MANAGING DEPRESSIVE SYMPTOMS IN SUBSTANCE ABUSE CLIENTS DURING EARLY RECOVERY

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— Maya Angelou

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ABOUT THE INSTRUCTOR

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He has been the president of the International Association of Addictions and Offender Counseling and the editor of the Journal of Addictions and Offender Counseling as well as a member of many Criminal Justice, criminology, and counseling professional organizations prior to retirement.

Depressive Symptoms in Early Recovery: What We Now Know

Since TIP 48 was published, research has substantially advanced our understanding of how depressive symptoms manifest during early substance use disorder recovery, who is most at risk, and what interventions produce the best outcomes for this population.

The scope of the problem is larger than previously understood. A 2023 study tracking 10,103 patients entering substance use disorder treatment found that depressive symptoms during the first month are not a single, uniform experience. Using weekly measurements of demoralization (hopelessness, loss of meaning) and anhedonia (inability to experience pleasure), the researchers identified four distinct subgroups: patients with high symptoms in both domains, those whose symptoms remitted during the first weeks, those with high demoralization but preserved capacity for pleasure, and those with low symptoms throughout. Critically, every subgroup except the low-symptom group showed elevated rates of treatment discontinuation — meaning that depressive symptoms in any configuration predicted dropout (Rabinowitz et al., 2023). For clinicians, the distinction between demoralization and anhedonia matters. A client who feels hopeless but can still experience pleasure presents differently and may respond to different interventions than one who has lost the capacity for pleasure entirely. Global depression screening scores miss this distinction.

The suicide risk within this population demands particular attention. A separate study of 10,242 individuals entering residential substance use disorder treatment found that over one-third reported suicidal ideation at intake. Past-month self-harm and lifetime suicide attempts were the strongest predictors, but co-occurring anxiety, depression, and PTSD all independently elevated risk. Two physical health conditions — chronic pain assessed during treatment (OR = 1.59) and hepatitis C infection (OR = 1.65) — also correlated with suicidal ideation, a finding that underscores the need for integrated screening that extends beyond psychiatric symptoms to include medical comorbidities (Ellis et al., 2023). The researchers recommended real-time predictive models to identify high-risk individuals, rather than relying solely on intake screening that may miss clients whose suicidal ideation emerges or intensifies during the early weeks of treatment.

Treating the Intersection: Current Evidence on Depression and Substance Use

The challenge of treating depressive symptoms in clients with substance use disorders is that these conditions interact — each worsening the other in ways that make isolated treatment of either condition insufficient. Recent research has quantified this treatment disadvantage and identified approaches that show promise.

A 2025 meta-analysis examined 13 primary studies drawn from 35 systematic reviews spanning 2000 to 2024 and confirmed that individuals with concurrent mental health and substance use disorders are approximately twice as likely to experience adverse outcomes — relapse, emergency department visits, rehospitalization, and mortality — compared to those with a single disorder, with a pooled risk ratio of 1.71 (Scott & Gorey, 2025). This finding validates TIP 48's emphasis on integrated treatment but also raises the stakes: counselors working with depressed clients in substance use treatment are serving a population at measurably higher risk for every negative outcome.

What works for this population? A 2022 randomized controlled trial tested motivational interviewing with 302 patients who had both depression symptoms and unhealthy alcohol or cannabis use. At six months, MI participants achieved higher abstinence rates than those receiving printed educational materials — 70.0% versus 60.2% for alcohol, and 74.6% versus 63.9% for cannabis. The cost per abstinent patient was modest: approximately $1,207 to $1,523 for alcohol and $1,040 to $1,313 for cannabis. However, outcomes converged by 12 months, with no sustained difference between groups (Satre et al., 2022). The implication is that brief motivational interventions can produce meaningful short-term gains in this population, but maintaining those gains requires continuing care — a finding consistent with TIP 48's recommendation that treatment for co-occurring depressive symptoms should not be time-limited.

The question of whether integrated care can be sustained over time in treatment programs received a direct answer from a 2022 cluster-randomized trial. Researchers tracked 49 addiction treatment programs for two years after implementing integrated mental health and substance use services and found that both intervention and control groups "sustained their capability to provide integrated treatment services" at comparable levels (Chokron Garneau et al., 2022). For programs building the infrastructure to screen for and treat depressive symptoms alongside substance use disorders, this is encouraging: the clinical capacity, once developed, tends to persist.

