the addicts' needs in each of the three phases of the treatment process—crisis intervention, progressive treatment, and social re-entry—are examined. A model using counselors in differential roles is proposed. The model attempts to match the experience and skill of the counselor to the needs of his client.

The counseling needs of addicts vary as they progress through each phase of treatment, and it is during this passage that different types of counselors with various skills and levels of training can be used for maximum benefit.

A major reason to employ counselors by matching skill and training to need and function is that treatment costs are lower. In studies reported in this article, a medium-sized treatment center with a capacity of about 1,000 addicts could save up to $100,000 annually if ex-addict counselors replace counselors with graduate level training in working with addicts during their first 8 months in treatment.