

Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery

Part 1, Chapter 2

Introduction

Counseling in substance abuse treatment is an interactive and collaborative process between counselor and client that supports change and enhances psychological and emotional growth. The relationship between counselor and client is the most critical component in determining a positive treatment outcome. Accordingly, counseling is not only a forum in which the counselor provides support, advice, and/or education to the client, nor is it simply a series of techniques or strategies undertaken by the counselor. Rather, it is a collaborative process using the client's strengths, experience, and motivation and the counselor's skills, experience, and insights to achieve a higher quality of life for the client.

Change is a natural process. In a collaborative model of counseling, the goal of the counselor is to learn how to tap into and support the client's natural desire to grow and change. The key element in the majority of positive outcomes in substance abuse treatment, regardless of the counseling approach or techniques used, is the relationship between the counselor and client (Hubble, Duncan, & Miller, 1999). When that relationship is based on mutuality, respect, and faith in the client's expertise in his or her own life experience, the relationship itself provides a safe therapeutic context in which people feel free to make healthier choices about their lives. Within this safe and supportive atmosphere, clients are able to explore their own experiences and find their own solutions to problems.

A number of factors work to facilitate change, and some of the most important are the qualities the counselor brings to the therapeutic relationship. Carl Rogers (1992) asserted that in a client-centered, collaborative approach to counseling, the counselor must possess three critical qualities to create the conditions that facilitate change: accurate empathy (expressions of understanding by the counselor of the client's experience), non-possessive warmth (or unconditional positive regard), and genuineness (authenticity and transparency). Manifestation of these three critical conditions fosters therapeutic change and recovery from substance use disorders. In particular, accurate empathy is associated with treatment success. A critical assumption of Rogers is that when counselors engage in accurate empathy, clients feel accepted and understood, and this increases their sense of self-worth. This is a crucial aspect of working with people with depressive symptoms because low self-worth or self-esteem is one of the most common symptoms of depression. In addition, constructive behavioral change follows from positive changes in self-worth (Rogers, 1992).

The primary counseling tool that facilitates the expression of accurate empathy is reflective listening, also known as active listening. Reflective listening involves listening beyond the content of what the client is saying for the meaning and feeling in the client's story, making a hypothesis about that meaning or feeling, then reflecting that meaning or feeling back to the client using the client's words, rephrasing, or paraphrasing using your own words. The goals of reflective listening are to build rapport by helping the client feel understood and to selectively reflect back to the client his or her own reasons for change instead of trying to convince the client that change is necessary. The four clinical vignettes that follow demonstrate reflective listening and accurate empathy. Notice that the counselor focuses on helping the client change the thoughts, beliefs, feelings, or behaviors associated with his or her depression.

While change is natural, it is not always easy. Whenever people are considering a change, it is normal for them to feel ambivalence. It is a natural part of the human experience to feel a sense of loss and regret when giving up one set of behaviors or a way of thinking in exchange for a new approach. The counselor's job is to recognize

that ambivalence is a normal part of the change process and that resistance to change is an expression of that ambivalence, not an intrinsic part of a client's personality or identity.

In fact, resistance serves a protective function in all of us. It works to keep us safe and maintain our equilibrium. When resistance is apparent in the counseling process, it can be explored with respectful curiosity. It is your job as a counselor to help clients resolve ambivalence.

Motivational interviewing (MI; Miller & Rollnick, 2002), which is based in part on Rogers' humanistic theory of change (as described above), is a directive, yet respectful and client-centered, approach to helping people resolve ambivalence about change. It has been shown to be effective in helping people change their alcohol and drug use patterns, as well as in supporting people as they resolve their ambivalence about taking medications or engaging in other healthy behaviors that decrease depressive symptoms. (See TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT 1999].) Below are some tools adapted from MI that will help you address a client's ambivalence about change.



How to Address Client Ambivalence About Change

1. While you are interviewing a client, keep in mind the idea that ambivalence about change is normal and that resistance to change is simply an expression of ambivalence, not an intrinsic part of who the person is.
 2. The following are some examples of questions that can be useful in helping clients explore ambivalence about engaging in behaviors that decrease depressive symptoms:
 - a. What are the good and not-so-good things about drinking when you are depressed?
 - b. What are the advantages and disadvantages of taking medication or exercising to combat your depression?
 - c. Who in your life would appreciate your decision to take care of yourself by exercising and not drinking in order to reduce the depression?
 - d. On a scale of 1–10, how important is it to you to make some changes to reduce the depression in your life?
 3. Invite clients to explore their ambivalence more deeply by empathically reflecting their comments back to them.
 4. Remember that the closer a client gets to change, the more their ambivalence can increase. It is important that clients make a life change because they see the need, not because a counselor forces it on them, so be particularly careful about not pushing your agenda on the client. It is through the exploration and expression of their own experience that clients resolve their ambivalence and take more ownership for the change.
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In working with substance abuse treatment clients with depressive symptoms, effective counseling supports people's efforts to change the thoughts, beliefs, feelings, and behaviors associated with both depression and substance abuse. For example, if a client can recognize that his or her difficulty concentrating (which he or she believes makes him or her defective) is not a personal failure but a symptom of depression, the client can take a step back from self-judgment. This will, in turn, improve the client's concentration and sense of worth. Your job as a counselor, in this instance, is to help the client explore the possibility that the problem (difficulty concentrating) has nothing to do with a sense of identity or value as a human being, but rather is a common experience associated with depression. Later in this chapter, you will learn more about counseling tools that focus on helping people recognize and challenge negative thinking patterns and core beliefs.



How to Help Clients With Substance Use Disorder and Depressive Symptoms

The counselor has several tasks with clients in treatment for a substance use disorder who have depressive symptoms, a diagnosed depressive disorder in remission, or an already-diagnosed depressive disorder for which they are currently in treatment (e.g., in therapy, taking medications, or receiving both). These tasks depend on the training and expertise of the counselor and the mission of the treatment program, and can include one or more of the following:

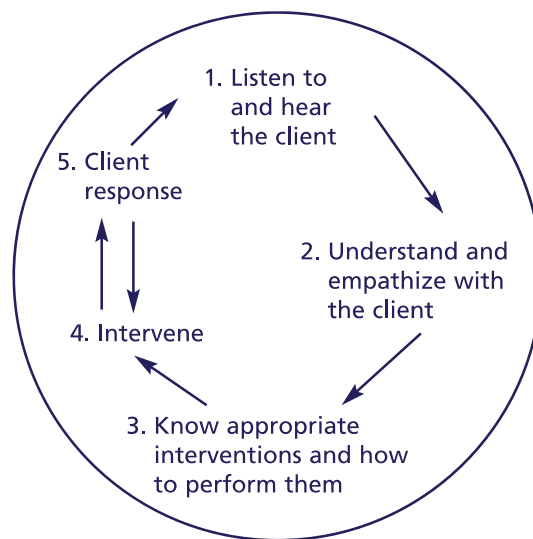
1. Screening of current depressive symptoms to determine if a more extensive clinical evaluation is needed. This screening can be accomplished through a clinical interview or completion of a mood inventory such as the Center for Epidemiologic Studies Depression Scale (CES-D; see Appendix B).
2. Monitoring depressive symptoms to observe whether they change significantly over time or require specific treatment. Monitoring can be accomplished through client reports as well as regular completion of the CES-D or another depression screening instrument, which can document changes in severity of depression over time.
3. Facilitating an evaluation and/or specialized treatment with a psychiatrist, psychologist, or mental health clinician for a more in-depth assessment of mood symptoms. Some clients will initially reject the idea that evaluation or treatment is needed. Education or explanation about the recommendation can help the client feel comfortable about participating in the evaluation. Additionally, education can address the client's fears about taking antidepressant medication.
4. Monitoring the client's recovery from depression and collaborating with any other mental health professionals involved in the client's care for a depressive disorder. This can require spending time in each counseling session reviewing the client's current mood, compliance with medications and/or therapy for depression, and resolving any major issues related to depression (e.g., devising a safety plan if the client feels suicidal). While integrated treatment addressing both disorders in the same treatment program is the ideal, in many instances, a client receives help from both a substance abuse treatment program and a mental health program or private practitioner.
5. Providing education on depressive symptoms, depressive illness (types, causes, and effects), treatment for depression, and mutual support groups. For example, it is important for a client diagnosed with a depressive disorder who receives medication to know that treatment should be continued for at least 6 months or longer after improvement in the acute symptoms of depression. Education can be accomplished through discussions in the sessions, and/or by providing or suggesting articles, books, workbooks, pamphlets, or Web pages where information is available.
6. Discussing the impact of depressive symptoms or a depressive disorder co-occurring with a substance use disorder on the client's family, including children.
7. Helping the client identify possible relationships between substance use and depressive symptoms, depressive disorder, or recovery from clinical depression.

8. Providing specific interventions related to depressive symptoms or the disorder based on the principles of an evidence-based treatment such as cognitive-behavioral therapy (CBT) or interpersonal psychotherapy (IPT). These interventions aim to help the client manage depressive symptoms, improve recovery efforts, and reduce future risk of recurrence. Some CBT and IPT interventions are relevant to treating both depressive symptoms and substance use disorders, for instance, structuring time or building pleasant activities not involving alcohol or drug use into a client's day, becoming active in a support system, or addressing interpersonal conflicts. Other interventions are specific to the depression, such as changing faulty thinking that contributes to sadness or suicidal feelings, learning sleep hygiene strategies, or addressing specific life problems that the client believes contribute to depression.

The role of the counselor in the collaborative counseling process is depicted in Figure 2.1. Counseling involves:

- *Listening to and hearing* the client (Figure 2.1, Step 1) as he or she first presents the problem, expresses new concerns as they arise, and responds to counselor interventions.
- *Understanding and empathizing* (Step 2) with the concerns, experience, and meaning embedded in the client's story.
- *Knowing* which techniques or strategies will be helpful to the client and possessing the knowledge and skill necessary to successfully use the correct techniques or strategies at any given moment in the counseling process (Step 3).
- *Performing* the intervention (Step 4).
- *The client's responding* (Step 5) in some way to the intervention, which the counselor *listens to and hears*, and so forth around the circle again and again (Step 1).

Figure 2.1
The Counseling Circle



This process unfolds in each moment of counseling, in each session, and in the totality of sessions held with each client. Eliminating any one of the five steps will result in a less effective, or perhaps ineffective, counseling experience.

The Culturally Competent Counselor

Throughout this TIP, you will find references to the culturally competent counselor. Cultural competency is:

“A set of values, behaviors, attitudes, and practices within a system, organization, program, or among individuals that enables people to work effectively across cultures. It refers to the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time” (U.S. Department of Health and Human Services, 2003, p. 12).

A critical element in this definition is the connection between attitude and behavior.

Figure 2.2 Attitudes and Behaviors of Culturally Competent Counselors	
Attitude	Behavior
Respect	<ul style="list-style-type: none"> • Acknowledging and validating the client’s opinions and worldview • Approaching the client as a partner in treatment • Communicating with clients in their primary language, either directly or through an interpreter • Respecting the client’s self-determination
Acceptance	<ul style="list-style-type: none"> • Maintaining a nonjudgmental attitude toward the client • Considering what is important to the client
Sensitivity	<ul style="list-style-type: none"> • Understanding the client’s experiences of racism, stereotyping, racial profiling, and discrimination • Understanding the life circumstances, daily realities, and financial constraints of the client
Commitment to Equity	<ul style="list-style-type: none"> • Intervening on behalf of clients when a problem stems from racism or bias • Actively involving oneself with minority individuals outside the counseling setting to foster a perspective that is more than academic or work-related
Openness	<ul style="list-style-type: none"> • Recognizing the value of indigenous helping practices and intrinsic help-giving networks in minority communities • Building ongoing collaborative alliances with indigenous caregivers • Seeking consultation with traditional healers and religious and spiritual leaders and practitioners in treatment of culturally different clients, when appropriate
Humility	<ul style="list-style-type: none"> • Acknowledging the limits of one’s competencies and expertise and being willing to refer clients to a more appropriate counselor when necessary • Seeking consultation and pursuing further training or education, or a combination of these • Constantly seeking to understand oneself as being influenced by ethnicity and culture and actively seeking a nonracist identity • Being sensitive to the power differentials between the client and the counselor
Flexibility	<ul style="list-style-type: none"> • Using a variety of verbal and nonverbal responses, approaches, or styles to suit the cultural context of the client • Using cultural, socioeconomic, and political contextual factors in conducting evaluations and providing interventions

In the four vignettes of counseling sessions in this chapter, note how issues of cultural competence, and particularly the connections between cultural attitudes and behavior of the counselor, can become important elements of the counseling process.

Methods and Approaches

In this chapter, you are invited to consider different methods and approaches to working with clients with substance use disorders who are experiencing depressive symptoms. The four approaches described in this chapter focus on:

1. Changing behaviors.
2. Changing patterns of thinking (cognitions).
3. Recognizing and deconstructing core beliefs that hinder growth and change.
4. Awareness and expression of feelings (affect).

Any of these approaches can be the entry point and primary focus in the counseling process. The goal of each is to help people change and grow. How the decision is made to choose one approach over another is discussed later in the chapter. It is important to note that effective counselors have a diverse repertoire of methods from which to choose, and that the choice of approach and the techniques associated with that approach are based on the perceived needs, strengths, and resources of the client, not the agenda or needs of the counselor. This is a primary assumption of the client-centered, collaborative approach to counseling.

The four vignettes in this chapter demonstrate the counseling process and specific strategies used when the primary focus of the session is on the client's behavior, thoughts, feelings, or core beliefs. The vignettes will enable you to better understand how clients with substance use disorders present themselves when they have depressive symptoms, and how you can help them reduce or alleviate those depressive symptoms while improving the likelihood of their successful recovery from substance abuse. Techniques described include behaviorally based approaches, techniques from CBT and IPT, and affect-based therapies. Additionally, core concepts, strategies, and techniques from MI, client-centered therapy, and active listening skills are demonstrated throughout, as are such basic concepts as empathy, support, and giving feedback. The vignettes of counselor and client dialog include several components, some of which are marked by icons for easier identification:



- **Decision trees** assist in making choices about various courses of action.



- **Master clinician notes** are comments from an experienced counselor or supervisor about the strategies used, possible alternative techniques, timing of interventions, and areas for improvement.



- **"How-to" boxes** contain information on how to implement a specific intervention.

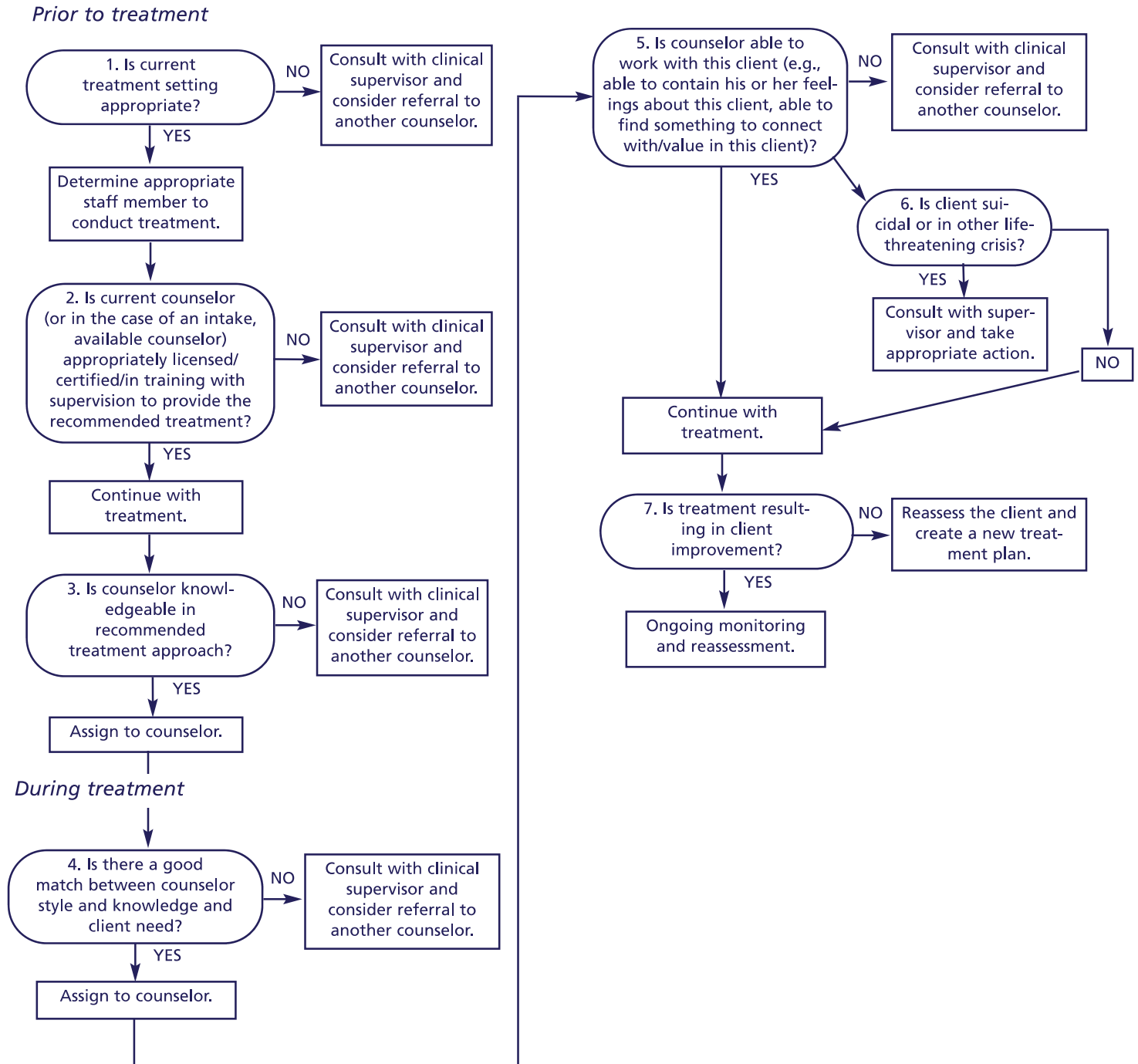
This format was chosen to assist counselors at all levels of mastery, including beginning counselors, those who have some experience but need more diversity and depth, and those with years of experience and training who are true master clinicians.

Before beginning counseling with clients with a substance abuse diagnosis and depressive symptoms, and periodically throughout treatment, a determination must be made as to whether the current treatment setting is

the one in which the client should continue. Considerations include whether the client has clinical depression (e.g., has been judged by a capable mental or behavioral health professional qualified in the state to diagnose mood disorders as meeting the criteria in the *Diagnostic and Statistical Manual, 4th Edition, Text Revision* [DSM-IV-TR; APA, 2000]) and whether the current treatment program and counselor are equipped to treat both disorders (see Figure 2.3, When to Refer a Client).



Figure 2.3
Decision Tree
When to Refer a Client



High-quality clinical supervision is necessary to bridge administrative mission and vision with the best practices offered to clients through competent counselors. Whether yours is a small program or large agency, effective and efficient supervision is critical to client care. The clinical supervisor seeks to enhance the personal well-being and professional knowledge and skill of the counselor through regular one-on-one supervision, group supervision, and relevant training programs.

Treatment Planning, Collaborative Goal Setting, and Counselor Expectations for Counseling Session

Three closely related processes should determine the content of a counseling session. First is the master treatment plan, developed by the treatment team with the client's input. This is the overall plan for the types and extent of services to be offered to the client during treatment. Ideally, this plan is flexible, and considers the range of services available from the treatment organization and the client's specific needs. It is adapted over time to meet the client's changing needs. Individual, group, and family counseling services should reflect the needs identified in the master treatment plan.

Second, the client should be engaged in an ongoing collaborative effort with the counselor to identify and address specific needs. This engagement of the client in goal setting reinforces clients' responsibility for their own change and invites them to be an integral part of treatment planning. This collaboration can be as simple as carefully rephrasing the client's hopes and dreams for recovery as treatment goals. It can also be the counselor simply asking the client what he or she would like to focus on in today's session. The collaborative effort can also be a more formalized structure implemented in programs to ensure that clients have a say in their treatment.

Finally, most experienced counselors enter a counseling session with an idea of what they might want to accomplish in their time with the client. For instance, in early sessions, counselors might expect to develop or enhance the therapeutic relationship with the client. They can have expectations of gathering information from the client, refining treatment goals, or identifying specific strategies to achieve identified goals. As treatment progresses, counselors can enter a specific session with expectations to follow up on homework from a previous session, to inquire about change efforts the client has made between sessions, or to continue work on a long-standing change effort.

These treatment planning efforts lead to goal-directed recovery and serve to differentiate professional counseling from simply "talking about" problems. Simply talking about problems rarely solves them. Results come from identifying specific, achievable goals and employing methods that can be instrumental in obtaining positive outcomes. In the following vignettes, note how the counselor begins each session with expectations for what he or she would like to accomplish in the session and then works with the client to identify goals the client would like to accomplish. Both efforts are essential in an effective treatment encounter.