The interaction between depressive symptoms, substance use, and criminal thinking patterns — relevant for justice-involved clients — was documented in a 2022 longitudinal study of 341 veterans in residential treatment. Using latent class analysis, the researchers found that 47% of participants fell into higher-risk subgroups characterized by elevated criminogenic thinking, substance use recurrence, or persistent drug use. These subgroups showed substantially elevated depression scores at follow-up compared to those showing normative improvement across all domains (Timko et al., 2022). The clinical takeaway is that depressive symptoms in justice-involved clients often signal a broader cluster of co-occurring conditions that require attention beyond depression-specific interventions.

Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery

A Treatment Improvement Protocol

TIP 48

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

DEPRESSION

Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery

Richard N. Rosenthal, M.D.
Expert Advisory Board Chair

Treatment Improvement Protocol (TIP) Series

48

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
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What Is a TIP?

Treatment Improvement Protocols (TIPs), developed by the Center for Substance Abuse Treatment (CSAT), part of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services (DHHS), are best-practices guidelines for the treatment of substance use disorders. CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to facilities and individuals across the country. As alcohol and drug use disorders are increasingly recognized as a major problem, the audience for the TIPs is expanding beyond public and private treatment facilities to include practitioners in mental health, criminal justice, primary care, and other healthcare and social service settings.

The recommendations contained in each TIP are grounded in evidence that includes scientific research findings and the opinion of the TIP consensus panel of experts that a particular practice will produce a specific clinical outcome (measurable change in client status). In making recommendations, consensus panelists engage in a process of "evidence-based thinking" in which they consider scientific research, clinical practice theory, practice principles, and practice guidelines, as well as their own individual clinical experiences. Based on this thinking, they arrive at recommendations for optimal clinical approaches for given clinical situations. Relevant citations (to research outcome reports, theoretic formulations, and practice principles and guidelines) are provided.

New TIP Format

Beginning with this TIP, 48, CSAT is embarking on a new approach to and format for TIPs. CSAT recognizes that its primary constituency is substance abuse treatment counselors. Working with and enabling the efforts of substance abuse counselors are program administrators and clinical supervisors. Market research conducted on the TIP series over the past several years has indicated these individuals want products that are short, concise, focused on how to perform relevant activities, and targeted to their particular needs. To those ends, this TIP is organized into three parts:

- *Part 1 for substance abuse counselors* focuses on providing appropriate counseling methods and frameworks.
- *Part 2 for program administrators* focuses on providing administrative support to implement adoption of the counseling recommendations made in Part 1.
- *Part 3 for clinical supervisors*, program administrators, and interested counselors is an online literature review that provides an in-depth look at relevant published resources. Part 3 will be updated every 6 months for 5 years.

Ideally, a supervisor might assemble a small group of counselors, hand out copies of this TIP (which are free), and begin a series of six or so meetings where the materials in the TIP would be reviewed, discussed, and in other ways used as an educational and training vehicle for the improvement of counseling skills (with the particulars of how this training would be done determined by the individual supervisor, based upon her or his unique situation, needs, and preferences). Thus, after a relatively short period of time and with few or no additional resources, this TIP could meet the challenge of fostering improvement in the delivery of substance abuse treatment services.

Development Process

This TIP was produced as a prototype for the new TIP series. Accordingly, the development process for this TIP differs from previous TIPs. The topic for this TIP was selected following an advisory meeting of experts in substance use disorders (Appendix E). Clinical staff members of the CDM/JBS Joint Venture developed the prototype (see p. v). An Expert Advisory Board, consisting of a chair and five panel members, was assembled to review the document (see p. vi). The Board provided guidance for revising the TIP prior to field review. The TIP then was field reviewed by an external group of subject matter experts, who provided suggestions for further refining the document (see Appendix F).

TIPs Online

TIPs can be accessed via the Internet at www.kap.samhsa.gov. The online *Managing Depressive Symptoms: A Review of the Literature, Part 3*, which will be updated every 6 months for 5 years, is also available at http://www.kap.samhsa.gov.

Foreword

The Treatment Improvement Protocol (TIP) series supports SAMHSA's mission of building resilience and facilitating recovery for people with or at risk for mental or substance use disorders by providing best-practices guidance to clinicians, program administrators, and payers to improve the quality and effectiveness of service delivery and, thereby, promote recovery. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. Clinical researchers, clinicians, and program administrators meet to debate and discuss their particular areas of expertise until they reach a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIP panelists and reviewers bring to this highly participatory process have helped bridge the gap between the promise of research and the needs of practicing clinicians and administrators to serve, in the most scientifically sound and effective ways, people who abuse substances. We are grateful to all who have joined with us to contribute to advances in the substance abuse treatment field.

