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 wildcatter 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

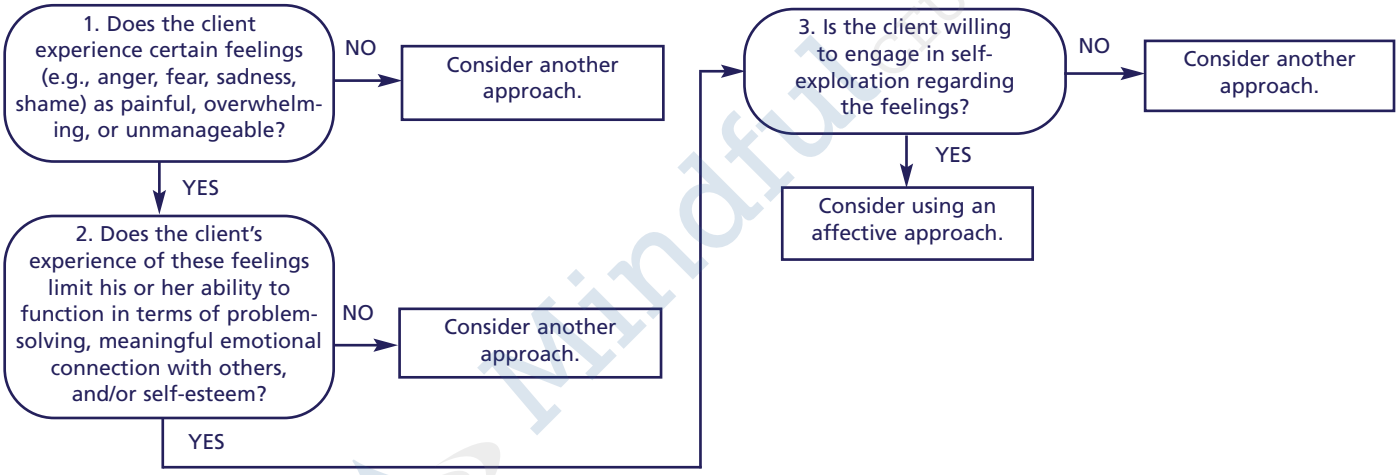
Feeling or affective-based therapies focus on feelings as a primary method of helping people change. These approaches are particularly appropriate when there are powerful primary feelings such as anger, fear, sadness, or shame that limit the individual's opportunity to solve problems, make meaningful 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.

"This course was developed from the public domain document: Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery: A Treatment Improvement Protocol (TIP 48) – Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services, 2014."