You will now meet four clients: Cherry, John, Sally, and Shirley. Each presents with depressive symptoms in addition to a substance use disorder diagnosis. Note that while their life situations are unique and the counseling approaches used with each are different, some commonalities do exist. With each case, the counselor is empathic, listens carefully to the client's story and dilemma, seeks to help the client help him or herself resolve the dilemmas he or she faces, and is able to relate in a nonjudgmental manner. As in the vignettes, your job as a counselor, regardless of your approach, is to help clients better understand their life dilemmas, identify and clarify their goals, examine and better tolerate their ambivalence about change, and achieve a positive outcome.

A Note on the Master Clinician

In this chapter you will be guided through cases (vignettes) by a "master clinician." This master clinician represents the combined experience and wisdom of the contributors to this TIP. The master clinician provides insights into the cases and suggests possible approaches. Some of the techniques described by the master clinician

cian may not be appropriate for you to use, depending on your training, certifications, and licenses. It is your responsibility to determine what services are legally and ethically appropriate for you to provide (see Figure 1.4, Scope of Practice, p. 15).

Vignette 1—Behavioral Interventions

Introduction

Behavioral interventions are a basic treatment approach used in substance abuse treatment. As treatment commences and if the client is ready, you initially focus on changing the behaviors that are driving the substance abuse; for instance, stopping drinking and drug use and avoiding people, places, and things where there is a risk of alcohol or drug use. You also want clients to quickly adopt behaviors that will help them maintain abstinence, such as attending 12-Step meetings and finding sober friends. The assumption is that changing behaviors will build an environment for subsequent changes in thinking, feeling, and beliefs. Another important part of behavioral change in substance abuse treatment is helping clients sustain the growth they are making and helping them use this growth to sustain even greater change. (See Figure 2.4 for how to determine whether a client is suitable for behaviorally oriented treatment.)

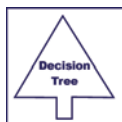
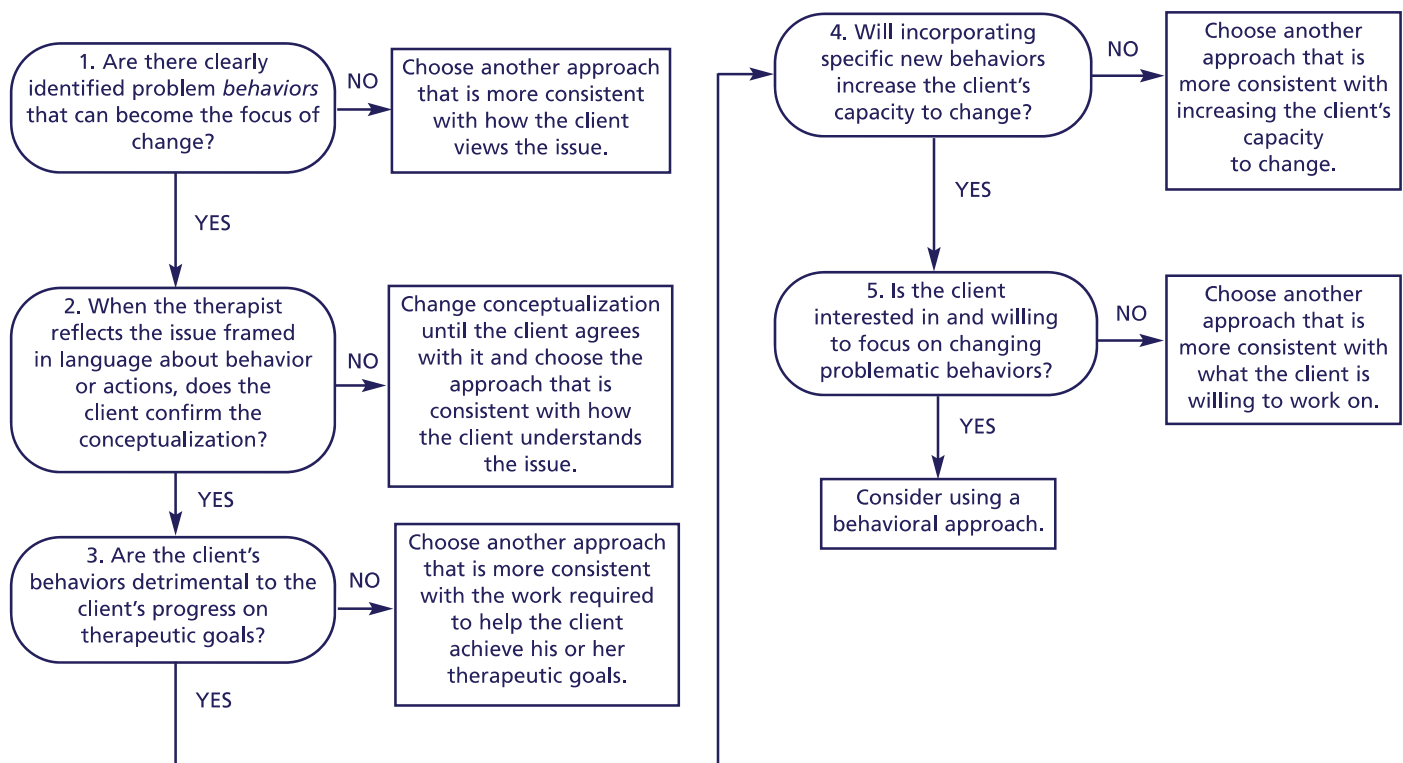


Figure 2.4
Decision Tree
How to Determine Whether a Person Is Suitable for Behaviorally Oriented Treatment



Behaviorally focused change is also appropriate in addressing depressive symptoms. We know that strengthening relationships, increasing the capacity to ask for help, mild or moderate physical exercise, learning sleep hygiene techniques, getting adequate rest, managing feelings that are common among clients with depression

(e.g., sadness, anxiety, anger, boredom, fatigue, shame, and guilt), and managing stress can all contribute to reducing depressive symptoms. Some of the counseling processes that support behavioral change include:

- Targeting specific behaviors to change, especially behaviors that the client identifies as limiting.
- Helping a client set achievable goals for behavioral change.
- Helping the client find the support he or she needs to plan for, initiate, and maintain behavioral changes.
- Helping the client take big changes and break them down into smaller changes that can be more easily accomplished and maintained. It is important to also explain the reasons for smaller, more targeted objectives, since many clients can feel that progress is not being made with smaller goals.
- Helping the client find internal and environmental resources that will help him or her develop and maintain the motivation necessary to sustain behavioral changes.

Observe how the counselor in the vignette about Cherry builds the therapeutic relationship, targets behavioral changes needed to support her abstinence from drug and alcohol use, builds resources to confront her depressive symptoms, works to help Cherry make changes, and then supports the changes she is making.

Case Study

Cherry, 34, has been drinking for at least 10 years, at first mostly socially with her husband and friends but with occasional periods of heavy drinking. When she divorced 3 years ago, she started drinking more frequently—almost every night—after her three children went to bed. Also, about 2 ½ years ago, she noticed that she was getting more anxious and stressed out from trying to get the kids to day care and school, taking care of them, not having enough money, hassling with her ex-husband over child support, and getting to work on time. She received a prescription for benzodiazepine from her family doctor and rapidly became dependent on the drug. Her doctor recognized her dependency and referred her to a psychiatrist trained in substance abuse. He recommended substance abuse treatment. After being monitored in a detoxification program, she began the 8-week intensive outpatient treatment program where she is now receiving treatment.

Substance Abuse History and Current Status

Cherry grew up in a verbally abusive home with a mother who battled alcohol abuse most of her life. Cherry drank two or three times during high school, not really liking the taste of alcohol. She smoked pot and enjoyed that more. Cherry went through a period of smoking pot regularly after ending her relationship with her high school sweetheart. Once she got into another relationship, she cut down her use, decided she was becoming dependent on marijuana, and quit entirely. Cherry has been drinking regularly for at least 10 years. After her divorce, her drinking increased to almost daily and her use of benzodiazepines began 2 ½ years ago. Cherry started “prescription shopping” as her need for the benzodiazepine increased. Consequences of her alcohol and benzodiazepine abuse are increased shame, blockage of grief from her divorce, loss of motivation, loss of self-esteem and self-confidence, ineffective parenting, increased isolation, and sleep disturbance.

Depression History and Current Status

On admission, Cherry revealed that she has lately felt depressed: feeling sad about the loss of her husband through divorce, guilty about not taking good enough care of her children, overwhelmed, lethargic, and unmotivated. Sometimes she sleeps too much. Other times, she wakes up feeling tired because she has trouble falling asleep or wakes up in the middle of the night. Her other physical complaints include headaches, a chronic cough, and an irregular menstrual cycle. She often feels “stressed out,” but has trouble taking action to reduce the stress. While in the detoxification program, her depression seemed to worsen. She is overwhelmed with issues of money, child care, and relationships.

SESSION 1

Clinician Expectations

The counselor begins Session 1 with the following expectations in mind:

1. Build the therapeutic relationship by developing an understanding of Cherry's issues from her perspective. This includes the client's motivation for treatment and her perception of and experience with her situation.
2. Ask Cherry about her goals for the session. Sometimes the client doesn't present with specific goals, but asking can invite the client to begin thinking about what she may want to change. Identify the issues the client would like to address.
3. Assist Cherry in seeing the connection between her depression and her substance abuse.
4. Identify specific behavioral changes needed to support abstinence from drug and alcohol use and reduce depressive symptoms.

[Cherry and the counselor exchange initial greetings and have a brief exchange in which Cherry expresses that she is feeling very tired.]

COUNSELOR: Cherry, we are meeting today so I can get a better understanding of your mood and some of the symptoms you reported to the intake worker. I'll ask you some questions, and then later have you complete a brief questionnaire about your moods, which should take just a few minutes. Let's start by your telling me more about feeling tired and your problem falling asleep, staying asleep, and waking up tired in the morning.

CHERRY: Well, I'm getting to bed at a pretty regular hour, but I toss and turn for a long time before I fall asleep. Then, I'll wake up during the night.

[The counselor explores Cherry's sleeping patterns and habits.]

COUNSELOR: You have to get up at 5:00 a.m., so that would be 6 hours of sleep. Now, is that how much sleep you get?

CHERRY: *[Sighs.]* I guess that's how much I get because, I mean, I don't get the kids down to bed till 9:30 p.m. or so. And then I get a little bit of quiet time to myself, but I have to be at work at 7:00 a.m., so I've got to get the kids up and dressed and fed and out of the house. My mother takes them before they go on to school and day care, so I've got to get up at 5:00 a.m. to get them ready, and in truth that's not enough sleep for me. I guess I'm always working on not enough sleep. But this is something different. I mean, I do not want to get up in the morning. I can't get up in the morning. I can't do it.

COUNSELOR: So it's more than just not getting enough sleep. It's like it's hard for you to just get up in the morning. There's something about that that makes it hard.

CHERRY: Yeah.

COUNSELOR: Tell me about it. What is it like when you try to get up in the morning?

CHERRY: It just feels like, I wake up and all I want to do is escape. I want to go back to sleep. I learned in group that sleep problems and fatigue are common in early recovery, but it seems more than that. The sleep is a safe place. And um, being awake is dangerous and horrible, and I wish I didn't have the kids and stuff. I don't mean I don't want my kids, I just mean that it's . . . I love my kids; they're my whole life really, but if I didn't have them, I could just stay in bed and sleep. I have to get up because I have my kids, but I don't . . . Well, what's been happening lately is I get up and get them out of there, and then I just go back to bed. I can't go to work.

COUNSELOR: Cherry, many of the drugs you have been taking have a depressive effect. That includes alcohol too. Have you ever considered that your drug use may play a role in your depressive symptoms?

CHERRY: No, I never even thought the two could be connected.



Master Clinician Note: Cherry is presenting classic depressive symptoms of lethargy, poor sleep, feeling overwhelmed, and hopelessness to change the situation. The impetus on the part of the counselor might be to immediately jump in and start giving advice and helpful suggestions. A better approach, adopted by the counselor in this case, is just to hear Cherry's concerns for a few minutes, make an effort to understand how she perceives her world, and develop some empathy for her dilemma. Once the relationship is strengthened and the counselor has a better understanding of why Cherry does what she does, then behavioral interventions can be initiated with Cherry as an active participant. Note that the counselor, so far, has focused primarily on steps 1 and 2 of the counseling process described in Figure 2.4, page 39).

COUNSELOR: This depressive effect is part of that unmanageability we speak of that comes with alcohol and drug dependence. So you go back to bed once you get the kids up and out of the house.

CHERRY: Yeah because it's . . . I can't keep going. I can get up just to get them out of the house, but the thought of having to go to work and get through a whole day, I can't . . . and so I've been missing more work. I'm using up all of my sick days. I'm calling in late. If I work really hard on getting myself out of bed, I can do it by 10:00 a.m., then work in the afternoon. But that's really hard.

COUNSELOR: So, tell me more about that. It sounds like there's been this kind of long-term problem with the sleep and being able to get up in the morning.

CHERRY: Yeah, I mean, I already told that intake worker about all that stuff, but just really quick so you'll understand, I've been . . . I was married for 12 years and then about 3 years ago we got divorced. And that was . . . I was really upset. He was running around on me. [Cherry briefly cries.]

CHERRY: When he left, I was torn up. It wasn't like we had all that great a marriage, on the one hand, but, on the other hand, he was . . . I had a difficult childhood, so when I found him, he was my way out of there—my way out of my parents' house. So when he left, that just like busted something.

COUNSELOR: Like the bottom fell out. It's sad losing a dream and someone who was your rescuer. There's a lot of pain when your spouse cheats on you. It seems like maybe you drifted away or gave up on relationships with people and sought relationships more with objects like alcohol and drugs. That seemed safer, especially when even your childhood relationships let you down. This can trap our pain leading to dependence and increased depression. More unmanageability.



Master Clinician Note: Cherry introduces another problem, her divorce and the feelings associated with it. The counselor adds it to the mental list she is creating for problems that will need to be addressed. She is also attempting to understand how all the problems Cherry has introduced are interrelated: the divorce, being a single parent, getting out of bed in the mornings, feeling overwhelmed, and getting to work. The counselor continues with steps 1 and 2 of the counseling process (Figure 2.4, page 39) and is also eliciting information to help begin formulating an intervention (steps 3 and 4).

A good intervention to use when people present with big and multiple problems is to help them learn problem-solving skills. Teaching clients to partialize their difficulties is an important step in problem-solving. Partializing helps people take big problems and break them down into smaller problems that can be addressed. In addition, partializing can help people differentiate problems that can be solved from problems that can't be solved: problems that have higher priority for being addressed, those that need to be addressed because they create or aggravate other difficulties, and those that require external resources to address versus ones that primarily require internal, personal resources.



How to Help People Achieve Behavioral Change: A Problem-Solving Technique

It is useful for a counselor to have a basic process for helping people achieve behavioral change. As the counselor and client work this process over and over, the client begins to incorporate the process into his or her behavioral change repertoire. One problem-solving process that works well for helping people achieve behavioral change is as follows:

1. **Identify a behavior** that can be addressed:
 - Keep it simple and achievable.
 - Break big problems down into smaller, achievable components.
 2. **Identify the goal** (outcome) the client would like to achieve:
 - Make the goal measurable so the client can know when he or she has achieved it.
 - Explore ways the client has achieved similar goals in the past.
 3. **Identify barriers** (internal and environmental) that might keep the client from achieving the goal. Frame the barriers in terms of something the client can control.
 4. **Identify how those barriers can be overcome** in specific behavioral terms. Make addressing the barrier something to do, rather than something not to do.
 5. **Identify supports needed** to achieve success and **specific steps** to achieve success.
 6. **Elicit a commitment** and take action to overcome roadblocks and achieve the goal.
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[Cherry continues to share information with the counselor on her marriage, her growing up, and her current dilemma of feeling overwhelmed. She also discusses feeling sad about losing her husband. The session continues.]

CHERRY: Yeah. And I guess I started drinking more. I don't know what to do. And this not getting out of bed stuff really scares me. Because if I lose that job, I mean, it's the best paying nurse's aide job around.

COUNSELOR: It's nice to see you making the connections between your drinking and how lost and depressed you felt. If you talk about this with people in your groups and in AA, you'll most likely see that feeling lost is something you share with other people who are dealing with dependence on alcohol and drugs.



Master Clinician Note: The counselor is starting to push Cherry out more and more into the recovery community to help develop relationships in the human world instead of the world of alcohol and drugs.

COUNSELOR: You mentioned that you do get out of bed to go to work some days, and you get out of bed to get the kids ready for school, and that you can get out of bed when it's time for them to come home. Is getting out of bed something you would like to work on this morning?

CHERRY: Yeah, that would be okay.

COUNSELOR: How do you get yourself out of bed at those times?



Master Clinician Note: First, the counselor gets Cherry's agreement to work on a behavior change, thus underscoring the relationship is collaborative. The counselor is now beginning the behavioral intervention, helping Cherry mobilize in the mornings. The counselor's first task is to have Cherry explore what has worked for her in the past.

CHERRY: [Pauses.] Because I have to . . . the same way how I get to work sometimes. Because I have to do it.

COUNSELOR: You're kind of beating yourself over the head and saying, "I've got to do this."



Master Clinician Note: The counselor is interested in the internal dialog that goes on in Cherry's head that limits her in taking action on the problem.

CHERRY: I prepare for it all the day long when I'm awake but can't go to work. If I'm not sleeping and I'm awake, I pressure myself all day long that I have to get up, and my stomach gets tied in knots.

COUNSELOR: That sounds awful.

CHERRY: And I push, and I push, and some days, it's like I have to get up for the kids, but I don't have to get up for work the same way.

COUNSELOR: But it sounds like that's a really high priority for you, getting to work.

CHERRY: It is. I need the job.

[The counselor then works with Cherry to help her see how to break getting to work into smaller steps that she can accomplish. The counselor does this by looking at each behavior in which Cherry engages between the time she wakes up and the time she arrives at work. Cherry reveals that she can get up if she has something to look forward to, like not going to work.]

COUNSELOR: So, as long as you're looking forward to something that feels like it's going to take the pressure off, then you can kind of white-knuckle it through what you have to do.

CHERRY: Yeah, as long as I know I don't have to go to work, then I can get through the rest of what I need to do for the day.

COUNSELOR: Is there something about the job that makes it especially difficult for you?

CHERRY: You know, once I get to work, I actually sort of like it. I like taking care of the people, and my only adult friends in the world are on that job. So when I get to the job, I'm really okay—I don't know, it seems, like totally irrational that I've got this connection to this job. The people are nice to me, while I've been like this; they've been covering for me.

COUNSELOR: So it's not that something happens at work that makes you not want to go there. It's something about getting from the house to work. Have you noticed if it might be tied to morning hangovers? Where do you start running into trouble there?

CHERRY: It's that feeling, it's that anxious feeling. It hits me when I wake up. Yes, it was tied to hangovers—it was worse back when I was drinking—but it's still there now that I'm not drinking or using the pills. Then, after the kids leave, I feel the same thing. And my only escape is to go back to bed.

COUNSELOR: Okay. So, one issue in terms of getting you to work would be how we can help you not end up back in bed. How can we help you do something else, instead? *[Pauses.]* Maybe we could come up with something that you could do right after the kids leave the house that wouldn't be consistent with going to bed, that wouldn't make that so easy for you. You've got about 40 minutes to get ready for work. How long does it take you to get ready for work—take a shower, do your hair?



Master Clinician Note: The counselor is searching for ways for Cherry to get motivated in the mornings. She's careful to use the information given by Cherry, not just take what would work for her and apply that to Cherry. While seeking to understand Cherry, the counselor also gets her to refocus on behaviors she routinely does. An important principle of behavior therapy is to emphasize behavior you "do" want rather than focus only on what you "don't" want.

CHERRY: It seems like about 30 minutes. I think I have it down to a fine science. I mean, maybe there's 10 minutes in there or something, of time. *[Pauses.]* You know, I remember I used to go out on the back porch in the morning with a cup of coffee—just spend a few minutes with nature. I can remember in the spring when it was buds and all green. The flowers would come up and I'd go on the back porch with my coffee and just sit there for a few minutes, and it was so quiet and I could listen to the birds, you know, without the kids and stuff. That used to be a time of the day I really enjoyed. It was a nice way to sort of get going. *[Pauses.]* Yeah, I haven't done that in such a long time. I wonder why I don't do that.

COUNSELOR: Well, how would you feel about trying it out? It sounds like a nice way to start your day. Sounds a lot better than what you were talking about before—all that pressure. It just sounds like a nice break for you.

CHERRY: Yeah, it is. So you're saying instead of going back to bed, I should go to the back yard.