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How This TIP Is Organized

This TIP is divided into three parts:

- *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery, Part 1.*
- *Managing Depressive Symptoms: An Implementation Guide for Administrators, Part 2.*
- *Managing Depressive Symptoms: A Review of the Literature, Part 3.*

Parts 1 and 2 are presented in this publication; Part 3 is available only online at www.kap.samhsa.gov. Each part is described below.

Part 1 of the TIP is for substance abuse counselors and consists of two chapters. Chapter 1 presents the "what" and "why" of working with clients with substance use disorders who have depressive symptoms. It covers:

- Background issues such as the nature and extent of depressive symptoms in clients receiving substance abuse treatment, an introduction to counseling approaches, issues related to the setting in which you work, cultural concerns, and your role and responsibilities.
- Preparing yourself to work with clients with depressive symptoms.
- Understanding the client with depressive symptoms and his or her world.
- Screening and assessment and knowing when to refer.
- Client-centered treatment planning.
- The treatment process.
- Continuing care.

Chapter 2 presents the "how to" of working with clients with depressive symptoms. Chapter 2 contains:

- Representative vignettes of counseling sessions with clients with depressive symptoms.
- How-to descriptions of specific counseling techniques.
- Master clinician notes and comments that help you understand the client, his or her issues related to depressive symptoms, and approaches you can take in your counseling work with clients with depressive symptoms.
- Decision trees that will assist you at key points in working with clients with depressive symptoms (e.g., when to refer and when to use a variety of differing counseling approaches).

It is strongly recommended that you read chapter 1 before reading chapter 2.

Part 2 is an implementation guide for program administrators and consists of two chapters. Chapter 1 lays out the rationale for the approach taken in chapter 2 and will help you understand the processes of organizational change and the factors that can facilitate or impede such change. Your understanding of these processes and factors will help you set reasonable goals and ensure that your journey is a rewarding one for all involved. Chapter 2 provides detailed information on how to achieve high-quality implementation of the recommendations in *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery, Part 1.*

Part 2 addresses:

- Why SAMHSA created an implementation guide as part of this TIP.
- Thinking about organizational change.
- The reasons for addressing depressive symptoms in treatment.
- The challenges of implementing new clinical practices.
- The role of the administrator in introducing and supporting new clinical practices.
- The steps of organizational change.

Part 3 of this TIP is a literature review on the topic of depressive symptoms, available for use by clinical supervisors, interested counselors, and administrators. Part 3 consists of three sections: an analysis of the available literature, an annotated bibliography of the literature most central to the topic, and a bibliography of other available literature. It includes literature that addresses both clinical and administrative concerns. To facilitate ongoing updates (which will be performed every 6 months for up to 5 years from first publication), the literature review will be available only online at www.kap.samhsa.gov.

And finally, a note about terminology. Throughout the TIP, the term "substance abuse" has been used to refer to both substance abuse and substance dependence (as defined by the *Diagnostic and Statistical Manual of Mental Disorders, 4th editing, Text Revision* [DSM-IV-TR] [American Psychiatric Association 2000]). This term was chosen partly because substance abuse treatment professionals commonly use the term "substance abuse" to describe any excessive use of addictive substances. In this TIP, the term refers to the use of alcohol as well as other substances of abuse. Readers should attend to the context in which the term occurs in order to determine what possible range of meanings it covers; in most cases, however, the term will refer to all varieties of substance use disorders described by DSM-IV.

Part 1

Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery

Chapter 1

Introduction

Overview

This Treatment Improvement Protocol (TIP) is designed to assist you—the substance abuse counselor—in working with clients who are experiencing depressive symptoms. These symptoms occur along a continuum of intensity from mild to severe. When they reach a certain level of intensity and frequency, they become consistent with a diagnosis of a mood disorder, such as major depressive disorder, dysthymic disorder, substance-induced mood disorder, or bipolar disorder. It is clear from clinical research and practice that a significant percentage of your clients have depressive symptoms. Some, but not all, will have these depressive symptoms in the context of a mood disorder diagnosis. Even if you will not be diagnosing and treating depressive illnesses—which is in the scope of practice of those mental and behavioral health professionals licensed in your State to diagnose and treat mood disorders, and capable of doing so—you will be providing substance abuse counseling to clients with these diagnoses and to clients with depressive symptoms but whose mood states do not reach a level that would warrant a mood disorder diagnosis (that is, clients whose symptoms do not meet the diagnostic criteria).

The contributors to this TIP have all had experience as substance abuse counselors or treatment researchers. They have used their understanding of the treatment process to make this TIP as relevant as possible to you. Although the focus of this TIP is on clients with substance use disorders who have depressive symptoms, some of the material presented should be useful to you in all your counseling work.

Depressive Symptoms

The term "depressive symptoms" refers to symptoms experienced by people who, although failing to meet DSM-IV-TR diagnostic criteria for a mood disorder, experience sadness, depressed mood, or "the blues," and one or more additional possible symptoms listed in Figure 1.1, p. 5.

Depressive symptoms are common among clients in substance abuse treatment. Findings from a 2001–2002 national survey indicate that substance abuse counselors will encounter significant numbers of individuals with co-occurring substance abuse and depressive symptoms. Among people who have had past year contact with health personnel or social service agencies and who also have had a past year substance use disorder, 40 percent of those with an alcohol use disorder also had an independent mood disorder and 60 percent of those with a drug use disorder had an independent mood disorder (Grant, Stinson, Dawson, Chou, Dufour, Compton, et al., 2004). Also, of all the people interviewed, one third indicated that sometime during their lives they had had 2 weeks or more during which they had felt down most of the time; sad, blue, or depressed; or didn't care about or enjoy the usual things (Compton, Conway, Stinson, & Grant, 2006). In general, women with substance use disorders have higher rates of co-occurring psychiatric disorders than men. Some studies suggest a higher rate of depressive symptoms in women, although other studies find no such differences.

These findings indicate that it is likely you will encounter clients with substance use disorders who have depressive symptoms—as many as half of the clients you see. Initial intake personnel are charged with identifying clients who are experiencing depressive symptoms when they enter treatment. However, depressive symptoms may appear at any time during substance abuse treatment. Look for pertinent notes in the client's chart and follow up on any indications that your client is experiencing symptoms of depression.

When they occur, depressive symptoms can interfere with clients' recovery and ability to participate in treatment. For example, someone with a depressive symptom such as poor concentration may have more difficulty paying attention to group therapy sessions or listening to another member share experiences in a 12-Step meeting. Thus, counselors must gain the skills necessary within their licensure and scope of practice to promote recovery in individuals with substance use disorders and depressive symptoms that affect their ability to participate fully in treatment.

The methods and techniques presented in this TIP are appropriate for clients in all stages of recovery. However, the focus of this TIP is on **early recovery**—that is, the first year of recovery—when depressive symptoms are particularly common.

This TIP is not about treating any mood disorder as defined in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, Text Revision (DSM-IV-TR; American Psychiatric Association [APA], 2000). Clients with diagnosed mood disorders (e.g., major depression, dysthymia, cyclothymia, bipolar disorder, substance-induced mood disorder) need specialized treatment from a trained and licensed mental health professional. However, it is important for you to be aware of the impact of these depressive symptoms on clients' recovery and your need to have the clinical skills to interact more effectively with these clients, who may or may not have a diagnosed mood disorder. (A review of mood disorder diagnoses is included in Appendix D of this TIP.).

Consensus Panel Recommendations

Although you have been trained in providing substance abuse treatment, that training most likely did not include management of your clients' depressive symptoms. This TIP was designed to fill that gap. In particular, the Consensus Panel recommends:

- All substance abuse treatment clients should be screened for depressive symptoms.
- You should be aware of the ways depressive symptoms can manifest in clients with substance use disorders and how those symptoms can affect substance abuse recovery.
- You should be aware of the ways depressive symptoms can affect clients' participation in treatment.
- Substance abuse treatment for clients with substance use disorders and depressive symptoms should be client centered and integrated.
- Several intervention methods have been used successfully to manage depressive symptoms in substance abuse treatment: behavioral, cognitive–behavioral, supportive, expressive, 12-Step facilitation, and motivational interviewing.
- You should be aware of the manner in which your attitudes toward clients with depressive symptoms can affect your ability to work with these individuals.

Substance Abuse Counselors—Scope of Practice

This TIP is designed for substance abuse counselors who have direct clinical contact with clients who have substance use disorders. The legal titles, levels, types of licenses, and certifications for substance abuse counselors differ across the 50 States and the District of Columbia. This TIP is intended to benefit all licensed or certified substance abuse counselors, regardless of their titles. The counseling activities described in this TIP are legally and ethically appropriate for substance abuse counselors to undertake in all 50 States and the District of Columbia. This TIP may also be beneficial for people preparing to become certified or licensed substance abuse counselors. *However, uncertified or unlicensed counselors should use these methods only under the supervision of an appropriately trained and certified or licensed substance abuse professional.* Furthermore, maintaining collaborative relationships with mental health treatment providers for consultation and referral is recommended, either directly or through clinical supervision.