COUNSELOR: Yeah, instead of making a deal with yourself that you can go back to bed right after the kids go off to school, you could make a deal with yourself that you can go have your coffee in the garden, after the kids leave.

CHERRY: I could try that.

COUNSELOR: All right, well, let's see how that works. See if that helps you get your day off to a better start, since it sounds like if you can get it started, you can do it. May I make another suggestion? I'd also like to just suggest it might be a nice time to do your AA readings, just a thought. *[Counselor smiles at Cherry.]*



Master Clinician Note: The counselor is working to sum up the behavioral change (getting up and having a cup of coffee on the porch in the morning) and get a commitment from Cherry to actually undertake the change. Getting the client to engage in pleasant activities is a simple, yet effective, behavioral strategy to help improve mood.

[While Cherry does not meet full criteria for major depression or dysthymia, she does present with enough depressive symptoms and impairment to justify having counseling sessions to help her with these symptoms.]

CHERRY: Okay.

COUNSELOR: So you'll try that until we meet next time. Before you leave, I want you to take a few minutes to complete this mood questionnaire. I'll then have you complete one each week. We can use this as one way to track changes in your mood symptoms over time.

[After having Cherry fill out the Center for Epidemiologic Studies Depression Scale (CES-D), the counselor asks if Cherry has any questions or concerns about the Scale, explains how the information from the Scale will be used in her treatment, and then wraps up the session. The counselor will continue to retest Cherry periodically with CES-D to measure changes in her depressive symptoms, take corrective action if changes aren't occurring, and show Cherry evidence of her improvement. Other programs might use other measures besides CES-D, but it is important to use some instrument to measure the changes that are taking place in recovery.]

It is also very important to ensure that scales and instruments used to screen or evaluate progress are culturally appropriate. The CES-D (Bardwell & Dimsdale, 2001; Cole Kawachi, Maller, & Berkman, 2000) and Beck Depression Inventory-II (Smith & Erford, 2001) have been evaluated for utility with specific racial and ethnic groups. Other depression screening instruments that are specific to certain cultures may be available. If a client is not fluent in English, it is important to have them screened in their primary language.

You should not simply note the total score on the CES-D or other instrument that measures depressive symptoms, but rather look at specific items in the scale and the reported changes that occur over time on the item. For instance, helpful discussions could follow reports that clients are sleeping better; feeling less sad, angry, or lonely; or are more contented. You can process specific changes and their meaning with the client, who is more likely to understand these changes than to understand the meaning of a numerical score. See the discussion of issues in screening and assessment in Chapter 4 of TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005b).

Session summary: Following the session, the counselor takes a few minutes to reflect on her expectations at the beginning of the session and the goals she and Cherry established during the session. She notes how the expectations and goals were addressed and considers what she might want to address in the next session with Cherry. Some of her expectations, such as building and maintaining a therapeutic relationship, will be ongoing throughout the treatment effort with Cherry. Some of the goals she and Cherry decided on, such as monitoring the impact of her depressive symptoms, will also be ongoing. The counselor will continue to monitor Cherry's master treatment plan to ensure that their work continues to be focused on treatment goals established by the treatment team and Cherry.

Finally, the counselor is careful to record the goals, methods, and accomplishments of the session in Cherry's treatment record. The chart, or master record of all treatment efforts for Cherry, allows appropriate staff to review the variety of treatment efforts undertaken, their goals, and Cherry's response.

SESSION 2

Clinician Expectations

The counselor begins Session 2 with the following expectations in mind:

1. Check Cherry's progress with identified goals and homework and affirm her efforts to address identified goals.
2. Work with Cherry to identify goals important to her for this session.
3. Continue to build the therapeutic relationship.
4. Continue to focus on behavioral changes to reduce depressive symptoms.

[The counselor has Cherry complete the CES-D before the session begins and quickly scores it.]

COUNSELOR: Hi, Cherry, how are you?

CHERRY: Um . . . doing somewhat better.

COUNSELOR: Yeah? Before we talk about what's been going on the past week, let's review your questionnaire. Last week, you scored 25, which is in the moderate range. This week, you scored 21, which shows some improvement. This is a good start. What's been going on the past week?



Master Clinician Note: Early in the session, it is useful to check on the progress the client has made in achieving the goals set in the last session. The counselor then has Cherry describe what she did and how it worked.

CHERRY: I went to work on time.

COUNSELOR: Excellent! Tell me how you did that.

CHERRY: I did what we talked about. I made my coffee while the kids were still there, so after they left I grabbed a cup of coffee and I went out on the porch, and I just. . . it's a nice time of year, the fall, and all the colors and stuff, and so I just sat there, you know, for a little while. In fact, I read from my daily meditation book I got at that AA meeting you have me going to. It was nice. Now that was sort of hard because I didn't want to leave—I wanted to stay there, but I started out with the idea that it was something I would do for 10 minutes. So after 10 minutes I guess I didn't feel as anxious and as nervous, you know. But I don't know if it's going to keep working.

COUNSELOR: It's great that you are using the recovery tools to help yourself and your sobriety. It also seems to be that during that time you weren't feeling depressed. What's your concern that it won't keep working?

CHERRY: Well, as it gets colder, it's not going to be as nice to sit out there, for one thing, and then, right now, it's the novelty of the thing, you know—it's new. I haven't done this for a long time, but I don't know if it will keep working long term, 'cause that state I get in is pretty strong.

COUNSELOR: Cherry, it is nice that you're thinking about these things and how to keep these new feelings. You know that phrase you heard in your groups and meetings, "Fake it 'til you make it." It's a reminder to keep doing these new behaviors until they and the new feeling that come with them become routine. Again, I'm glad you're thinking ahead.



Master Clinician Note: A specific strategy for helping people who are depressed is for them to commit to undertaking behavioral routines that support feeling better, more hopeful, more engaged with life. The counselor begins working with Cherry to get her to incorporate routines that will help her stay up in the mornings and get the kids off to school.

COUNSELOR: The idea is to get up and do something and put one foot in front of the other and keep doing something. It helps you build the momentum to get out of the house. Routines help. Like you get to work and you know what to do, and you just go do it.

CHERRY: Yeah, there's no choice there.

COUNSELOR: Right. And so at home, you could make this a part of your routine, and so you naturally get up, you take care of the kids, you go have your coffee and enjoy the back yard, and then you get ready for work and you go to work. And it may be that that small addition of time for yourself, that time to just do something that feels good to you helps you maintain that momentum to get on with your day, to do what you need to do.

[Discussion ensues about other things Cherry might do to help her get to work.]

CHERRY: But what's really bothering me is that I'm not taking care of the kids well, and so it's nice thinking about this stuff—walking and all that—that's nice, that's the stuff that I like, but what about my poor kids? They're being totally neglected here. They're getting cold cereal for breakfast and a bologna sandwich for supper, and probably the only decent food they get is at school. I can't *[sighs]* . . . I can't even do simple things. It's like, it's lucky that I get laundry done when they don't have any more clothes. But I can't. I used to cook for them, and I can't do that. And I need to do stuff for the kids. When they're taken care of, then I can take care of myself. I mean, a good parent takes care of her children; they don't let them get hurt. And I want to take care of them. That would bring me more pleasure than anything—to be able to be a good mother to them.



Master Clinician Note: It is important for the counselor to be aware of symptoms of child abuse or neglect and report relevant information to the appropriate authorities. At the same time, it is important to get the facts before acting and not simply act on the client's worries. It is imperative, if child abuse is suspected, that the counselor seek advice and support from his or her supervisor or other senior agency personnel and that it be reported to the appropriate governmental reporting agency.

COUNSELOR: Two things: First, remember your illness has resulted in your becoming less and less able to care for yourself and those you love. Second, I can tell that you are stepping more and more into your recovery because of your increasing desire to care for and nurture your children. It's clear you love your children a lot. Tell me about what you'd like to be doing differently for the kids.



Master Clinician Note: The counselor is exploring for a behavioral intervention based on Cherry's wishes to be a better parent. The counselor is also probing for information on possible child neglect.

CHERRY: I would like to keep the house the way I used to, so they would have a clean house. And I'd like to be able to do the laundry on a regular schedule instead of waiting until there's nothing left that anyone can wear, and then there's these huge piles that take forever to get done. And I'm mostly concerned about their food because I don't have the energy to be shopping, and I don't make them meals, so I just get stuff that they can put together themselves, and they're basically fending for themselves with the food. I get them cold cereal and sandwich stuff and that's what they eat. They don't ever get a nutritional meal, not that I have a #*%! of a lot of money to be buying fruits and vegetables and stuff anyhow, but...



Master Clinician Note: Low motivation to fulfill usual daily obligations and low energy are common when a person is depressed. Cherry has presented several concerns about parenting (keeping a clean house, doing laundry, and preparing meals) that may reflect her low motivation and low energy. The counselor selects one for them to work on. Sometimes, getting a client active in completing a behavior will precede an improved mood.

COUNSELOR: You would like to get back some of things you lost to your addiction and depression—nice. You'd like to make them a hot meal.

CHERRY: Yes.

COUNSELOR: Tell me what happens now when you think about that—wanting to cook for them.

CHERRY: [*Pauses.*] I can't. I can't do it. [*Pauses.*] Well, what do you think I should do?

COUNSELOR: Well, I'm wondering when you think about what it would take for you to cook for them, what is it that you're thinking about? What are the steps that you're thinking about?



Master Clinician Note: The counselor doesn't give Cherry the answer to her question but, rather, encourages Cherry to explore her own steps.

CHERRY: I'm so...well...what steps? I mean, I can't even...I don't have the food there to do anything with.

COUNSELOR: So the first thing is that you would need to get something from the grocery store, right?

CHERRY: Yup.

COUNSELOR: And then what?

[*The counselor starts writing a list: grocery shopping.*]

CHERRY: Well, then the kids have to be . . . the kids want their food right away when they get home, and that's right away when I get home. So it just doesn't all fit in there. If I think about it, God, I don't want to cook. I want to sit down. I want to . . .

COUNSELOR: You start to feel overwhelmed, and you start to feel like you don't have enough energy to do that.



Master Clinician Note: The counselor is actively listening. The skill of listening is more difficult than it appears. Some counselors learn it easily, and others learn it one step at a time. All counselors improve their listening ability by responding to what their clients are saying with a statement that reflects what they think the client means and observing the way their clients respond to it. The more anxious a counselor is (e.g., concern about the client or concern about his or her ability to help the client), the more likely the counselor is to stop listening and start using less effective techniques like persuasion or confrontation.

CHERRY: Yeah, and then besides that, then you cook it, well you gotta set the table, and then you gotta do the dishes, I mean there's a whole . . . right?

COUNSELOR: Yup.

CHERRY: So then, you're 2 or 2½ hours into the night doing all that. Then the kids need stuff for their homework.

COUNSELOR: Mm-hmm. So again, I see the pressure building up there, and you're feeling really overwhelmed. I'm wondering if we can't look at this list [of steps involved in making a meal] and make it into something more manageable.



Master Clinician Note: Here the counselor is using the technique of partializing, in which a complex task is broken into smaller, more manageable steps that the client is more likely to be able to achieve.

[The counselor breaks down the list, making a simple shopping list of fresh items that can be used as snacks and easily prepared by the kids.]



Master Clinician Note: The counselor begins to make suggestions for what food Cherry should buy. This works with Cherry, this time. Often, however, this takes the responsibility for change away from the client and places it on the counselor. In addition, a client with a lot of negativity will begin to focus on why whatever the counselor suggests won't work rather than focus on the positive of what would work.

CHERRY: Well. [Pauses.] I guess we could get apples.

COUNSELOR: So it makes sense to you maybe to get stuff that is easy for them, that's easy to prepare anyway.

CHERRY: Things they can make without me, so I don't have to do it. You say, make them a snack, get some fruit and let all of us snack on some fruit?

COUNSELOR: Uh-huh. And, then when you think about what you'd like to prepare for them, what kind of food . . . when you think about what a supper would be, what do you think of?

CHERRY: I just... [Exasperatedly sighs.] It's just so much more manageable to eat potato chips out of a bag or something. I just . . . cooking—it's beyond me.

COUNSELOR: There it is happening again, as you start to think about it, you start to feel overwhelmed.

CHERRY: Mm-hmm. I feel overwhelmed all the time.



Master Clinician Note: The counselor chooses to stay with problem-solving and behavioral change rather than shift into work on the feeling of being overwhelmed.

COUNSELOR: Yeah, and so what we are trying to do is to make things simpler, so you can do some simple things to get yourself rolling.

CHERRY: So you are saying it would be okay to do simple things, like a simple meal. I don't need to think of something fancy, just keep it simple; make a simple meal. Like they say in my AA meetings, KISS—Keep It Simple, Sweetheart.

COUNSELOR: Yes. So, we need to make a plan that includes simple meals, right? You could do the same meals every week, so your shopping list doesn't change until you are feeling better and you want to start doing some more stuff.

[The counselor facilitates Cherry in designing menus.]



Master Clinician Note: The therapeutic alliance builds as the counselor supports Cherry and goes into detail about menus, foods, and the like.

[Cherry and the counselor arrive at an agreement about frequency and timing of cooking meals.]



Master Clinician Note: An important component of behavior change is making a commitment to act on a plan. Observe how the counselor gets Cherry to make a commitment to act on cooking meals and then sum up what they've focused on this session.

COUNSELOR: Great. Now, tell me again what you are going to do.

CHERRY: I'm going to buy the food tomorrow afternoon after work. I'm going to fix a meal three nights this week, and next. I'm going to have some fruit in the house for the kids to eat when they get home. Yes, I can do that.

COUNSELOR: Okay, well that's great. So I'll see you on Monday.

Session summary: Following the session, the counselor again reviews her expectations for the session and finds that her expectations were met, particularly in terms of developing behavioral strategies with Cherry to lessen her depressive symptoms. She also was careful during the session to elicit Cherry's goals for what she would like to accomplish and what she thought was practical and achievable. Finally, the counselor charts her observations of work toward goals in Cherry's client record.

SESSION 3

Clinician Expectations

The counselor begins Session 3 with the following expectations in mind:

1. Check Cherry's progress with identified goals and homework (e.g., cooking for her children) and affirm her efforts toward goal achievement.
2. Elicit Cherry's goals and expectations for the session.
3. Respond to Cherry's goals for the session with behavioral strategies (if appropriate).
4. Administer and score CES-D to monitor changes in depressive symptoms.

[The counselor has Cherry complete another CES-D depression scale, then briefly reviews and discusses it. The CES-D score this week is very similar to last week. This is a brief session in which Cherry raises the issue of headaches and the counselor helps her with relaxation techniques. Cherry also reports success with preparing food for her family.]

COUNSELOR: Hi, Cherry, welcome back.

CHERRY: Hi.

COUNSELOR: How's it going?

CHERRY: Well, I have a really bad headache.

COUNSELOR: Yeah? How long have you had the headache?



Master Clinician Note: Normally, a counselor might want to start a session by following up on the homework. But in this situation, Cherry has raised something that is important to her, and it would be inappropriate for the counselor to rigidly assert her own agenda. That said, it will still be important for the counselor to do the followup later in the session.

CHERRY: I get them a lot.

[The counselor and Cherry have an extended discussion about Cherry's headaches; when she has them, where they start in her head, how she deals with them. Cherry volunteers that she has consulted a doctor about them and that he has recommended that she needs to relax and feel less stress.]

COUNSELOR: Okay. *[Pauses.]* Well, I think there are some things we can do to help you with relaxing. We can work on that in a few minutes. But first, we haven't talked yet about your homework from last Thursday. You were going to continue to spend some time drinking your coffee and looking at your back yard, and you were going to try out that new shopping list we made.

CHERRY: The shopping list actually worked. I made dinner twice on the weekend.

COUNSELOR: You did! Great! What did you cook?

[Pleasant memories of Cherry's behavioral successes are shared with the counselor. Then, the counselor works with Cherry on some relaxation techniques, which are described in the How-To sections below. Cherry can use these relaxation techniques to help her fall asleep at night or during the day whenever she needs a break or is feeling overwhelmed.]



How to Conduct a Deep Breathing Relaxation Technique

Ask the client to tell you about anything he or she has done before to relax. Use the client's knowledge and prior experience with what works and doesn't work to tailor the exercise to his or her particular needs. Ask the client if he or she is familiar with relaxation exercises and if he or she would be willing to try the exercise with you in the session. If the client says yes, then take a few minutes before you begin to explain the exercise and to let the client know that he or she can stop at anytime if he or she feels uncomfortable for any reason. ***Please note that any form of relaxation exercise, guided meditation, or guided imagery can not only help clients relax, but may trigger unwanted or unintended reactions such as increased anxiety or, with clients who have a history of trauma, a dissociative reaction. It is very important that you have tried the exercise before you introduce it to your clients and have an understanding of how to manage unintended or unpleasant experiences that can arise.*** What follows is a script for a deep breathing relaxation exercise for a client who has stress-related symptoms, like Cherry's headaches. Please modify this script as noted. Read this out loud to your client during a session, using a soft, calm, slow voice. You can also give a written copy of the exercise to the client to practice at home or record it so your client can listen between sessions.

1. This will take about 10 minutes. Sit in a comfortable position with both feet on the floor or lie down. If your feet are on the floor, take a moment or two to notice that the bottoms of your feet are making contact with the floor, which is part of a structure that is sitting on the earth and that you are making contact with the earth. If you lie down, take a moment or two to feel your entire body being supported by the bed or couch or floor and make note of the fact that the structure you are in is sitting on the earth and you are being supported by the earth. [*This helps the client feel grounded if any uncomfortable feelings arise.*]
2. Close your eyes if you wish to; it is not necessary to close them. This will work just as well with your eyes open. If you keep your eyes open, soften your gaze. Allow all the tiny muscles in your face to relax.
3. Notice your breathing. Is it shallow? Is it quick? Focus your attention on taking slow, deep breaths. Notice as you inhale that your stomach rises and as you exhale your stomach falls and you become more relaxed. Focus on the sensation of your stomach rising and falling. Inhale slowly and deeply and let your stomach rise with the breath. Exhale slowly and let your stomach fall and notice how you become more deeply relaxed. If you lose your focus or your mind wanders, gently return your attention to your breathing. Notice that you breathe in and breathe out. Just do this quietly for a little while, softly noticing that your stomach rises as you inhale and falls as you exhale. Relax into each exhale. Feel yourself getting more and more relaxed. Breathing in. (*Count to five silently.*) Breathing out. (*Count to five silently.*) You may hear things from outside or happening around you. Make note of them, then gently return your focus of attention back to your breath. Focus your attention on the physical sensation of relaxation in your body. Breathing in. (*Count to five silently.*) Breathing out. (*Count to five silently.*)
4. Notice whether there is any tension in your legs. As you exhale, notice that the tension melts away. Breathing in. (*Count to five silently.*) Breathing out. (*Count to five silently.*) Melting away the tension in your legs. Breathing in. (*Count to five silently.*) Breathing out. (*Count to five silently.*)
5. Repeat Step 4 for the following body parts: hips, back, arms, chest and shoulders, neck, jaw, cheeks, and forehead.
6. Now take a slightly deeper breath. Begin to get ready to open your eyes and become aware of what is going on around you. You don't have to do it right now; simply get ready to do it.
7. Notice how calm and relaxed you feel. Notice if there is an area of your body that feels particularly relaxed or if there is simply a general sense of relaxation. I invite you to bring this felt sense of relaxation with you as you become more aware of what is going on around you. Okay, begin to become more aware, still feeling calm and relaxed. Okay, your eyes are open and you are aware of what is going on around you and you are calm and relaxed.

After conducting this exercise with the client, make sure you spend several minutes debriefing the client. Pay particular attention to what was helpful in enhancing the client's sense of relaxation and if there were moments when the client felt uncomfortable or the anxiety or tension increased. Let the client know

that this is very common and that it simply means that the exercise needs to be adjusted. Work collaboratively with the client to make those modifications. Clients often feel that they haven't done the exercise correctly if they feel uncomfortable or have a hard time concentrating. Let your client know that there is no right or wrong way to do the exercise and that with practice they will find what works for them.

For additional information on relaxation techniques, consult *Stress Relief and Relaxation Techniques*, by J. Lazarus (2000) or *The Stress Management Handbook*, by L. A. Leyden-Rubenstein (1999).

Another technique that may be helpful for stress management and relaxation is guided imagery. While progressive relaxation and imagery have many similarities, they differ in that relaxation focuses more on releasing tension in the body while guided imagery focuses more on visualizing pleasant scenes that invite relaxation and calmness. Guided imagery can be useful in achieving other ends, such as building positive affirming thoughts, increasing awareness of underlying thoughts or feelings, and enhancing motivation, but in Cherry's case, the primary goal is to reduce the feeling of being stressed and overwhelmed.