This TIP also provides useful ideas for dealing with depressive symptoms for those of you with advanced degrees and/or additional clinical experience.

Framework

This chapter provides basic information on:

- The nature of depressive symptoms.
- The relationship between depressive symptoms and the toxic or withdrawal effects of substances.
- The relationship between depressive symptoms and substance use disorders.
- The effect of substances on recovery from depressive symptoms.
- Suicidality among clients in substance abuse treatment with depressive symptoms.
- How depressive symptoms affect treatment participation.
- The concept of integrated care for substance abuse and depressive symptoms.
- Approaches and psychosocial interventions for working with depressive symptoms.
- Special considerations related to the substance abuse treatment setting in which you work.

- Special considerations related to the cultures of your clients.
- Your professional role and responsibilities in relation to clients with depressive symptoms.
- Preparing yourself to work with clients with depressive symptoms.
- Screening and assessment.
- Treatment planning.
- Treatment.
- Continuing care and treatment termination.

The Nature of Depressive Symptoms

The term "depressive symptoms" is generally applied to a mood state of sadness, depressed mood, "the blues," or other related feelings and behaviors (see Figure 1.1) that do not meet the diagnostic criteria for a DSM-IV-TR mood disorder. People who have depressive symptoms may experience considerable emotional pain and may have significantly impaired functioning in some areas.

Symptoms of depression exist on a continuum. At one end of the spectrum is the experience of sadness and other depressive symptoms occurring at appropriate times and for short periods, during which the individual successfully uses coping strategies. At the other end is clinical (or "major") depression, as described in DSM-IV-TR. The line between depressive symptoms and psychiatric depressive disorders is a question of degree. Having depressive symptoms differs from having a major depressive disorder in terms of the number or severity of symptoms experienced by a client, not in terms of the types of symptoms. *Only a professional credentialed to diagnose mental illness can determine for certain whether a client has a serious depressive disorder such as major depression, dysthymia, bipolar disorder, or substance-induced mood disorder* (See Figure 1.3 on p. 8 for more information on substance-induced depressive symptoms). If you suspect that a client has a depressive illness, you should refer the client to a mental health professional for assessment, diagnosis, and treatment. Screening for depression, as discussed later in this chapter, will help you to decide when to refer.

Clients may have more or less intense depressive symptoms over time. This may be due to the client's biology, stressful events in the client's life, or the client's stopping or starting substance use. For example, someone who is drinking heavily may have intense depressive symptoms that seemingly meet criteria for depressive illness except that the symptoms dramatically lessen in the weeks after initial abstinence from alcohol. Similarly, someone with major depression or dysthymia who is taking antidepressant medication over several weeks may also show fewer or no currently debilitating depressive symptoms. Conversely, a client who now demonstrates only mild depressive symptoms may be on his or her way to a significant depressive episode.

Figure 1.1
Depressive Symptoms and Related Feelings and Behaviors

- Loss of interest in most activities
- Significant unintentional change in weight or appetite
- Sleep disturbances
- Decreased energy, chronic fatigue or tiredness, feeling exhausted
- Feelings of excessive guilt
- Feelings of low self-esteem, low self-confidence, or worthlessness
- Feelings of despair or hopelessness (pervasive pessimism about the future)
- Avoidance of normal familial and social contacts
- Frequent agitation, restlessness
- Psychologically or emotionally detached
- Feelings of irritability or frustration
- Decrease in activity, effectiveness, or productivity
- Difficulty in thinking (poor concentration, poor memory, or indecisiveness)
- Excessive or inappropriate worries
- Being easily moved to tears
- Anticipation of the worst
- Thoughts of suicide

As with substance abuse, even though a person may be in remission from a depressive illness, the disorder remains. Prevention of and early intervention in recurrences must be addressed in treatment, especially in early recovery from substance use disorders. Many depressive disorders cycle and recur. If a client has a history of a mood disorder, the client and counselor should both be on the lookout for a recurrence of symptoms.

In addition, there are significant individual and cultural differences in how people talk about depressive symptoms. Counselors need to listen carefully to what clients say and probe for clarification. For instance,

many people say they are "stressed." This could range in meaning from having too much work to a significant symptom of depression.