How To Conduct Guided Imagery Relaxation Technique

Ask the client to tell you about anything he or she has done before to relax. Use the client's knowledge and prior experience with what works and doesn't work to tailor the exercise to his or her particular needs. Ask the client if he or she is familiar with guided imagery and if he or she would be willing to try the exercise with you in the session. If the client says yes, then take a few minutes before you begin to explain the exercise and ***let the client know that he or she can stop at anytime if they feel uncomfortable for any reason.*** It is not uncommon for clients to become tearful during this type of exercise, and this is not necessarily a problem. ***Please note, however, that any form of relaxation exercise, guided meditation, or guided imagery can not only help clients relax but may trigger unwanted or unintended reactions such as increased anxiety or other powerful emotions. For clients with a history of psychological trauma, clients who have a psychological trauma diagnosis, or clients who have been diagnosed with a dissociative disorder or other psychiatric illness, special cautions should be taken. Any unusual reactions should be discussed with the client and reported to your clinical supervisor. It is very important to have tried the exercise before you introduce it.*** What follows is a script for a guided imagery relaxation exercise for a client who has stress-related symptoms, like Cherry's headaches. Please modify this script as necessary. Read this out loud to your client during a session, using a soft, calm, slow voice. You can also give a written copy of the exercise to the client to practice at home or record it so your client can listen between sessions. You might want to discuss in detail how the client might use such relaxation techniques independently.

1. This will take about 10 minutes. Sit in a comfortable position with both feet on the floor or lie down. If your feet are on the floor, take a moment or two to notice that the bottoms of your feet are making contact with the floor, which

is part of a structure that is sitting on the earth and that you are making contact with the earth. If you lie down, take a moment or two to feel your entire body being supported by the bed or couch or floor and make note of the fact that the structure you are in is sitting on the earth and you are being supported by the earth. *(This helps the client feel grounded if any uncomfortable feelings arise.)*

2. Close your eyes if you wish to; it's not necessary to close them. This will work just as well with your eyes open. If you keep your eyes open soften your gaze. Allow all the tiny muscles in your face to relax.
3. Imagine a place you like to be . . . a place where you feel peaceful, calm, relaxed, or quiet. It doesn't have to be a real place; it could be a place that you create for yourself right now. Some people imagine sitting on a beach, listening to the ocean, smelling the salt air, hearing the seagulls. Others imagine being in a mossy green forest with tall trees and birds singing and the smell of wildflowers. Still others imagine sitting on top of a mountain looking out over a valley that goes on forever and noticing the blue of the mountains in the distance and the solitude and peacefulness of the mountain top and the feel of a cool breeze and the smell of the fresh mountain air. Trust whatever image arises in your awareness.
4. Now, imagine yourself in this place. Look around. Notice whatever sights, sounds, smells, or sensations arise in your awareness. Choose a comfortable spot on the earth to sit or lie down. Perhaps it is a soft bed of moss or a hollow in a white sand beach that molds to your shape. Allow your body to relax. Notice how the earth feels beneath you. Allow your body to relax as the earth supports your body. No need to hold yourself up. Look around you at the colors and shapes in your vision. Notice how you feel as you look at each one. Inhale and notice the smells. Listen to the sounds around you. Let yourself relax into the peaceful solitude of this quiet place. *(Give the client some time to enjoy this space.)*
5. Feel how peaceful and calm you are. Notice something about where you are that you will bring back with you to help you become calm. It may be the feel of the sun on your face, or the smell of the salt air, or the colors of your surroundings, or the way it sounds where you are, or a small object, such as a shell or round stone or a flower petal. Notice whatever that is and bring it back with you. Take a deep breath and release the breath on the exhale.
6. Slowly open your eyes and stretch. Remember what you brought back with you from your quiet place. Bring this image to mind and you can return to your peaceful, calm, quiet space whenever you want to relax.

After conducting this exercise with the client, make sure you spend several minutes debriefing the client. Pay particular attention to what was helpful in enhancing the client's sense of relaxation and if there were moments when the client felt uncomfortable or the anxiety or tension increased. Let the client know that this is very common and that it simply means that the exercise needs to be adjusted. Work collaboratively with the client to make those modifications. Also, clients often feel that they haven't done the exercise correctly if they feel uncomfortable or have a hard time concentrating. Let your clients know that there is

no right or wrong way to do the exercise and with practice they will find what works for them. Pay particular attention to whatever your clients bring back with them from their quiet place. Spend time exploring this sensation, image, or feeling. This image can be a touchstone or anchor that clients can remember whenever they need to relax.

Summary

The work between Cherry and her counselor has been largely behaviorally focused. The treatment goals have been to help a woman with depressive symptoms be able to mobilize to take care of some basic needs: caring for her children, obtaining medical care, staying in treatment, and beginning to engage with other adults. The counselor has been able to introduce a specific behavioral strategy (relaxation) and positively affirmed her efforts to take some time for herself for self-support. The behaviorally oriented treatment with Cherry is not the end in itself, just the first step in a process of change that will include abstinence from alcohol and benzodiazepines; reduction of depression symptoms; and an increase in self-confidence, competence, and self-esteem.

Vignette 2—Cognitive Interventions

Introduction

Managing negative or faulty thinking is a method commonly used in substance abuse treatment when a client's pattern of negative thinking activates patterns of self-defeating behaviors. The underlying theory of cognitive therapies is that a person changes his or her feelings and behavior by changing how they think about themselves and their experiences. The rationale for this approach is that changing negative or faulty thoughts about triggering events and substituting more positive and healthy responses reduce the risk of unhealthy behaviors and increase the opportunity for more productive behavior choices.

Cognitive therapy techniques are based on the premise that how you interpret your experiences in life determines the way you feel and behave. The patterns of thought typical of people who are experiencing depressive symptoms include negative thoughts about self (e.g., worthlessness), negative thoughts about the world (e.g., negative interpretation of experiences), and negative thoughts about the future (e.g., expectation of failure). This negative thinking is often inaccurate and contributes to increased feelings of depression and less functional behaviors. Replacing inaccurate, negative self-talk with accurate and more positive assessments of the situation results in decreased distress in response to the situation and leads to improved mood and behavioral choices. In addition, many clients with substance use disorders have not learned to cope well with powerful feelings, such as shame, guilt, loneliness, or anger. It may prove helpful to focus on feelings in treatment as well as thinking about behavior and events.

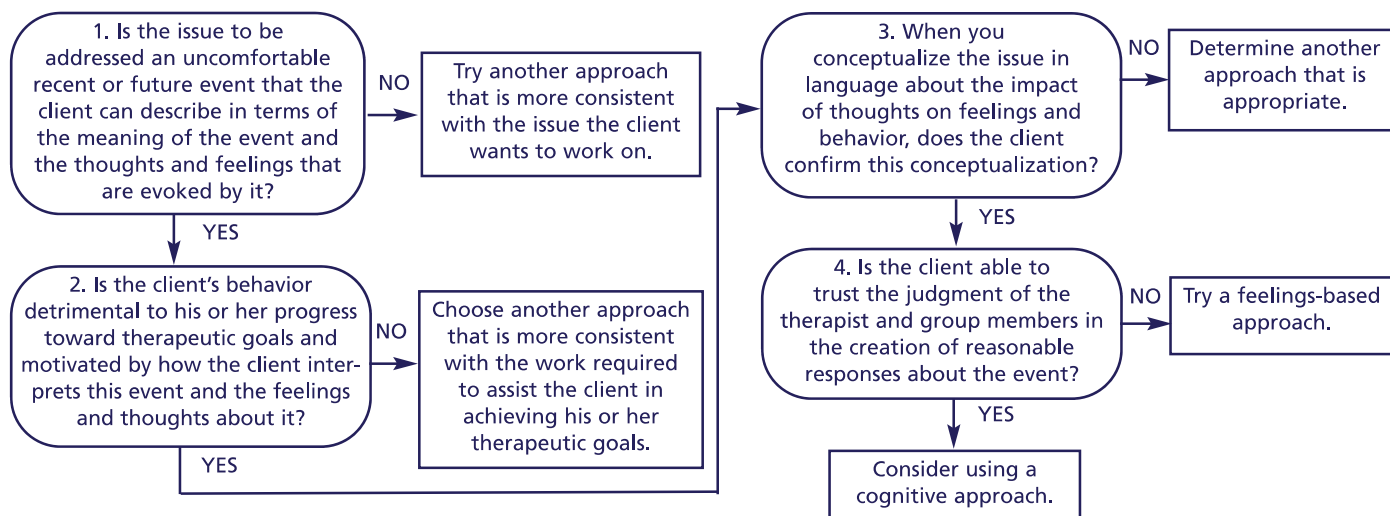
A cognitive treatment approach focuses on current problems and experiences and is designed to help clients identify and correct distorted thought patterns that can lead to feelings and behaviors that are troublesome. It is particularly helpful for clients who experience helplessness and hopelessness. (See Figure 2.5 for how to determine whether a cognitive treatment approach is appropriate for a client.)

Case History

John is a junior in college. He is a voluntary admission at a residential college-based treatment program. John reports that he was doing all right until his girlfriend broke up with him at the beginning of the semester. At about the same time he started having difficulty in physics and statistics, two classes he had been “dreading.”



Figure 2.5
Decision Tree
How to Determine Whether a Cognitive Treatment Approach Is Appropriate



He reports that as his stress increased, he started spending more time by himself instead of socializing with his friends. John said that before the breakup he drank alcohol and smoked pot with his friends on the weekends, but it did not affect his ability to attend classes or perform in his part-time job. After the breakup, his drinking and pot use increased to the extent that he uses both alcohol and marijuana daily. When he failed his midterms in the physics and statistics courses, out of fear that he might flunk out of school, he went to the college counseling office. The counselor did a comprehensive assessment of John's alcohol use and depression and recommended that he enter a residential treatment program operated by the college. The program allows John to continue classes while participating in an intensive substance abuse treatment program. In her note to the treatment program, the counselor noted that she thought it would be difficult for John to address both problems on an outpatient basis because of his inability to abstain from alcohol and drug use.

Depressive History and Current Status

John has been in residential treatment for substance dependence for 7 days and has been frustrating other people in his group with his negativity, poor social skills, and lack of connection with other group members. The group counselor noticed that John was irritable, complained of being depressed, and felt hopeless. John reported in group that he was having thoughts that he was not measuring up to others; was not able to make it in school, with others, or with sobriety; and was different from others. The group leader recommended that in addition to group, John be placed in individual therapy. There is no prior diagnosis of clinical depression or any history of treatment for depression or prior depressive symptoms in John's records.

Substance Abuse History and Current Status

John has been drinking since his junior year in high school where he once received a 3-day suspension from school for being intoxicated at a school function. He was primarily a weekend user, but at times he would smoke pot on lunch break with friends. Since entering college 3 years ago, he drinks to the point of having blackouts on occasion—more frequently as of late. Since the breakup with his girlfriend, John's drinking and pot use is daily, and he often drinks to the point of passing out. John reports "trying to get it under control" but of late he has not been able to stop when he knows he should. John quit his part-time job because it was creating a conflict with his drinking. John's grades have been suffering as his pot and alcohol use have increased.

SESSION 1

Clinician Expectations

The counselor begins Session 1 with the following expectations in mind:

1. Build a therapeutic relationship by developing an understanding of John's problems from his perspective. This includes his motivation for treatment and his perception of and experience with his situation.
2. Ask John about his goals for the session.
3. Identify specific changes he would like to achieve to support abstinence from marijuana and alcohol use and reduce depressive symptoms.
4. Identify internal strengths and resources John might use to achieve his goals.
5. Explore specific thoughts and beliefs that might help or hinder John in achieving his goals.

[After some initial time in rapport building, the vignette picks up with the counselor exploring John's depressive symptoms and their relation to his drug and alcohol use.]



Master Clinician Note: People who experience depressive symptoms do not always present as sad. Some present as more anxious, others irritable, still others with somatic complaints. Most show a mixture of the above. Untreated depressive symptoms can contribute to a relapse.

COUNSELOR: Your group counselor mentioned that, on the list you made in group about how you think about yourself, you noted that you are not measuring up to others and not able to make it in school, people don't want to be friends with you, and that you can't do anything right. I think those kinds of issues would feed into both your drinking and smoking pot and your feeling depressed.

JOHN: Yeah, I think about those things all the time now. I'm pretty down. The only thing that makes me feel better is drinking and smoking pot. And my parents are going to kill me!

COUNSELOR: So, it sounds like two issues there. First, feeling really down and using alcohol and pot to deal with it, and second that your parents are going to be really angry at you.

JOHN: I'm here. I guess it beats flunking out of school. I can see that maybe I was drinking and smoking pot more than I should, but I don't know that I need to be in this kind of program. I have enough problems without having to deal with this.

COUNSELOR: So this is aggravating for you—having to be in a program for your alcohol and pot use.

JOHN: I would like to think I could quit on my own.

COUNSELOR: So the first two things that come to mind are that you don't know how to manage things with your parents and when you think about spending time here dealing with all of these things, you start to worry about catching up with your work at school.

JOHN: I don't think I can do any of it.

COUNSELOR: John, let's take things one step at a time. You've mentioned feeling down and how that is a load for you. You also say your parents are going to be angry at you, and that you are really frustrated with being in the program. Where would you like to start?



Master Clinician Note: In formulating a change approach, the counselor assesses that John's ways of thinking are a significant barrier to his ability to change and therefore decides to approach John from a cognitive, "change thinking" perspective. As a precursor to beginning to intervene, the counselor does several things:

1. She learns more about John's depressive symptoms, examining what being "down" means to John, how severe the symptoms are (in terms of limiting John's life and fostering his drug and alcohol use) and how long he has felt this way.
 2. She explores John's hopeless and helpless thinking, common features of depression, which, if unaddressed, can become significant barriers to change.
 3. The counselor recognizes that John needs to appreciate how much he increased his alcohol and drug use as a primary coping mechanism to handle the loss of his relationship with his girlfriend. John also needs to review the relationship and what role his alcohol and drug use played in ending it.
 4. The counselor purposefully takes a collaborative, empathic, and supportive stance with John, as opposed to a more authoritarian, directive stance. This tends to diffuse some of John's anger about his predicament and the people who are trying to help him. An example of how the counselor achieves this is in giving John choices rather than suggestions.
 5. She does some education with John about the process of changing behavior by changing his thinking. The counselor has prepared an informational sheet entitled "Changing Who We Are by Changing How We Think" and offers John a copy to read.
 6. Eventually the counselor would like John to clarify the relative values of alcohol and drugs, school success, and relationship satisfaction in his life and make some hard choices as to what will satisfy his core needs in the long run.
-

JOHN: My parents.

COUNSELOR: Tell me more about your concerns about talking to your parents about this.

JOHN: They always wanted me to go to school and become a doctor. This ruins everything. They are going to be furious with me and not speak to me anymore.

COUNSELOR: That sounds like you think that situation is hopeless and that your parents won't be able to understand what you want from school. Have they ever expressed concern about your use?

JOHN: They'll be really upset. Back in high school when I got suspended, they said they didn't want me to end up a drunk like my grandfather. They took away my car keys for months.

COUNSELOR: I'd like to talk with you about your expectations about how this situation will go with your parents. Is that okay with you? And your grandfather was an alcoholic?

JOHN: Yeah, it'd be okay to talk about that. My mother's father was the one who drank.



Master Clinician Note: Notice how the counselor is working with the depression and the substance abuse issues at the same time, gathering information as she goes along. This is one of the things that are special about counseling clients with depressive symptoms: that you must deal with both issues simultaneously.

COUNSELOR: Tell me how they have responded to other situations like this.

JOHN: Well, there were a couple of times in high school when I got in trouble. They didn't handle it well. They were mad and disappointed in me.

COUNSELOR: If you think that this situation is as bad, how do you think they'll react this time?

JOHN: They always wanted me to go to college, to be a doctor. They'll be upset, disappointed, angry.

COUNSELOR: And yet when you got drunk and in trouble in high school, it sounds like they got over it.

JOHN: Yeah, I guess they got over it. Time passed. They moved on.

COUNSELOR: Did you get over it?

JOHN: Yeah.

COUNSELOR: So they may be disappointed and angry at first, but it sounds like they will eventually move on. Telling them what happened may be unpleasant. They'll be angry and disappointed, but your earlier experience suggests that they will move on.

JOHN: Yeah, it will be unpleasant, but I guess it might not be as bad as I thought.

COUNSELOR: So what do you think about telling them?

JOHN: *[Pauses and reflects on this.]* Well, I'm thinking I probably should call them.



Master Clinician Note: It might be tempting to try to persuade John to call his parents and "face the music," but the counselor chooses not to do this because it would increase John's resistance in the session. The counselor knows that if John doesn't call his parents, the opportunity to talk about it again will come up in a later session.

The counselor is also sensitive to the cultural meanings of family and an individual's family roles. If John is from a racial or ethnic minority, it would be important for the counselor to explore specific cultural implications in John's bringing shame on his family by not measuring up to their expectations for college, of the relationship of his family role(s) to his substance abuse and depressive symptoms, and the implication of specific treatment methods (individual, group, or family counseling, for instance) to his specific culture.

[John and the counselor continue to work on how he will approach his parents, what he will say, and how he might respond to his parents' reactions.]

COUNSELOR: Sounds like you are ready to move on to the second problem. What's your understanding of why you were referred to this program?

JOHN: Haven't thought about that. I imagine I have to participate in whatever programs are part of this so that it looks meaningful to someone at school. I have to appear to be in recovery or interested in it or on the road. Meaning that I'm not going to drink or use pot anymore.

COUNSELOR: So somehow the people who wanted you to be here have to be reasonably sure you're not going to end up in the same situation that got you here.

JOHN: Yeah.

COUNSELOR: So tell me some more about the situation that led you to be here.

JOHN: You want me to tell you what I was doing before? After I started school I started drinking some, smoking, trying some other stuff now and then. But it didn't interfere with school. But somehow something different happened this year—something changed. I lost my girlfriend at the beginning of the year. Then I had to take a couple of really hard classes that I'd been putting off, and I wasn't doing well in those. I was having trouble concentrating, and I wasn't sleeping very well. I was lonely and missing my girlfriend. I didn't want to spend time with my friends, and they didn't want much to do with me either. So I guess I started drinking and smoking more than I had been. It got harder and harder, and I kept thinking that "this is futile, I should just quit. I'll never make it." I was cutting classes. It just seemed like stuff was getting worse and worse. And I live in the dorm, and the RA [resident assistant] caught me a few times when I was drunk; then he caught me one time smoking pot in the bathroom. So I'm here.

COUNSELOR: So you were having trouble concentrating, sleeping, missing your girlfriend, you stopped spending time with your friends, started using more, drinking more, and feeling like everything was hopeless.

JOHN: Yeah, like a self-fulfilling prophecy.

COUNSELOR: So it would be helpful for us to find ways for you to feel more hopeful, be able to concentrate on your work, spend more time with your friends, and stop using. Is that right?

JOHN: Yes. I don't understand why she left; that really hurt me.

COUNSELOR: That's also a question for you—what happened there? I'm curious. Did losing your girlfriend have anything to do with your use?

JOHN: I don't know. She drank too, and we would drink together, but she wouldn't smoke or do drugs with me. Her brother got in a car accident when he was high on drugs. She just told me she wanted to see other people. But no one is going to want to go out with me anyway.

COUNSELOR: And that's the hopelessness I heard you talking about here and in group: the sense that you won't be able to do it, there's nothing that will work for you.

JOHN: That's it. I have to and I can't.

COUNSELOR: So there's both—nothing is going to work for you, and you're not able to make it work.

JOHN: Right.



Master Clinician Note: When John came into the session, he did not trust the counselor to be helpful. When she focused on listening to John and understanding what was important from John's perspective, he started to feel less anxious and began to trust her. He is still skeptical about whether this will be helpful to him, but he is willing to see where this goes. John's anxiety and ambivalence about the therapeutic relationship is a natural part of the process. This is a good time for the counselor to educate him about depression and its symptoms, simi-

lar to the way substance abuse counselors educate clients about substance use disorders and treatment.

The counselor is also interested in John's "attribution style," which seems to perpetuate his feelings of helplessness. "Attribution style" refers to how people qualify or ascribe meaning of events in terms of their mindset. Depressed people tend to attribute the fact that bad things happen to them to some personal flaw or deficiency. They tend to look for negative experiences in their world and expect negative things to happen in the future. This outlook justifies basic depressive feelings of hopelessness, helplessness, and being trapped. The counselor would like John to begin to challenge the thinking, beliefs, and perceptions that are filtered through this negativity.

COUNSELOR: I wonder if I can tell you a little bit about the relationship between thoughts and feelings of hopelessness, trouble concentrating, sleeping, and difficulties with relationships and your alcohol and drug use.

JOHN: Okay.

COUNSELOR: I've noticed that you seem to think that all of this trouble is because you "can't do anything right."

JOHN: Yes, it's my fault. I screwed things up. I don't know what I did, but it's my fault with my girlfriend. I've screwed up my classes.

COUNSELOR: So that sounds pretty familiar to you. Another thing I heard you say is that "no one is going to want to go out" with you.

JOHN: Yeah.

COUNSELOR: And the third thing is that it doesn't seem to matter what the situation is; this is always going to be a problem. Does that sound familiar?

JOHN: It *does* happen; it keeps happening. Are you saying some of this negative thinking is tied to my drug use?

COUNSELOR: Maybe. These ways of thinking can cause unpleasant feelings like helplessness, sadness, and anger, and lead to having trouble sleeping, drinking, smoking pot, and trouble in relationships, and make drinking and smoking pot more attractive. If we look at what you are thinking and see if there are some changes you can make in your perception, then we can change how you feel and your choices about what you do about it. Does this make sense to you?

JOHN: I guess so.

COUNSELOR: Are you willing to try it out?

JOHN: Yeah, okay.



Master Clinician Note: The counselor seeks to obtain commitment from John to proceed with this approach. She doesn't just assume that he is ready or willing to proceed. People with depression will often not have the energy to take on tasks that require them to change. It is useful to first elicit their agreement to take on the task, then proceed with small steps that have a high potential for success and don't feel overwhelming.



How to Assess for Negative Self-Talk and Offer Alternative Responses

The goal of this technique is to increase clients' objectivity about their thoughts; to demonstrate the connection between negative self-talk, unpleasant emotions, and unproductive behavior; and to differentiate between unrealistic and realistic meanings of events. When using this technique, the focus is on a specific thought, even though others will arise. One variation on this is to have the client identify situations such as homework and use that in the following session. The steps are:

1. Identify the situations that make the client feel uncomfortable.
 2. For each uncomfortable situation, make a list of the uncomfortable feelings the client experienced after the situation.
 3. Ask the client to identify the first thought that comes to mind when he thinks of the uncomfortable situation and has the negative feelings. Proceed to identify other thoughts (cognitions) that often arise with this situation and feelings. It is not uncommon that a theme can be elicited from the thoughts.
 4. Identify how the thought(s) or theme limits the client's options in life.
 5. Help the client identify different ways of thinking about the situation and feelings that can lead to better options.
 6. Once the list of reasonable responses is completed, summarize it, go back through the list of feelings generated for that situation in Step 2, and discuss the decrease in intensity of each feeling for the new list of reasonable responses compared with the feelings related to the old, negative thoughts.
 7. Plan for continuing practice of this new skill.
-

COUNSELOR: What I'd like to do now is have you try out some real-world examples of how you think about things and how you feel about those things. I'd like you to start paying attention to these thoughts when you're not here so when you come back we can talk about them.

JOHN: Okay. I can pay attention to how I'm thinking when different things happen.

COUNSELOR: Yes, write down one or two things that came up throughout the day that affected you.

JOHN: Yeah, I can do that.

COUNSELOR: Terrific! I'll see you on Friday, and we can talk about how to identify negative self-talk and change it.

JOHN: Okay.

Session summary: The counselor takes a few minutes at the end of the session to evaluate her work with John and to make a note in John's chart about goals addressed. She is pleased with the efforts they have made to establish a working relationship and with John's willingness to pursue examining the relationship between his thoughts and his behavior.

SESSION 2

Clinician Expectations

The counselor begins Session 2 with the following expectations in mind:

1. Check John's homework, particularly recording his thoughts about everyday experiences and the connection between his thoughts and his feelings.
2. Affirm John's effort specific to his progress and/or homework, thereby building his self-efficacy.
3. Ask John about his goals for the session and collaborate to make the goals a part of the counseling session.
4. Continue to help John find the connections between his thoughts and his behavior.

[John does the homework. He finds that in some areas he actually does feel that he does okay. He finds that he enjoys this assignment because it's a way to vent. However, he writes down his thoughts but does not relate them to how he feels. He continues to be angry about being in treatment. At the beginning of the session, John describes various situations that have occurred during the week and his related thoughts.]

COUNSELOR: So, in the first situation, you went into the room and everyone was watching a show you weren't interested in and they were talking to each other but not to you. So your thought was that nobody wanted to talk to you.



Master Clinician Note: The counselor identifies the unpleasant situation and the meaning of this event for John.

JOHN: Those brain-dead people weren't interested in talking to me. And I'm not interested in talking to them either.

COUNSELOR: You sound kind of angry about that.



Master Clinician Note: The counselor identifies the unpleasant feelings connected to the event.

JOHN: I was #*%!.

COUNSELOR: Tell me more about being angry.

JOHN: I felt alone.



Master Clinician Note: The counselor identifies the negative self-talk that happened between the event and the feelings.

COUNSELOR: *[Makes a list.]* So it started out with "these people don't want to talk to me" and you felt angry and lonely and, it sounds like, kind of sad. And the thought that followed that was "And I don't want to talk to them either."

JOHN: Yeah.

COUNSELOR: What other negative thoughts did you have about the situation?

JOHN: They didn't talk to me because they don't like me.

COUNSELOR: So you are thinking that they're not talking to you because they don't like you. What else?

JOHN: That it is my fault because maybe I don't like them either. [*Pauses.*] And maybe they don't think I'm worth talking to.

COUNSELOR: You think maybe you're sending out signals that you don't want to talk to them.

JOHN: Maybe. I guess I'm not very nice to them.

COUNSELOR: So you interact with people in a way that holds them at a distance, keeps them apart from you.

JOHN: Yes, maybe.

COUNSELOR: [*Reads from the list.*] Okay, so the negative thoughts that you've identified about this situation are "they don't want to talk to me," "they think I am not worth their time." And then there is the thought that "they don't like me" and "I am not very nice to them." Is there anything else?

JOHN: That's all I can think of.



Master Clinician Note: The counselor is helping the client think of alternative responses.

COUNSELOR: Okay, this was a really good example. Before you entered the program, what behavior would have followed those thoughts and feelings? What would you have done?

JOHN: I'd go to my room and smoke a joint. [*Laughs.*]

COUNSELOR: [*Smiles.*] I'll bet you there have been a few times in here that you wish you could have gone to your room and smoked a joint.

JOHN: Yeah, especially after group.

COUNSELOR: I'm glad you brought this up because now we can talk about other ways to respond to the situation. Let's start with your first thought, "they don't want to talk to me." What are some other possible responses to the situation?

JOHN: They're watching TV?

COUNSELOR: [*Makes another list.*] Good! Maybe they're doing something else. They're watching TV. What other reasonable responses are there?

JOHN: Maybe if I talked to them first they would talk to me?

COUNSELOR: Yes, maybe if you made the first move, they would talk to you; that would give them permission to talk to you.

JOHN: [*Pauses to think about this.*] So you're saying they aren't talking to me because they think I don't want them to.

COUNSELOR: Is that a possibility? Often people with substance abuse problems send out "stay away from me" messages. You must be seeing others in here doing that.

JOHN: I guess so.

COUNSELOR: [*Refers to the list.*] So far, in response to the negative thought “they don’t want to talk to me” we have the following reasonable responses: “they’re watching TV,” “if I talked to them first they might talk to me,” and “they might not be talking to me because they think I don’t want them to.” Can you think of any other possible alternatives for this negative thought?

JOHN: No, I think that’s it.

COUNSELOR: Okay, let me ask you this: when you had the thought “they don’t want to talk to me” you felt worthless, angry, lonely, and sad. Thinking about the first reasonable response—“they are watching TV”—how do you feel?

JOHN: I think my feelings would still be hurt.

COUNSELOR: So your feelings would still be hurt. Do you feel worthless?

JOHN: No, kind of lonely.

COUNSELOR: Okay, so hurt and lonely, that sounds less distressing than angry, worthless, lonely, and sad, doesn’t it?

JOHN: Yes.

COUNSELOR: Let’s look at the next reasonable response, “if I talked to them first they might talk to me.” How do you feel about that?

JOHN: I don’t know if it’s true, if they really would talk to me, but I feel like it’s possible.

COUNSELOR: How does it compare to feeling worthless, angry, lonely, and sad when you think “they don’t want to talk to me”?

JOHN: It’s better; it’s like maybe if I did something different—but I don’t know that it would really work.

COUNSELOR: Well, if you want to test it out, you can. If you’d like to talk about it more next time, then we can do that. Do you think you understand how this works?

JOHN: Let me see. When I think something about myself that’s really negative, I should think about whether that makes sense. Maybe I can do that sometimes but not all the time. Sometimes I feel so bad I don’t think I can do that, but when I’m feeling a little better I can.

COUNSELOR: If you want to we can talk about other things you can try when you feel so bad you have trouble doing this. I’ll see you on Monday, but in the meantime how do you feel about working on coming up with alternative thoughts when situations come up?

JOHN: Not all the time. But, a couple of times? I can do that.

[*The counselor wraps up the session.*]

Summary

The work between John and his counselor in these two sessions has focused on managing negative thoughts and the relationship of the negative thoughts to his alcohol and drug use and his depressive symptoms. The counselor is aware that she was negligent in getting John’s agreement on the goals for the work in session 2 before initiating the work.

The treatment goals have been to reduce the client's experience of negative thoughts about himself, his environment, and his future, thereby decreasing his experience of hopelessness and helplessness. Changing his thoughts and feelings about negative events increases his options for healthier responses to future events. This process needs to be repeated numerous times to help John learn to use these skills independently. This thought-oriented treatment with John is not the ultimate goal in his treatment; it is the initial step in a process of change that will include abstinence from alcohol and marijuana, reduction of symptoms of depression, improved ability to communicate with others, and an increase in self-confidence, competence, and self-esteem.

Vignette 3—Interventions With Core Beliefs

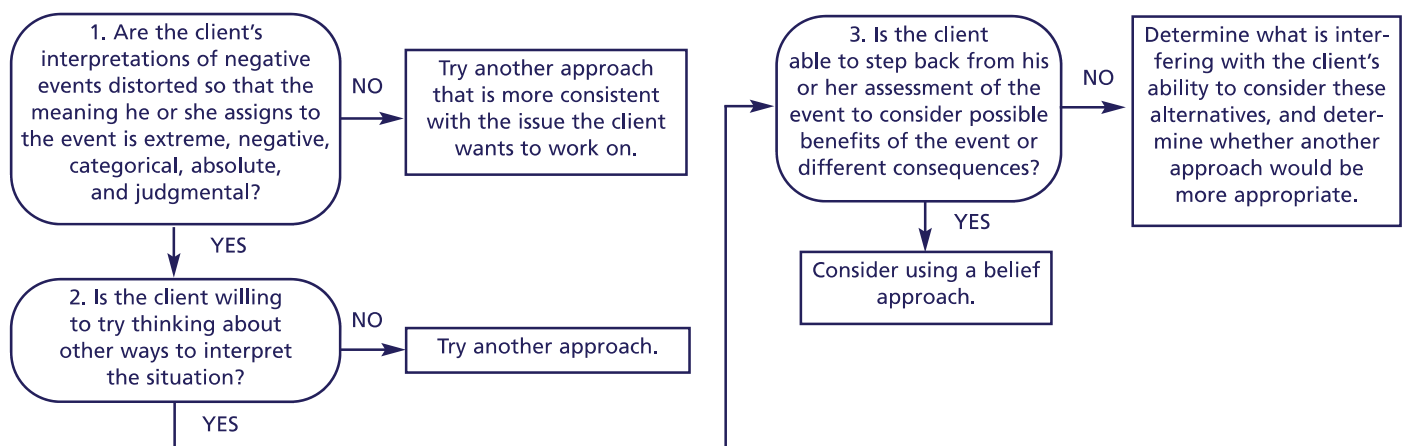
Introduction

Core beliefs are the filters a person uses to make sense of different experiences. People with depressive symptoms often have core beliefs that lead to negative perceptions of their environment and negative thoughts about themselves, their potency, and their future. These core beliefs may cause people to interpret experiences in negative and all-or-nothing ways and to view consequences as irreversible. Changing these core beliefs allows people to realistically assess their situations, decrease their distress and sadness, and improve their ability to respond to a situation with healthier behaviors.

Clients with depressive symptoms often have multiple core beliefs that affect these symptoms and their recovery from substance use. In this vignette, the client has many core beliefs, one of which is that if she stops driving her truck, her means for taking care of herself will be very limited. The counselor's challenge is to understand this and other core beliefs the client has and address them in a systematic and sensitive manner. (See Figure 2.6 for how to determine whether a belief approach is appropriate for a client; see also the How-To for how to assess for beliefs.)



Figure 2.6
Decision Tree
How to Determine Whether a Belief Approach Is Appropriate





How To Assess for Beliefs

1. Listen carefully to grasp the underlying meaning of what the client is saying.
 2. Elicit beliefs with such questions as “what makes you believe that?” or “how did you come by that belief?”
 3. When the client offers a description of an experience that sounds like an entrenched belief, paraphrase the statement, and ask the client to confirm if that statement is true. If the client replies in the negative, ask him or her to describe what *is* true for him or her.
 4. Explore the belief. (How long have you had the belief? How would your life be different if you did not believe this? How has holding this belief helped you in your life?)
 5. Who else believes this? Is this a family belief? Does the client see this as a belief that all people (or all people in a certain group) hold?
-

To find out about challenging beliefs, see *How to Challenge Beliefs* on page 70.

It is important to remember that a significant component of entrenched beliefs comes from cultural experience. Specific racial and ethnic groups hold beliefs that are rooted in their cultural experience and are completely valid in that context, although they may appear “dysfunctional” if one doesn’t understand the cultural context. A culturally competent counselor will recognize that questioning or challenging a belief has to be done in the context of understanding cultural underpinnings and must be undertaken in a respectful, sensitive, accepting, and open manner.

Case Study

Sally, 53, is an independent truck driver (“wildcatter”) from Marcelline, Missouri, who owns her own rig. She’s been driving a truck for 30 years. She started off riding with her husband, but after he died in an accident, she continued on her own. She’s addicted to Benzedrine, also called “West Coast turnarounds” or “bennies,” which she’s been using during long hauls. She’s been using the turnarounds for about 25 years and is finding that she needs to take a lot more as she gets older. She knows she has been taking more than is good for her.

She’s starting to question whether she should continue as a truck driver—her back hurts and she’s been having stomach pains. She has some money set aside, but retirement at this age would severely strain her financially. She is lonely. She has had sex partners and friends but nobody with whom she is truly intimate. Sally experienced intense stomach pain when she was passing through Biloxi, Mississippi. She went to the emergency room, and the staff there found out about the turnarounds and told her that she was going to kill herself taking that many bennies. They recommended that she enter a substance abuse treatment program, so she parked her rig in a lot and entered an inpatient treatment program. On intake at the treatment program, Sally acknowledged that she knew she was drug dependent and the doctor’s recommendation that she seek help was what she needed to let herself enter rehab.

Depression History and Current Status

Sally told the intake worker that she is tired and “blue.” The intake worker noted this and other depressive symptoms. Sally reported that she had lost weight, took a long time getting to sleep, and woke up in the middle of the night and could not go back to sleep. She said on many days, she felt life was just a struggle, and that she had periods of feeling hopeless and helpless, and often was irritable. Because of the depressive symptoms noted, her history of stimulant drug abuse, and her history of psychological trauma related to the death of her husband, the intake worker referred Sally to the consultant psychiatrist for assessment and possible medication. The psychiatrist’s report suggested that Sally did not meet the diagnostic criteria for dysthymia or a major depressive disorder. He did note that she had experienced a substance-induced mood disorder about a year ago and should be observed for another onset of this illness. He also noted that she had significant unresolved grief and deep-seated beliefs about hopelessness, and could potentially benefit from counseling focused on her depressive symptoms. Sally has been participating in a twice-weekly depression group that focuses on psychoeducation and building coping skills. She has attended 3 sessions since entering the program.

Substance Abuse History and Current Status

Sally drank a little in high school, but because her mother was a heavy drinker and she associated drinking with her mother, she stopped after she got drunk and made a fool of herself one night. She has drunk very little since that day. She started taking Benzedrine, also called “bennies,” after her husband Larry died in an accident and she had to support herself as a trucker. Sally has built up quite a tolerance and has been taking amounts that are now causing physical problems. Sally has known that she was dependent on the pills ever since she tried to quit a year ago. She went into a deep depression, during which she holed up in a hotel room for 3 days thinking about killing herself. She started using the Benzedrine again and was able to carry on with her life. As of late, Sally has been using over-the-counter sleep medication to help her sleep.

SESSION 1

Clinician Expectations

The counselor begins Session 1 with the following expectations in mind:

1. Build a therapeutic relationship by developing an understanding of the client’s problems from the client’s perspective.
2. Ask the client about her goals for the session and elicit her commitment to addressing the goals she identifies.
3. Explore specific beliefs to change to address the client’s goals, support abstinence from Benzedrine use, and reduce depressive symptoms.
4. Explore beliefs that Sally might have that will help or hinder her recovery from substance abuse and depressive symptoms.

[At the beginning of the session, the counselor and Sally exchange greetings, followed by preliminary interchanges aimed at establishing rapport and beginning engagement.]

COUNSELOR: So, what brings you to see me?

SALLY: I don’t know what I’m going to do when I get out of here. I don’t know what you can do for me. You don’t know anything about trucking. You don’t know about my life. You’re a nice guy, but I can’t see how you can help me.

COUNSELOR: I can understand that you have concerns about what will happen when you leave here. The reason I was asked to see you is that the staff were concerned about your depressed mood and wanted me to see if we can work together to improve how you feel.



Master Clinician Note: The counselor avoids responding to whether he can help Sally. Getting in a discussion of the counselor's skills and experience would probably be counterproductive. Rather, the counselor will let Sally reassess on her own whether he can be of help to her after a few visits. Sally is likely experiencing some ambivalence and the counselor is in the beginning stages of building a therapeutic alliance.

SALLY: Yeah, I don't know what I'll do when I leave here. I could go back to pouring coffee like I was doing when Larry [her deceased husband] found me. I could go back to where I started and die there like my mother did. That's not what I want to do.



How to Challenge Beliefs: The Search for Alternative Solutions

Our beliefs about the nature of our problems, who is responsible for them, what needs to be done about them, whether it is even worth the effort to try to change them, are all critically important to the counseling process. Here are five steps to help a client challenge beliefs that limit options for change:

1. Listen to the client's organization of the problem and identify the beliefs (cognitions) that are expressed about the problem.
2. Offer the client your understanding of the belief ("It sounds like you believe that . . ."); see if the client agrees or disagrees with that assessment.
- 3A. If the client disagrees with your assessment of the belief, then ask for a more accurate statement of what he or she believes.
- 3B. If the client agrees with your assessment of the belief, explore with the client how holding that belief affects the client's ability to address the problem.
- 3C. If the client agrees with your assessment, inquire if he or she would add or change anything about the way you phrased the belief (to be as specific as possible about the belief).
4. Help the client begin to move the belief from a *truth* (which cannot be changed) to a *thought* (which can be altered in light of additional information).
5. Help the client alter this belief to include better options for changing the problem.

See also *Anger Management: A Cognitive Behavioral Therapy Manual*, by Reilly & Shopshire, and *Substance Abuse Relapse Prevention for Older Adults: A Group Treatment Approach* (CSAT, 2005).

COUNSELOR: Well, then, let's go back to thinking about your future. Is there something else you can do in the trucking industry?



Master Clinician Note: This is the counselor's first attempt to define the problem arising from Sally's belief that if she can't drive a rig, she will have to return to waitressing (this is Step 1 in How to Challenge Beliefs, p. 70).

SALLY: I only know how to drive. I don't want to work as a dispatcher. I don't know what I'd do, I don't want to be depressed and pour coffee like my mother and sister.

COUNSELOR: Tell me about your mother and sister and what you mean when you say they were depressed. Did they take pills?

SALLY: They poured coffee at Hecklemeyer's. They worked hard all their lives and didn't make much money. Then my mother died. Mom didn't do drugs; that wasn't something their generation did. But I think she was alcoholic.

COUNSELOR: How do you know they were depressed?

SALLY: People are just born depressed, they're born blue.



Master Clinician Note: In the process of defining the problem, Sally has identified multiple beliefs: not driving the rig means having to be a waitress, which is intolerable; continuing to drive a truck is a way to avoid feeling helpless, hopeless, and depressed; and depression is just something people are born with and nothing can be done about it. All of these beliefs are examples of "all-or-nothing" thinking and contribute to Sally's feeling depressed and hopeless about the future. The counselor might be tempted to begin challenging these beliefs at this point, but the problem is not yet fully defined. The counselor's patience and curiosity about how Sally sees this problem allows both of them to develop a clearer sense of the problem and can lead to Sally's generating some solutions. The counselor is continuing to listen and trying to understand Sally, which furthers the development of a therapeutic relationship.

COUNSELOR: You believe that depression, being blue, is something you are born with and there is nothing that can be done about it. It sounds like the important people in your life growing up were depressed, and that came to look like a normal state.

[The counselor explores Sally's family history, the depressive symptoms of her mother and sister, how their depression manifested itself in day-to-day life and, particularly, how that affected Sally's understanding of depression and what it means to be depressed. The counselor takes a family drug history and finds out alcoholism and drug dependence are common in Sally's family.]

SALLY: My mother said she wasn't supposed to be happy. My sister, too. You know, I don't think they were ever not depressed. Even when my mother seemed happy she would say she had a terrible good time or an awful nice weekend. At least twice that I know of, she tried to kill herself by taking too many pills [*pause while Sally reflects*]. If I stop driving, I'd miss it, the road, the sounds, the smell, the diesel. It makes me sad to think about it, leaves me empty.



Master Clinician Note: Sally has changed the subject from her beliefs about depression to what would happen to her if she quit truck driving. The counselor, rather than being directive, just follows Sally and her line of thinking to see where it might lead.

COUNSELOR: So, driving the rig doesn't just mean making a living and not feeling blue. Driving the rig means a lot more to you, and giving that up is like losing a part of yourself.

SALLY: The semi is my life. The only thing I loved more was Larry.

COUNSELOR: How were you affected by Larry's death?



Master Clinician Note: Once again, Sally moves to another topic, and the counselor follows.

SALLY: [*Sighs.*] Twenty-five years this December, Jim. We were outside Denver in a snow storm. Stupid #*%! wanted to make up time, jackknifed the rig. Rig wasn't hurt bad, I wasn't hurt, but that stupid jerk was thrown from the cab and broke his neck. I was 25, a widow with a half-paid-for rig. [*Sighs.*] I got him buried, got the rig fixed up. I thought I'd finish the run and then sell the rig and move back to Missouri. I drove 1,000 miles and hit Salinas, and I thought the #*%! with it. I delivered the load, and I picked up artichokes for some supermarket chain and headed east. I was the youngest woman wildcatter in the country, and everyone knew it. Everyone knew when I was coming, and everyone wanted to talk to me on the CB [radio]. I did okay. I had some money. I didn't use the turnarounds with Larry. We just drove 4 or 5 hours at a time, trading off, and I didn't need the stuff. So how did I feel about Larry being gone? If he hadn't tried to make up the time, we'd still be driving together. I wouldn't have gotten on turnarounds, and I wouldn't be here, no way to pay my debts, no way to support myself anymore.



Master Clinician Note: This story is evidence of things Sally has been successful at in the past. The counselor could refer to this (e.g., "Tell me about how you managed to drive that rig after Larry's death") when the time comes (this is Step 2 in *How to Challenge Beliefs*, p. 70). She is proud of having been "the youngest female wildcatter" but sees this and her success as a trucker as a thing of the past. The counselor is currently working on Step 1 of *How to Challenge Beliefs*, defining the problem.

COUNSELOR: If Larry hadn't died, you would still be driving together and you wouldn't be in this place, believing that there are no other options for you. And you wouldn't be taking bennies to drive a little further.

SALLY: Yes, sometimes. I still look over sometimes when I'm driving because I think he's sitting there. The stupid jerk. Oh, there have been other guys. Then I'd see Larry's ghost sitting in the other seat, and I'd be good. [*Pauses.*] I don't see how you can help me.



Master Clinician Note: Sally might not really understand how the counseling process can help. (Refer back to the counseling process described in the introduction to Chapter 2.) Particularly in intensive treatment settings, where clients participate in a variety of treatment modalities and with a variety of counselors, understanding how the process works can be of great help to the client.

Sally's statement, "I don't see how you can help me," might be mistaken as resistance, as "you can't help me," but a better explanation in this instance might be that Sally is having a hard time imagining how things will work out. It is not clear yet how her husband's death fits into the picture.

COUNSELOR: That keeps coming up—what you could do instead of driving the rig. You seem to believe that I can't help you with that and that you can't do it on your own. That may be true, but I get the sense that you have some real strengths that you aren't aware of that could help you out of this. On the other hand, this conversation seems to be bringing up Larry's death and I'm wondering how that is related to your future.

SALLY: I'm not ready to talk about my future. I've never told anyone about Larry, that I sometimes see his ghost. Can we maybe talk about that more? I don't talk to people much, sometimes on the CB.



Master Clinician Note: Larry's death was a major psychological trauma in Sally's life. It is important for the counselor to recognize that how we experience and express our traumas is based significantly in our cultural orientation. In some cultures, emotional expression of tragedy is stoically withheld. In others, there is significant public emoting, demonstrating the significance of the loss. For other cultures, expression of trauma is a "family affair" and not for discussion with strangers. It is important for the counselor to recognize the cultural contexts of how trauma is expressed, to explore the meaning of the trauma in the context of the cultural orientation, and to help clients express their loss in a manner that is culturally acceptable to the client.

COUNSELOR: Sure. Why don't we meet again on Thursday and whatever you want to talk about we can talk about.

SALLY: Really?

COUNSELOR: Sometimes talking about those things can help you feel better about them.

SALLY: Really? We can talk about this stuff? Nobody has ever wanted to do that before.



Master Clinician Note: Sally's counselor recognizes several indicators that Sally might be at risk for suicide. She abuses drugs, she uses stimulant drugs, she has episodes of depressive symptoms, she feels alone and disconnected from family and significant others, and, earlier in the interview, she noted that her mother had been suicidal. In light of these indicators he feels it important and necessary to approach the subject with Sally and to screen her for suicide potential.

COUNSELOR: Sally, before we stop, there is one more thing I would just like to touch on with you. People sometimes have thoughts of harming themselves, of killing themselves. And I'm wondering if you are having those thoughts now or if you have had them in the past.

SALLY: There have been times over the last 25 years, especially when I'm alone, that I've thought about . . . you know . . . just ending it, just killing myself and being out of this #*%! rat race.

[Sally pauses. The counselor lets her reflect and organize what she wants to say without interrupting.]

SALLY: I don't feel that way right now, but it bothers me sometimes. When I'm driving and I start having those thoughts, I actually feel better, like I don't have to keep fighting this #*%!. Then, after a little while, the thoughts go away. Now, is that crazy or what?

COUNSELOR: No, it doesn't sound crazy to me, but it does sound like sometimes the pressure has been so great that you look for ways out of the pressure.

[The counselor proceeds to explore suicidal ideation with Sally. He conducts a careful screening (see TIP 42, Substance Abuse Treatment for Persons With Co-Occurring Disorders [CSAT 2005] for information on screening for suicidality) of Sally's current suicidal thoughts and decides to his satisfaction that Sally is not currently suicidal and that her suicidal ideation tends to occur when she is "coming down" from Benzedrine (a stimulant). The counselor also discusses with his supervisor the advisability of getting a consult from a mental health professional regarding Sally's suicidal ideation, and together they decide not to pursue a referral at this time. Sally does not meet the agency's guidelines for referral or additional assessment at this point, so the counselor and his supervisor plan to discuss Sally again in a week or at the first sign of any negative changes. The counselor does decide that in a subsequent meeting with Sally, he will provide more information on suicide and help her build skills to seek resources when those thoughts occur. For more information on assessing suicidality and safety screening (for harm to self or others), see TIP 42, Substance Abuse Treatment for Persons With Co-Occurring Disorders (CSAT, 2005) and the forthcoming TIP, Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment (CSAT, in development a).]

COUNSELOR: Sally, if you do begin having thoughts of harming yourself, thoughts that you might be better off dead, I would like to have an agreement with you that you will contact me, this program, or a mental health professional right away. Having thoughts of suicide doesn't mean you are going to do it. But it does mean that something needs to be addressed. Those are really disturbing thoughts, and I don't want to see you continue to struggle with things like that entirely on your own.

SALLY: Well, I'm not thinking about it now.

COUNSELOR: Okay. Will you be sure to let me know immediately if you have any thoughts and feelings like that?

SALLY: Okay, I can do that.

COUNSELOR: One more question. When Nancy said you should go into treatment, you just parked your rig and entered treatment. Was that the addicted, depressed you or the woman who was the youngest woman wild-catter in the country?

SALLY: I get your point! See you later.



Master Clinician Note: It's important for substance abuse treatment programs to screen clients for suicidality as part of the intake process. All substance abuse treatment counselors should know how to conduct a basic screening and triage. You should know what immediate resources are available both onsite and offsite to help someone who is identified as suicidal.

Session summary: Before the session, the counselor reviewed a CES-D Scale administered at intake. Because this was their first session, he decided to forego readministering the scale today but will use it again in the next session. In this session, the counselor was quickly able to establish a working rapport with Sally and engage her in exploring the relationship between the beliefs that arose from her history and her current stimulant use and depressive symptoms. The counselor also carefully screened Sally for suicidal ideation and consulted with his supervisor about possible interventions that might be indicated for suicidality. He documented the screening in Sally's chart, including the discussion with his supervisor and the actions taken as a result.

SESSION 2

Clinician Expectations

The counselor begins Session 2 with the following expectations in mind:

1. Check the client's thoughts and reactions to the previous session.
2. Invite Sally to raise issues she would like to discuss today.
3. Determine the focus for this session, based on Sally's goals, and identify specific beliefs to address that relate to these goals.
4. Encourage Sally to continue to explore her emotions and beliefs about her husband's death.
5. Administer the CES-D Scale to measure changes in Sally's depressive symptoms.

[The counselor checks with Sally to find out if she has had any recent thoughts or feelings of self-harm or suicide. She says that she has not, and they continue on with the session.]

SALLY: I've been thinking about old Larry. *[Sighs.]* I call him a stupid jerk, but he wasn't except for that one night outside Denver. He was smart, tall, good-looking. He was very good to me and changed my life. If it wasn't for him, I'd still be pouring coffee at Hecklemeyer's in Marceline. I don't understand it, all these bad guys live out their lives, and here's Larry, poor guy, good-looking, good guy. One mistake: he tried to make up time. Truckers always try to make up time . . . and he's gone.

[Silence.]

COUNSELOR: Go ahead.

SALLY: You know, I was the youngest female wildcatter in the country. They called me Mud Flap Sally. Do you know what that means? Probably not. You know the girl on the mud flaps? Larry called me Mud Flap Sal. We were such a good looking couple. I did a good job running the business after Larry died. *[Sighs.]* God, Jim, I'd give my right arm to be back there, December of 1980. I told him, "Larry, let me drive, we can't make up time. We can't do it."

[Silence.]



Master Clinician Note: Sally's silence is self-reflective, and the counselor's acceptance of her need for this allows her to explore her thoughts and feelings about her husband's death.

SALLY: I've never told anyone that part. And, when the cops came, I just said he lost control of the truck and they nodded. They didn't ask questions, anyone could have lost control in that situation. The truth is I knew he was going too fast, he was rushing. I knew I should have been driving and not him.

COUNSELOR: How does it feel to talk about that?

SALLY: [*Quiet for a moment.*] I don't know yet.



Master Clinician Note: The counselor elicits Sally's belief that she is responsible for her husband's death.

COUNSELOR: Have you had the thought that you should have done something?

SALLY: I think that every time I see his ghost sitting in the seat. [*Silence.*] I talk about seeing Larry, I call it his ghost but I don't believe in ghosts. I keep thinking that one day I'm going to get in the truck and he's going to be there and things will be okay and it will be like it was. I won't have to drive 16 hours and I'll have that handsome man and I'll be Mud Flap Sally again. [*Starts to cry.*] That's what I hope will happen again. [*Pauses.*] That ain't realistic, is it? It's a little crazy.

COUNSELOR: Often people talk about things they might not talk about with other people. Many report seeing someone who is deceased or in some other way, experience their presence.

SALLY: Really?

COUNSELOR: The fact that you know that Larry isn't going to suddenly appear for real means you aren't crazy. Instead, it sounds like you are still grieving. It tells me how important Larry is to you. Tell me about your love for him.



Master Clinician Note: The counselor normalizes Sally's response to her grief (i.e., "you aren't crazy") and affirms the importance of her connection to her deceased husband. The cost of giving up driving her rig is becoming more clear to the counselor—Sally believes that the rig keeps her connected to Larry. This completes the definition of the problem (completion of Step 1 of How to Challenge Beliefs, p. 70). Sally can't move forward until she feels confident enough to do it. The counselor will help Sally identify her strengths in a way that she can feel confident about taking action (Step 2 of How to Challenge Beliefs).

SALLY: Can I get through this? I'm so tired. I'm 53 and I'm not Mud Flap Sally anymore. [*Starts to cry.*] I'm an old lady.

COUNSELOR: Actually you are getting through it. You had your stomach looked at; you're in treatment. You're not comfortable, but you're making use of the opportunities in front of you. That is the road to recovery. I wish I could tell you it wasn't a hard road, but the unmanageability of substance abuse plus the grief of losing a good man like Larry is a hard road.

SALLY: I've been driving hard roads for 25 years.

COUNSELOR: Sally, you've listened to the AA speakers who've come into treatment, so I know you must have heard about other hard roads. These people come here to let you know you don't have to ever drive them alone anymore—that's part of what sobriety means.

SALLY: Yeah, one woman last week had a real ugly life worse than mine, but she gave me her number and said she'd take me to a meeting if ever I wanted.

COUNSELOR: Mud Flap, as your counselor you have my permission to call her and go to an AA meeting with her next week again, if you want.

SALLY: Maybe.

[Silence.]



Master Clinician Note: Now the counselor has identified some of Sally's strengths as evident in the present. The next step is to see whether she is confident enough to try planning for taking action (Step 3 of How to Challenge Beliefs, p. 70) or whether she is still too ambivalent.

SALLY: I have a question. I'm a Teamster. I always thought that someone like me could be real useful to the Teamsters. What do you think?

COUNSELOR: The Teamsters help a lot of people, and your experience would definitely be an asset in that type of work.

SALLY: Is there a local chapter here?

COUNSELOR: I don't know, would you like to look into it before our next session?

SALLY: Yes.

COUNSELOR: Sally, you may remember when you entered the program, the intake worker gave you a brief test to measure depressive symptoms. Would you mind taking a minute to complete it again and when you return, we can compare your scores from two weeks ago with your score today.

[Sally agrees to complete the CES-D Scale and does so as the session ends.]

Session summary: The counselor began the session by allowing Sally to define her own agenda and to talk more about Larry, his death, and their relationship. He guided Sally's focus toward her core beliefs that arose as a result of Larry's death and how those beliefs limit Sally's options today. The counselor also supported an environment in which Sally could explore this powerful loss in her life. Because early in the session Sally expressed an interest in discussing her relationship with Larry, the counselor decided to delay administering the CES-D Scale until the end of the session and will discuss the results in their next meeting.

SESSION 3

Clinician Expectations

The counselor begins Session 3 with the following expectations in mind:

1. Discuss the results of CES-D Scale administered at the end of last session.
2. Ask Sally about her goals for the session (e.g., making plans for a future career).
3. Explore some hunches the counselor has about the impacts of Sally's "all-or-nothing" thinking.

COUNSELOR: Sally, before we begin, let me just tell you that there is a significant reduction in the depressive symptoms reported on the CES-D. I think that's something you can really be proud of.

SALLY: I'm certainly feeling better. More hopeful. And Jim, I have a route mapped out to the local Teamster's union. On Thursday can I be excused from the program to go talk with them? Betty, the lady from the AA meeting, said she'd take me there and to a meeting.



Master Clinician Note: Sally has a plan (Step 3 of How to Challenge Beliefs, p. 70). Now the counselor confirms with her that this is what she wants to do.

COUNSELOR: It sounds like you have a plan for talking to the Teamsters. Excellent! So this is what you really want to do?

SALLY: Yes.

COUNSELOR: Great! Yes, you have my permission to go with Betty to the union office and an AA meeting, and if you want, you and Betty go out to supper and talk. I'll be interested in hearing how it goes. *[Pauses.]* There have been a few other things that have come up during the last few sessions that I'd like to talk more about. Maybe we can figure out how to deal with them. One is that I think you have a deep-seated belief that if you are not able to drive anymore, you are going to somehow not be able to hold it together or have a life worth living. I think you also believe that if you can't drive anymore that you're going to somehow lose Larry.



Master Clinician Note: Now that Sally is no longer ambivalent about discussing her future, the counselor is addressing the core beliefs as stated in earlier sessions. The quality of the beliefs is "all-or-nothing." Sally believes that if she can't drive, she will have no choice but to become a waitress again, which is intolerable to her and causes her to feel helpless and depressed. If she gives up driving, she will lose her connection to Larry, which she is unwilling to do. If these beliefs go unaddressed, Sally's hopelessness will not be resolved. The counselor is now addressing her belief about losing Larry.

SALLY: That's a #**%! of a funny thing to say. Lose Larry. Lose Larry. *[Sniffs.]* I already lost him once; I don't want to lose him again.

COUNSELOR: I understand. That's why I'm bringing it up. I think some of the concern about not driving is that if you're not driving, he won't be sitting in the seat next to you anymore.

SALLY: He's not sitting here in this place.

COUNSELOR: I hear that. That may be one reason you've been so down lately. What I've been hearing is that you've had some ideas, even though you can't quite see beyond driving and you don't want to lose Larry. You have some ideas of something you could do as an alternative to driving. Can you tell me about that?



Master Clinician Note: Sally now has momentum for addressing these beliefs. Sally's willingness to explore alternatives to driving a truck or waiting on tables is directly linked to Sally's belief that she won't lose Larry. The counselor is addressing these beliefs at the same time because they are intertwined. The counselor chooses to address the less threatening belief first. He is now eliciting Sally's strengths (Step 2 of How to Challenge Beliefs, p. 70) for the belief about having to become a waitress.

SALLY: Yeah, I can. There are things about Larry I haven't told you. He cared about people; he cared about fairness and being treated right. That's why we joined the Teamsters. He talked about the labor movement and

how people banded together and got their rights, and about labor organizers. I thought I'd be good at that. If I can't drive, I can help other people who do drive. I would make Larry proud.

COUNSELOR: How would you feel about yourself if you did that?

SALLY: I'd be proud, too. People know who I am; they know who Mud Flap Sally is.

COUNSELOR: That's right. I think that's a wonderful idea.

SALLY: I know enough from Larry to be good at organizing. To tell people they should join the union. I guess that would make him happy. Maybe he would even be there when I did that.

COUNSELOR: Maybe it would even make you happy. You know the only way I think you'd lose Larry is if you started doing pills again. I guess "lose" is not the right word; maybe "dishonor" what you and Larry had together.

SALLY: Yeah.

COUNSELOR: Maybe you'd have some of the feelings you had with Larry, the Mud Flap Sally gal that everyone knew and who was happy, even the way you felt with Larry.

SALLY: You wouldn't have to take turnarounds to do that job.

COUNSELOR: No, you wouldn't. So maybe that's one option you could look at.

SALLY: I'd know it was right if Larry were there with me while I was trying to do it.

COUNSELOR: What do you think Larry would think about you being in treatment?

SALLY: At first I thought he'd be ashamed of me, but over the past couple of weeks I think he'd be proud. He'd like the people I'm meeting here, and he'd like Betty.

COUNSELOR: So, he wouldn't mind your going to AA?

SALLY: He'd be okay with it. He was independent, but getting help when needed was okay with him; I think that's why he was so pro-union. Heck, those AA meetings are a bit like a union meeting: lots of talk and lots of coffee, but without the beers afterwards.

COUNSELOR: Where do you think Larry is?

SALLY: We always talk about The Great Truck Stop in the Sky. Best coffee. Prettiest waitresses. I hope he's there.



Master Clinician Note: A potential option has been identified that Sally can pursue. The counselor is now using the technique of providing contradictory information to address Step 2 (How to Challenge Beliefs, p. 70) for alternatives to the belief about losing Larry.

COUNSELOR: You know where I think he may be? I think he's there [*points to her heart*] and there [*points to her head*]. I think he's in there, and you can call him up when you need to have him because he's right in here.

SALLY: You're not some kind of preacher are you?

COUNSELOR: No. But if Larry is in there [*points to her heart*] and there [*points to her head*] and you're being a Teamster, maybe you'll be able to call him up at those times too.

SALLY: You're saying something that I want to make sure I understand. When Larry was in the cab, it was because I wanted him to be there, I put him there?

COUNSELOR: Yes, you want Larry, you love Larry. You have a relationship with Larry, not past tense; you have a relationship with him now. It's not crazy; that's the way people live. When we leave this room and do our separate things, when we think of each other or remember each other, we bring each other alive within ourselves, and that's what you're doing with Larry.



Master Clinician Note: The counselor has identified an alternative solution for Sally's belief that she will lose Larry if she stops driving the rig.

SALLY: You wanna know something funny? Damn jerk is still 30. His hair is still dark.

COUNSELOR: That's good! *[Laughs.]* Who would want him around at 55? *[Jokingly.]*

SALLY: I would want him around. And you want to know something? Way back when I was the one who got into the cab of his truck and I told him I wasn't getting out. He knew better than to argue. *[Smiles softly. Pauses.]* You're a really nice person, Jim. This is a nice talk. Can we talk some more about this?

COUNSELOR: You know, there's another thing I wanted to explain to you about your experience with Larry. Some people who have had a traumatic experience relive it and get caught in their thoughts and feelings about it. Whether it happened recently or long ago, trauma is still trauma. I just want you to be aware that that's happening to you.

SALLY: That was 25 years ago.

COUNSELOR: I know. It struck me that when you told me about it, it seems like it wasn't that long ago. It's not that we should forget a loved one, but we can get caught up in thoughts and feelings about their death and in doing so, not be able to really honor what they gave us.

SALLY: When I get sad, I see him lying on that pavement twisted. When I'm driving, I don't see him like that. But when I'm down, I see him like that.

COUNSELOR: I thought maybe you said somehow you believe you were responsible. Perhaps this is a belief that is keeping you stuck?

SALLY: I was responsible. I should have told that jerk to get in the back and let me drive.



Master Clinician Note: The counselor has defined another belief. Sally and counselor have identified a number of beliefs that all anchor back to a core belief that Sally is destined to be depressed.

COUNSELOR: That was a decision you made, and without getting into why you made that decision, he was doing the driving and was capable of making those decisions, too.

SALLY: He wouldn't have done what I said anyway.



Master Clinician Note: The counselor is using the technique of contradictory information to dispute the belief that Sally is responsible for Larry's death (Step 2 of How to Challenge Beliefs, p. 70). He is encouraging Sally to consider letting go of the belief.

COUNSELOR: So how come you're carrying this weight?

SALLY: I don't know.

COUNSELOR: That's a hard thing to let go of. Let's talk about that next time. What I'm concerned about now is this sense you have that . . . you've told me a little about your family and what it was like growing up, and as you were talking I felt this heavy grayness.



Master Clinician Note: The counselor determines that the belief about her responsibility for Larry's death is going to be a difficult belief for her to let go of. He postpones working on it until the next session and chooses to increase her sense of self-efficacy in the time he has left in this session.

SALLY: It wasn't pretty. It wasn't pretty.

COUNSELOR: And it sounds horrible, in a sense of just a muddled kind of having nothing to look forward to.

SALLY: You got that right.

COUNSELOR: And you kind of describe that you think your mom and sister had feelings like that too.

SALLY: They were depressed, no doubt about it. My mom was depressed, my sister, and me until Larry came along.

COUNSELOR: But you were able to emerge from that depression and come to life, and come into being. You said something really important. You said *you* got into the cab of the truck with Larry and you wouldn't get out. So who made their life different?



Master Clinician Note: The counselor has identified and is disputing Sally's belief that she is helpless to bring about change in her life by eliciting information from Sally about her past successes. The counselor is increasing Sally's confidence in her ability to make her plan work.

SALLY: I did. Something else. He wanted to throw me out. So I told him, "Larry, did you know that the first time we had sex, I was underage? Do you want me to talk to the cops about that?" So he married me when we got to Nevada.

COUNSELOR: So when I'm hearing that you can't do this, or survive without that, it may not quite be the reality of the way it is.

SALLY: [*Sniffs.*] Yeah.

COUNSELOR: Sally, I think you are a strong woman, and we can look at some of the things I've brought up today over the next few sessions and come up with a plan. I want you to give some thought to what I've told you. I don't want you to walk around feeling that you can't do anything to fix anything. . . . What's going to happen?

SALLY: I can fix things. I fixed ol' Larry, too. I haven't thought about that in years. The sheriff was having coffee at the truck stop.

COUNSELOR: Well, let's explore this more next time, Sally. Are you going to follow through with your plan to go to the union hall on Thursday?

SALLY: Yes.

COUNSELOR: So I'm looking forward to hearing about that in our next session. Good luck at the Teamsters office and have fun with Betty at the AA meeting.

[The counselor wraps up the session.]



Master Clinician Note: The counselor is:

1. Continuously assessing how distressing it is for Sally to challenge each belief.
 2. Prioritizing which belief needs to be challenged next.
 3. Increasing Sally's sense of self-efficacy.
 4. Helping Sally understand the value of viewing her beliefs objectively to determine their validity.
 5. Helping Sally begin to understand the connection between challenging her invalid beliefs and developing new opportunities.
-

Summary

The work between Sally and her counselor has focused on establishing rapport, determining Sally's specific goals, identifying core beliefs, and challenging core beliefs. The treatment goals have been to reduce Sally's experience of helplessness and hopelessness and increase her options for healthier, recovery-oriented choices. This belief-oriented treatment with Sally is one part of the process of change that will include abstaining from Benzedrine, reducing her symptoms of depression, working through her grief, and increasing her self-confidence, competence, and self-esteem. A core element in the success Sally has experienced in counseling has been the rapport she developed with her counselor. His willingness to allow her, in a nonjudgmental and accepting way, to express her thoughts and beliefs, his optimism toward her potential for change, and his empathy toward the burdens she has carried served to facilitate an environment in which she could feel safe and affirmed to explore her painful history and examine options for the future.

Vignette 4—Interventions With Feelings

Introduction

Feeling or affective-based therapies focus on feelings as a primary method of helping people change. These approaches are particularly appropriate when there are powerful primary feelings such as anger, fear, sadness, or shame that limit the individual's opportunity to solve problems, make meaningful emotional connections to others, and have healthy self-esteem. When people no longer have to repress pain and sorrow, they typically become more spontaneous. Affective therapies assume that individuals tend to avoid feelings that are painful, overwhelming, or perceived as unmanageable. In avoiding certain feelings, people then have to limit opportunities in their lives. Limiting these opportunities means that life is more constricted and less fulfilling. Some contemporary therapeutic orientations that use feelings as a basis for change are the emotive therapies, emotionally focused therapy (EFT), forgiveness therapy, and specific elements of trauma therapy and grief work.

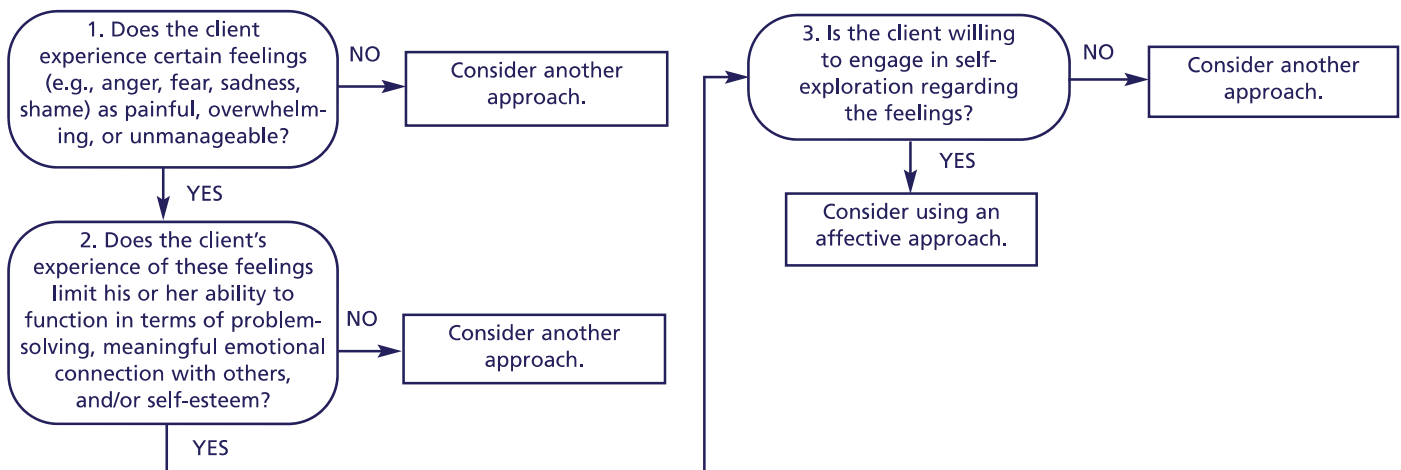
The affective therapies are particularly appropriate for problems that have a significant emotional component. These therapies consider depressive symptoms such as hopelessness, despair, emptiness, guilt, and anger to be significant stumbling blocks in recovery. In addition, a number of therapies focus on a specific emotion, such as shame, guilt, or anger, but incorporate a variety of other change processes such as behaviorally focused or cognitively based strategies. (See Figure 2.7 for how to determine whether affective therapies are appropriate for a client.)

Since drugs and alcohol have a numbing effect on feelings, the experience of feelings in early recovery often presents particular problems. Many clients tend to be inexperienced in managing even low-intensity feelings. For some, particularly those who began using alcohol and drugs early in life, learning how to identify feelings is an important therapeutic task. For others, feelings can often be a trigger to return to use. This treatment approach is most often undertaken after clients have gained skills in using new behaviors and cognitions that support recovery.

For some clients, such as Shirley, problems with feelings present a hindrance to developing and practicing new cognitive and behavioral skills. In this vignette, Shirley's shame and grief are major limitations in her ability to maintain sobriety, relate effectively to others, and feel comfortable with herself. Observe how the counselor, in a sensitive and respectful way, helps Shirley become aware of how these emotions limit her ability to function and how the counselor and Shirley address these feelings.



Figure 2.7
Decision Tree
How to Assess Whether Feeling (Affective) Therapies
Are Appropriate for a Specific Case



Case Study

Shirley, 65, is from New Jersey. She has been divorced three times and was widowed by her fourth husband, Norton. She has three sets of children, six total, and three grandchildren. She retired last year from a 30-year career as a social worker for child protective services. A few days before intake, her friends did an intervention with her, and she came to the outpatient program to get them off her back. Her friends tell her that her family members have told them they have noticed personality changes when she drinks, and that, when drinking, she becomes irritable, opinionated, and judgmental of others.

Substance Abuse History and Current Status

Shirley grew up in an abusive home with an alcoholic father. Because of this, Shirley did not start drinking until her junior year of college, and then only on weekends. This pattern of social drinking continued until her second marriage, to Frank. While married to Frank she developed a pattern of daily drinks after work. Shirley would stop after two, believing that she couldn't have a problem if she could stop at two. She would break this rule and "drink too much" two or three times a year. She divorced Frank, because while drunk he would become angry and abusive. This brought back all Shirley's feelings from growing up with an angry, abusive, alcoholic

father. After the divorce, Shirley continued to drink daily after work, occasionally drinking “way too much” on weekends. After retirement, Shirley’s drinking increased to four, five, or more shots every night with uncontrolled drinking bouts about once a week. Continuing her long-standing drinking pattern in retirement, Shirley usually drinks at home, but when out with friends will limit herself to two drinks. Sometimes after drinking Shirley will call friends and talk in abusive ways about the world and then take her phone off the hook. Shirley is increasingly having blackouts. On several occasions, when her children were not able to reach her, they would go to her apartment and find her passed out on the couch or floor. On one occasion, she fell into a coffee table and was bleeding from a cut above her eye.

Depression History and Current Status

At intake, Shirley was given a standard evaluation including a screening for depression using the CES-D. Some depressive symptoms were noted, including sleeplessness. She denied being irritable but says she is angry about how people treat each other, what “the system” does and doesn’t do, and how it fails. She is particularly angry at her “meddling friends” who confronted her about her drinking. She denies feeling sad or depressed. Her appetite is poor. She doesn’t enjoy life, and she has been feeling this way since she retired. Although these depressive symptoms were noted, no full depression assessment was done at intake. She was assigned to regular group meetings four times a week for the first month in addition to educational sessions twice a week. Additionally, after the first week of the program, because of her interpersonal difficulties with other clients, she was assigned to individual therapy once a week. Shirley dismisses what the group members and the group therapist say to her. She is angry all of the time while in treatment, with an underlying feeling of sadness. She is generally cynical and credits this to her experiences as a social worker.

SESSION 1

Clinician Expectations

The counselor begins Session 1 with the following expectations in mind:

1. Build a therapeutic relationship by developing an understanding of Shirley’s problems from her perspective.
2. Collaboratively begin to identify treatment goals for the sessions.
3. Identify Shirley’s perceptions of her most pressing problems.
4. Identify strengths Shirley might use in addressing her identified problems.

[The session begins with Shirley and her counselor talking about what brought her into treatment, her drinking patterns, and her experience with being in the treatment program, particularly her difficulty in identifying with other clients in group. Early in the interview, two points emerge: (1) Although she does not directly label it as such, Shirley feels a lot of shame that her friends and family were aware of her drinking and the resultant problems, and (2) she feels isolated from others in the treatment program and thinks she is not as “sick” as other clients.]

SHIRLEY: My friends intervened. My family members have told my friends they think I have a drinking problem. So I thought I’d check it out to see if there was anything to it.

COUNSELOR: That’s kind of a heroic thing to undertake. Some people are unwilling to look at their drinking and what’s going on in their lives. You’ve taken to heart what those other people are telling you, and that’s hard to do.



Master Clinician Note: The counselor is using affirmation to increase rapport with Shirley and elicit her best perception of herself. This perception of herself will assist Shirley in feeling confident in her ability to bring about any changes she identifies as necessary.

SHIRLEY: Well, yes, I pride myself on being able to look at things and deal with them as they come up. That's how I live my life. My life is my own life. The fact that this has happened to me with my friends and my family, this is troubling. I'm a professional woman. I've worked my whole life helping other people. Frankly I'm embarrassed. I can't believe that my friends came to me to tell me this.



Master Clinician Note: People with excess shame are very sensitive to being seen in a negative light. They are particularly sensitive to being “blindsided” by information about themselves. Shirley has high expectations for herself (to cover her underlying feelings of shame) and then feels significant shame when it appears that others don't think she is measuring up and when they see parts of Shirley that she would like to keep hidden from herself and others.

COUNSELOR: Yes, I can understand that this whole experience is very difficult for you.



Master Clinician Note: The counselor is expressing acceptance of Shirley and affirming the difficulty of examining parts of her life of which she is not proud. This begins creating an environment in which Shirley can examine how shame is a limiting emotion in her life.

SHIRLEY: Yes, this is a hard thing. These idiot kids in my group, they don't know what it's like to get up in the morning and feel numb. I worked for 30 plus years, I raised six kids, been married four times. They have no idea. I'm coming in here, and it's really hard for me. I'm glad to have a counselor close to my own age.



Master Clinician Note: Projection (taking disowned parts of oneself and placing those attributes onto others) is a primary psychological defense of people with a great deal of shame. Observe how Shirley takes a part of herself (inadequacy) and assigns that attribute to others in her treatment group. In later sessions, as rapport develops between the counselor and Shirley, it might be appropriate to confront the projection. Right now it would probably just make Shirley more defensive, so the counselor lets the projection pass.

Shirley's comment about the counselor being the same age suggests some sense of connection or comfort, which bodes well for the relationship. Many clients, particularly those from some rural or minority groups in our culture, will need to find “kinship” with the counselor before the relationship can develop (as in the Hispanic/Latino *personalismo*). For some, kinship may be knowing someone in common; for others, it might be having connections to one another's home town. Counselors may perceive this kind of “kinship finding” intrusive. It is actually a way of strengthening the relationship.

COUNSELOR: People generally fight and run from these feelings. Especially for someone who has had to be strong, for so many, for so long. It's hard, but part of what you're going through is why you came here. Taking a look at your life. It sounds like you're not happy with the role alcohol is playing in your life.

SHIRLEY: It's *my* life. [Pauses.] Well, since I've been retired and alone in the house, I may be drinking more than I should. A couple of weeks ago I was drinking and got up to answer the phone and tripped over the coffee table. I probably wouldn't have done that if I wasn't drinking. I'm feeling trapped between wanting and needing to lead my life as an independent person and needing to look at the drinking.

COUNSELOR: I'm glad to hear you start to accept your drinking problem. But I'm concerned about your feeling trapped. Do you feel trapped every day?

SHIRLEY: Trapped, yes, but it's not just here. It's not just you. Where I really feel trapped is in that group with all those idiots. I actually start feeling panicky in there; I can't wait to get out. Like I'm going to be attacked at any moment.



Master Clinician Note: A primary method of establishing rapport with a client is to suggest that the counselor understands some of the experience, the feelings, and the situation. However, people with a great deal of shame often feel quite vulnerable with this identification. In effect, they feel other people will see their shame, their deficiencies, their inadequacies, and therefore they become defensive when the counselor seeks to suggest he understands. The client may try to find differences between herself and the counselor and suggest that the counselor *can't* understand, that the counselor is too young, too inexperienced, of a different race or sex, or some other reason.

COUNSELOR: I think we can help you reduce feeling trapped in group. Group is something where you're a member and yet you can work on your own program. Perhaps there are some ways I can help you tolerate group and feel less frightened.

SHIRLEY: *Frightened?* I'm not scared of those people!



Master Clinician Note: The counselor labels Shirley as frightened, which Shirley immediately refutes. It is important to Shirley to be seen as strong and she believes feeling frightened is an indication she is weak, something to be ashamed of.

COUNSELOR: Maybe tolerate the group and even get something from it would be a better way of putting it.

SHIRLEY: Yes, tolerate. I need to find a way to tolerate those losers in group. I don't think the group thing is right for me. Most people around here don't have any life experience, how can they help me?



Master Clinician Note: The counselor infers from Shirley's description of others in group as "losers" and her problem with identifying with other group members that shame may be a primary emotional struggle for Shirley. He also suspects that some of Shirley's anger might be a cover for the shame. He knows that to confront Shirley with this hunch at this time would probably be too

threatening, so he stores the information and will get back to it later. If his hunch about shame as a primary emotional struggle is true, then the counselor also knows that changing her environment (e.g., taking her out of group) will only serve to avoid addressing the shame, not resolve it. Also, educating her about alcoholism as an illness, particularly some of the physical aspects of substance abuse that can affect anyone at any age, would be useful in reducing shame.

COUNSELOR: I'm less worried about group than I am about your feelings of being trapped and how those will affect you. I certainly hope that they don't cause you to end up leaving treatment. Shirley, I'd like to throw something out and have you tell me what you think. You raised six children, survived four marriages, and for more than 30 years you fought to protect the children of your city. You're a fighter, a warrior; but with retirement there are no more battles. What does a warrior do when the fighting is over?

SHIRLEY: Sit in her apartment and get drunk.

COUNSELOR: And in treatment, how does it feel to be someone who needs help rather than a helper?

SHIRLEY: I'll go crazy! I don't know how to let people help me. I don't want to be one of them.

COUNSELOR: Shirley, one of things we know is the alcoholism often starts when people have to make transitions. They reach a critical junction where the life they had before doesn't exist and they need to create a new life. Drinking offers a solution; an empty solution, but a solution nevertheless. Those are tough feelings to face.



Master Clinician Note: The counselor's compassion and concern for Shirley are clearly expressed and make it possible for her to do some self-exploration regarding her drinking. The counselor is gently broaching her difficulty exploring her feelings by expressing concern that if she doesn't find a way to do this now, she may end up in greater difficulty later. The counselor also implicitly acknowledges that he understands her struggle with shame without naming the feeling or making it a negative.

[The counselor proceeds to explore Shirley's understanding of how people develop drinking problems, and gently corrects misinformation, reminding her of the lecture she heard about alcoholism as an illness.]

SHIRLEY: I am worried that something worse could happen as I get older. I would like to look at some of these feelings I'm having here in relation to my drinking and figure out if I need to do something. The worst thing about this whole experience is having my friends and family tell me about this. I'm the one they look up to. I'm the friend, the parent, the grandparent. So this group coming to me, I can't describe how horrible that feels to me. I can't divorce my family but I can divorce my friends and that's what I feel like doing.

COUNSELOR: From hero to scapegoat?

SHIRLEY: *Yes!* But, then, I do remember hearing how drug and alcohol problems have nothing to do with intelligence, strength, or income.

COUNSELOR: That's true, but this is a difficult thing to happen to you, and I hope you can find a way to stick with it until we all get a better understanding of what's happening and what might help. It sounds like you are open to new information. It sounds like its time for you to be a hero again: a hero but a human hero.

SHIRLEY: What do you mean?

COUNSELOR: As you face your illness of alcoholism, as you put together a new sober life, I'm sure you will become a hero to your family and friends. However, this hero will be one who walks with them, instead of being up on a pedestal.

SHIRLEY: I've been so scared, so lost. I can't tell my family and friends that; I've always been the strong one.

COUNSELOR: That's entirely up to you. But while they maybe gave you a push, you're here on your own, and that's something you have a right to feel good about. It's a big step and not an easy one. Many people say it's the hardest thing they've ever done—to let others know that they are vulnerable.

[Counselor wraps up the session.]

Session summary: Because of her shame, developing a trusting relationship with Shirley is particularly difficult. The counselor had to consider carefully how he wanted to position himself in relation to Shirley in order not to activate more resistance and defensiveness. It has also been important for the counselor to accept Shirley's anger and blaming in a nonjudgmental way. He has been able to elicit Shirley's perceptions of her problems without critique or judgment. As the counselor enters case notes in Shirley's record, he makes a conscious decision to continue to be nonconfrontational and supportive in the next session.

SESSION 2

Clinician Expectations

The counselor begins Session 2 with the following expectations in mind:

1. Continue to build the therapeutic relationship with Shirley.
2. Encourage Shirley to collaborate on goals for the session.
3. Continue to explore the impact of Shirley's shame on her life functioning.
4. Continue to support and build safety to explore disavowed feelings.
5. Continue to explore with Shirley the relationship between her alcohol use, her depressive symptoms, and her emotions.

[Shirley comes to the second session continuing to feel aggravated by the group and feeling ashamed because of the intervention by her friends. She wants to drink more than ever and finds it hard not to drink.]

SHIRLEY: Darn it, Ken, when I talked to you last week, you said you'd help me tolerate those people in group. This is too much; those people are not helpful. I've been having such a hard time this week. I can't stand it.

COUNSELOR: I'm surprised group has such a grip on you. I know you've been going through a lot, but it's other people's problems, not yours. What is it that upsets you about group?



Master Clinician Note: The counselor reframes the identified problem as “other people’s problems, not yours” and asks for elaboration about the problem. This is an example from motivational interviewing, eliciting change talk by asking for elaboration. Reframing is also a technique from motivational interviewing and other cognitive therapies.

SHIRLEY: I'm doing fine, and they're talking about how they're craving and all these things. It's so annoying. It's harder and harder to be there, and nobody can help me in there. They've started telling me that I have this problem. I'm sick of defending myself and everyone thinks they know me better than they do.

COUNSELOR: What do you feel is the real problem?

SHIRLEY: *[Sighs.]* I've been wanting to drink a lot. I've been getting really sad, and I'm not sleeping well. I keep thinking that I'd feel better if I had a drink. It's harder to stay here and not leave and have a drink. And then sitting in group and having all these people tell me what they think about me. I don't want to do it.

COUNSELOR: Did you think being here would be like this?



Master Clinician Note: The counselor makes a mental note for a later session to introduce concepts of relapse prevention with Shirley and to encourage her to participate in a relapse prevention education program. Shirley's current constellation of repressing her feelings, depressive symptoms, and her substance abuse indicate a high risk for relapse.

SHIRLEY: No. I thought I could walk away from it, come here, then walk away and go back to my life. I'd show everyone that I don't have a problem. But I don't think I can. I don't know how I'm going to do what I have to do to make it, to feel like much means anything anymore. This isn't who I am.



Master Clinician Note: Shirley is reiterating her belief that she is a self-sufficient person. The counselor does not follow up on this. Instead, he pursues his own agenda, in which he tries to elicit examples of when Shirley may have successfully turned to others for support. The counselor wants to do this to build support for her reaching out to others.

COUNSELOR: When you've been in this kind of a jam or had these feelings before, has anyone been of help?

SHIRLEY: I told you before—I don't talk to people about this stuff. I'm telling you now and hoping you're going to help. I'm the person people talk to, come to for advice. I don't talk about this stuff.

COUNSELOR: Yet you don't look down on people who come to you for help.

SHIRLEY: It's okay for them to have those problems, but I'm the person who always does fine. I've never felt so out of control and unable to manage my life, my thoughts, my feelings.

[Shirley starts crying, and a few moments pass.]



Master Clinician Note: Shirley's feelings of sadness and helplessness are being aggravated by the counselor's failure to acknowledge Shirley's request for help. Allowing Shirley to experience her feelings and to cry, however, permits her to confront them and to become open to alternatives. When clients cry, counselor anxiety levels tend to increase. Efforts to stop the crying or to interrupt their crying to comfort them are made to reduce counselor anxiety. By recognizing and respecting Shirley's need to cry, the counselor creates a safe space where she can feel what she is feeling.

COUNSELOR: Shirley, do you see this program as being able to help you as it helps others, or is there something about it that you can't see yourself being a part of?

SHIRLEY: [*Sniffles.*] I can't see myself doing this in group. I don't think those people in group can help me. You sound like you've got some experience.

COUNSELOR: Well, I'm concerned about your saying that you just don't get to have a problem in your life. It's okay for everyone else to have problems and get support or need help, but somehow you just don't get that like everyone else does. It's not your birthright.

SHIRLEY: I'm asking you for help. I don't ask for it from my friends or family and especially that group.

COUNSELOR: Have you ever felt like this before?

[*Silence.*]



Master Clinician Note: The counselor, feeling confused, wonders why she isn't responding. He thinks he may have been out of step with her. Both are feeling frustrated. He has been missing the opportunity to join with Shirley in her request for assistance. This is called a misattunement. She responds with silence after he misses another opportunity. The counselor internally reflects on what may be causing the silence (a signal of increased resistance) and realizes that he has not accepted the client's invitation to help her in dealing with this problem. The counselor has also acknowledged his part in the misattunement. His ability to be open not only allows him to reconnect with Shirley, but also models adaptability and flexibility.

Historically, resistance was thought to be a negative, defensive effort on the part of the client that, if allowed to prevail, would limit growth and recovery. Accordingly, direct confrontation (and, unfortunately, sometimes blaming and shaming) was used in an effort to cause clients to stop resisting recovery contributions made by counselors. However, we now understand that all people resist change that threatens their current way of being and doing. When they come to understand that change is inevitable, and/or desirable, and that there are alternatives to current ways of being and doing that they can do and that are acceptable (even pleasurable) to them, resistance diminishes. When resistance is confronted head-on, the natural tendency for all of us is to dig in our heels and resist even further, like a tug of war. Rolling with the resistance allows the kind of nonjudgmental exploration that will permit clients to collaborate more fully in counseling, when they are ready to do so (see *How to Roll With Resistance*, below).



How to Roll With Resistance

Six techniques from motivational interviewing are described here for handling resistance. The first three are techniques based on the use of reflection and the last three are strategies for rolling with resistance.

1. The main way to handle resistance is to simply reflect it, not at a greater intensity, but enough to let the person know that she is being heard. An example of this would be to say, "This week has been really hard for you, and the stress of group on top of that feels like too much."

2. You can amplify or emphasize the part of the statement that you are most tempted to argue with. An example of amplified reflection would be “There is nothing you can do to make group a helpful experience for you.”
 3. A third technique is to reflect both sides of the ambivalence (from earlier in the session or from another session), which allows the client to see his or her ambivalence. An example of this is “So, on the one hand, you feel that you can handle group by pretending the other members are part of a play, and, on the other hand, it feels as if this doesn’t work when you are really stressed out.”
 4. *Reframing* is taking the statement and recasting it. An example is “Group is actually other people’s problems, not yours.” This can be used to take something that the client thinks is a strength and make it a concern, or something the client is embarrassed about and make it a strength. *Agreement with a twist* is a reflection and a reframe: “Right now group feels unbearable to you, but I wonder whether you have considered that it is actually other people’s problems, not yours.”
 5. *Emphasizing personal choice* is reinforcing with the client that ultimately the choice is hers or his, and that no one can make the choice for him or her: “You may decide that group will never be helpful to you, and that is your choice.”
 6. *Shifting focus* is changing the subject to allow the anxiety about the issue to dissipate. “Tell me what you feel would be helpful to you.”
-

COUNSELOR: You’ve been talking a lot about how you would rather figure out this drinking thing on your own and that the group isn’t a place where you feel like you can get help. I’m wondering if I’ve missed the boat a bit by focusing on that too much, because I have also heard you say that you want me to help and you think maybe I have some experience that might be helpful. That’s good. I am wondering if at our next session we could talk more about this tension between doing it on your own and asking for help. Also, I am wondering if you might be willing to think about some of the ways you think my experience might help you. Does that sound good?



Master Clinician Note: The counselor has missed an opportunity with Shirley, but takes the time to reflect on his own frustration and is able to be authentic and transparent while offering a simple reflection to acknowledge the client and rejoin with her.

[While he is speaking, the counselor is dipping down to make eye contact with Shirley, who has her head down in shame. The counselor is sitting close, acknowledging that she’s down, and saying that we’re going to deal with this next time.]

SHIRLEY: Yes.

[Shirley is looking up at the counselor; she has accepted his offer to do that.]



Master Clinician Note: Shirley's head was down until the counselor accepted her invitation to help her reach her goal. The counselor hopes Shirley will feel heard when he demonstrates that he understands what she is saying and frames her goals as the tasks for the next session. The counselor also conveys his understanding and commitment with his body language, leaning forward attentively and making eye contact with Shirley as her head came up. Shirley's eye contact was a signal to the counselor that she felt understood and respected by him. Her experience of feeling understood and of having the counselor commit to helping her with her goals increases her confidence in the counselor. The counselor is confident that the combination of his experience, skills, and training with Shirley's knowledge of what works for her will result in an understanding of how to help Shirley navigate her recovery from her depression.

Session summary: The counselor initially missed an opportunity in this session to build the relationship with Shirley by pushing his agenda to focus on Shirley's resistance to group rather than hearing her request for help. He was able to correct this misattunement by acknowledging his misdirected efforts and redirecting the session to her goals. This acknowledgement on his part might ultimately serve to strengthen the relationship.

SESSION 3

Clinician Expectations

The counselor begins Session 3 with the following expectations in mind:

1. Follow up with Shirley's feelings about their last meeting.
2. Explore Shirley's perception of losses in her life history.
3. Help Shirley create safety to explore disavowed feelings about losses in her life.
4. Help Shirley continue to make the connections between her feelings, her drinking, and her depressive symptoms.

[Shirley has two primary problems related to feelings. First is her abundant shame, which she covers with anger, distancing from others, drinking, and a sense of being better than others, for instance, other clients in group. Second, as a result of the last session, the counselor is touched by the depth of Shirley's sadness, her references to distancing herself from her feelings, and her difficulty in asking for help. The counselor suspects this is a product of multiple losses over years. After some initial comments about what has happened over the last few days, the counselor offers a reference to the last session.]

COUNSELOR: Shirley, I was touched last week by the depth of your sadness and how hard it is for you to manage right now. And how you help others with their problems but don't let your own humanness emerge.

SHIRLEY: Well, everybody needs to break down every now and then I suppose. But, I'm not somebody who does that. When I left here last week, I felt really out of control. Remember my saying I was wanting to drink every time I leave here? Well, I really had to work not to drink after our meeting last week.



Master Clinician Note: Shirley, like many clients who tend to repress feelings, sees her emotions as her enemy. They are something to be contained and controlled and are dangerous if they come out. The counselor is going to want Shirley to begin to experience her feelings, rather than stifle them. In addition, it would be helpful to suggest more constructive ways to tolerate distressful feelings than drinking.

COUNSELOR: I'm glad you didn't. It seems like drinking has been pretty much the only way you have had to keep a lid on all of these feelings, and I'm wondering if staying isolated, keeping up the image of always having it all together, and being tough don't also come into play here.

[There is a long pause.]

SHIRLEY: Sometimes I think I could just lose it . . . if all of this stuff came pouring out.

[There is another long pause. The counselor doesn't want to interrupt or distract Shirley from reflecting on the power of feelings that have been sedated and avoided for so long.]



Master Clinician Note: Two metaphors seem particularly effective when describing unresolved grief. The first is the description of a “log jam” that develops when people can't experience all these losses for whatever reasons. The bigger the log jam gets, the harder it is to open up the river because if things start flowing, who knows where it might go. So it's important to just take away a few logs at a time; you don't have to dynamite the whole thing. A second picture that people can often relate to is of a closet where we stuff all sorts of things that we don't want the neighbors to see. The fuller the closet becomes, the greater the resistance to opening the door because you just don't know what is going to fall out. So the impetus is just to keep on keeping the door shut even though the pressure grows and grows, and it takes more and more energy to keep that door shut. Sometimes when we actually get around to peeking in the door, we find that the contents are not as overwhelming as we've imagined, and we can begin to take things out of the closet one piece at a time.

COUNSELOR: What does it feel like right now?

SHIRLEY: Like I want a drink. A big drink. Like I need to get the #*%! out of here.

COUNSELOR: *[Smiling]* It's like you want Jim Beam to ride up on his White Label horse and take you away.

SHIRLEY: You got it!

[Another pause.]

COUNSELOR: Shirley, it doesn't seem to feel safe enough for you to be able to stay in the presence of your feelings.

SHIRLEY: It *isn't* safe.



Master Clinician Note: The counselor recognizes that powerful feelings such as loss, shame, and feeling overwhelmed and/or lonely can only be faced when Shirley feels safe enough to manage them as they emerge. He wants her to create a safe enough environment for herself in the counseling session so she won't have to resort to her usual defenses of isolating, projecting, and drinking. One important step in this process is to give her the power to create her own safety, rather than having her rely on the counselor to make it safe enough for her.

COUNSELOR: Okay, then.

[*No response from Shirley.*]

COUNSELOR: Okay, well, it seems like from what I've observed since you've been in the program is that anger has been a pretty safe emotion for you. You're good at expressing it.

SHIRLEY: My anger is justified. I have plenty to be angry about, wouldn't you say? For instance, the idiots in group, the fact that my friends "turned me in," that I'm 65 years old and stuck *here*.

COUNSELOR: I'd say you have plenty to be sad about too.

SHIRLEY: Like . . .



How To Process Grief

1. *Recognize when a client has significant unresolved grief.* People with repressed grief are often irritable, controlling, and opinionated; have apparent feelings on the surface that are denied or displaced by the individual; show a lot of perfectionism and are judgmental toward others; have difficulty accepting feedback (positive or negative) from others; are obsessive in thought and compulsive in their behavior; and lack spontaneity in life.
2. *Educate about grief.* In much the same way that counselors help people with substance use disorders understand their illness through psychoeducation, counselors can be immensely helpful to people with unresolved grief by helping them understand that their behavior and unhappiness come from feelings that can be changed.
3. *Explore the client's experience with grief.* People with unresolved grief often see their emotions as their enemy. It may be that their grief has, in the past, poured out inappropriately or in overwhelming volume. They may feel that to experience feelings that have been repressed will cause them to lose control or "fall apart." They may also feel deeply ashamed of exposing powerful feelings. It is useful to have this information to understand a client's resistance to exploring grief.
4. *Create safety for expressing feelings.* Feelings that have been unsafe in the past have to find a safe place for expression. This not only means a safe environment, such as the counselor's office, but also safety in knowing the emotion can be controlled as it emerges. It is important to learn where the client has felt safe to expose disavowed feelings in the past and how that environ-

ment can be recreated today. In addition, the client needs to know that he or she can stop the emotion if it becomes overwhelming. It is helpful for the counselor to give the client specific permission to stop anytime he or she feels the emotions are becoming too overwhelming.

5. *Facilitate grieving.* Experiencing the emotions that have been repressed is usually accompanied by telling the story that contains the emotions. This process is grieving. Counselors need to pay close attention to how the client is responding to experiencing emotions. Some clients, especially those with traumatic histories (physical, psychological, and relational trauma) will re-experience the trauma as they have the feelings about it. The counselor needs to ask the client how he or she is experiencing the work. In addition, the counselor should encourage the client to tell the counselor if it feels as though they are moving too quickly toward something too painful to experience.
6. *Get closure on events that precipitated the grief.* This involves saying goodbye—letting go of or finishing unfinished business and forgiving self and/or others. Grieving is a process that may take substantial time to finish. It is often done in small doses over time. In short-term treatment settings, the counselor may only be able to help the client initiate the process.

COUNSELOR: I can only speculate, but let me make some educated guesses. Losses tend to come in several ways: There are *tangible losses*, that is, losses we can touch or count, and you've certainly had a bunch of those in recent years, the most recent being giving up drinking. But also 2 years ago you lost your work, which was important to you. Your husband died, you've had several divorces, and so far, I'm only touching on the big ones. Second, there are *intangible losses*, like the emotional losses you had when you left work, like losing the sense that you were really doing something important for children and the loss of trust in your friends when they confronted you about your drinking. And a third kind of loss, and maybe the most difficult to deal with, are *losses of what could have been* if such and such hadn't happened. I don't know if there have been a lot of "could have been" losses in your life, but I'd like for you to think about that, too.

SHIRLEY: Well, I don't *do* sad.

COUNSELOR: To paraphrase an old saying, "When the going gets sad, the sad get going."



Master Clinician Note: The counselor wants Shirley to consider that a lot of her anger is a cover for her sadness and other feelings, such as shame. Later, as time permits, the counselor might want Shirley to look at how her anger reinforces her distancing from others and keeps her isolated. But, for now, the focus of the session is still on creating safety with feelings other than anger.

SHIRLEY: Well, anger is safer.

COUNSELOR: And what is it about anger that makes it safer?

SHIRLEY: Well, for openers, it's not going to get out of control, although there have been times in this program in the last 3 weeks that I've wondered about that too.

COUNSELOR: Well, besides anger, I think there are places that may be safe enough for you to express some of your sadness. I kind of feel honored that you felt it was safe enough last week in the office to express some of that sadness and being overwhelmed and loneliness.

[Long pause. Shirley seems to be becoming detached from contact with the counselor.]

COUNSELOR: Shirley, I'm wondering where you have been safe enough with yourself in the past to feel sadness.

[Another long pause.]

SHIRLEY: You know, it was never safe as a kid to have any feelings. The only feeling anybody was allowed to have in our family was anger. Anything else could get you clobbered. I think one reason I worked in child welfare services for so long is that I didn't want kids to have to experience what I did. But the only place that comes to mind where I could really have my sadness was with Frank, my second husband. He drank heavily and that was the cause of our divorce, but when he was sober, or at least not dead drunk, he was there for me and I knew he wasn't going to look down on me or tell me to quit blubbering or any of that #*%!.

[Another long pause. Shirley looks sad. The counselor doesn't comment or intervene in a way that would distract Shirley. Shirley begins to wipe tears from her eyes. The counselor doesn't comment or intervene.]



Master Clinician Note: It's important for the counselor to maintain contact with Shirley, for instance, by just sitting quietly with her, but not interrupting this moment that is important for her. People need to grieve in their own ways. Some people "pour it out," others need to experience their losses in small steps. Still others need to put their losses into words and tell stories of their experience. Others need to conduct rituals, such as saying goodbye. Some experience their grief by watching movies or reading books that tend to describe their experience. Most people do a combination of all of these. It is important for the counselor not to impose his or her ways of grieving on the client. Different cultures, too, have differing ways of expressing grief and the counselor should be sensitive to the nuances of cultural influences.

[Finally, Shirley looks at the counselor.]

SHIRLEY: Well, you made me do this. Are you happy now?

COUNSELOR: I just want you to have the choice to be able to feel safe enough in some places to allow yourself to experience some of the feelings you hold inside. Because for every one of those losses or hurts, there was some kind of joy or happiness or pride or something special that was attached that you also open up to remember and hold close to you. That is to say, when we have to hold back on our losses and hurts, we also have to hold back on our joys and treasures that are connected to those losses.

[Pause.]

COUNSELOR: Before we stop, I remember what you told me when we started today: that when you left last week you felt out of control and wanted to drink. And I think that had a lot to do with the feelings that came up last week. And I just want to know where you are with that right now.



Master Clinician Note: Shirley has used alcohol as a cover for powerful feelings. Before the session ends, the counselor wants to be sure that Shirley will not leave the office, as in their last session, needing to drink “to get back in control.” He explores this with Shirley and helps her find options for feeling in control without alcohol use.

SHIRLEY: Well, actually, I feel . . . well, I feel okay right now. I don’t feel out of control. Actually, I feel a little relief. But, I’m not so sure I will feel okay at home alone if I start to feel sad.

COUNSELOR: What I want you to appreciate is that you really can allow some of your sadness to emerge and that at any time, you can just as quickly cut it off if you need to. And if you feel it’s getting too overwhelming, you can call someone you do trust, or perhaps, distract yourself by listening to music, or going for a walk. I think your work in this area is only beginning, that we just touched a little piece of it today. But, you know what? It’s not a race. It’s work you need to do on your own timetable and as you feel ready. Now, I know it would be easy for you to just touch on the surface of some of this stuff and then head in another direction, like getting busy or getting angry, so I’m going to keep reminding you of how important this is to you. And we’ll keep practicing, on your time schedule.

[The counselor wraps up the session.]

Summary

Shirley is just beginning the process of understanding the relationship of her emotions and the impact they have had on her alcohol use and her depressive symptoms. The process of grieving is likely to continue over some time, and it is important to build a treatment plan that supports her continued need to grieve. Similarly, it will continue to be important to help Shirley understand how her underlying shame has been a primary emotional dynamic in her life for years and how it is critically important for her to understand the role of shame in her alcohol use and emotional distancing. Twelve-Step programs, as well as counseling, can play an important role in addressing these issues in her recovery.