Depressive symptoms must be distinguished from normal moods or emotions, such as sadness, that occur in all of us (see Figure 1.2). Normal sadness is connected to a specific experience, perhaps a specific loss, while depressive sadness may be without conscious reason to the individual. People who are depressed may say "I'm sad and I don't know why." Generally, normal sadness or depressed mood lasts for no more than a few days, while sadness driven by depression may be ongoing. As an exception, acute grief is a normal state of sadness that can last weeks or months.

Depressive symptoms may come and go for a period up to a few months; these are sometimes called "episodic." Other depressive symptoms are always or almost always present, and these are referred to as "chronic."

Life events associated with depressive symptoms include loss (e.g., of a loved one, of a job), stresses of various kinds (e.g., financial, family, work), major life

Figure 1.2
How To Distinguish Among Normal Moods, Depressive Symptoms, and Depressive Illness

Symptoms of depression exist on a continuum that ranges from transient, relatively brief periods of "the blues" to major, debilitating symptoms that immobilize a person. The actual symptoms that occur across this continuum are similar but vary substantially in their frequency, their intensity, and the impact they have on the person. A list of depressive symptoms and related feelings and behaviors is in Figure 1.1 (see page 5).

When individuals are experiencing normal moods, you might expect the following:

- A variety of affects are available and can be experienced by the individual, or conversely stated, powerful affects do not have to be blocked or avoided.
- The range of affects expressed is appropriate to the context and stimuli.
- Affects can vary over a period of time, such as a day or week.
- The individual can continue to engage in solving life's dilemmas.
- The individual does not get locked into an extreme emotion.
- The individual is able to cognitively assess and change a mood.
- Mood swings or "the blues" are time limited.
- These moods don't impact functioning in major life areas.

For individuals experiencing depressive symptoms:

- The symptoms might be more pervasive extending beyond an expected time frame.
- Some affects may feel too powerful to the individual and have to be blocked or distorted.
- While the affect expressed might feel "normal" or appropriate to the person, others might consider the person to be emotionally over- or underreacting.
- A person will get stuck in an emotion, such as fearful or sad and not be able to shake it, or he or she may look to an outside influence, such as a drug, to change the mood.
- There may be significant impairment in a life-functioning area, such as relationships or work performance.
- There may be significant reduction in use of healthy coping styles, resulting in adaptive responses that limit choice or alienate others.
- There might be a significant negative or pessimistic cognitive bias, resulting in a person seeing life through negative filters.
- A person might not be able to consistently identify his or her mood or might label an affect in a way that seems confusing to others. For instance, a person may identify himself as scared when he seems sad to others.

In addition to the emotional expressions noted under depressive symptoms, someone with depressive illness:

- May be severely limited in the emotions he or she is able to experience.
- May, at the same time, get "locked in" to an emotion, such as anger, sadness, or anxiety, and respond to almost all stimuli through that emotion.
- May express emotions in response to stimuli that seem incongruent to others.
- May recognize that the emotional response is extreme or muted but not be able to change the response.
- May have significant impairment in most areas of life functioning.
- May have significantly distorted cognitive functions.

changes (e.g., graduation, marriage, divorce, birth of a child, starting a new job), past losses and traumatic events (sometimes forgotten), hormonal changes, and brain chemistry. Note that some of these life changes are generally viewed by society as positive. Nonetheless, they can initiate depressive symptoms in some people. It is a natural part of the human experience to feel a sense of loss and regret when making a change, whether it is positive or negative.

People with certain medical conditions, such as hypothyroidism and B-12 deficiency, may have depressive symptoms (e.g., low energy, fatigue, weight gain, poor concentration and memory) as part of their clinical presentation. Therefore, a physical examination is recommended to rule out medical conditions that might mimic or enhance a depressive illness. Finally, the experience of "hitting bottom," entering substance abuse treatment, and beginning a sober life can precipitate depressive symptoms or even a depressive illness.

Depressive symptoms may also correlate to the high level of stress that often accompanies substance abuse, including financial problems; job loss; and alienation from friends, significant others, and family members. Clients using alcohol or drugs often neglect their health as well as friends, family, work, hobbies, and other sources of normal satisfaction. This in itself can lead to depressive symptoms or depression. Stress is one of the most important risk factors, not only for the development of substance use disorders, but also for the development of depressive symptoms.

Some people have depressive symptoms during some periods of their lives and depressive illnesses during other periods (see *Managing Depressive Symptoms: A Review of the Literature*, Part 3, at www.kap.samhsa.gov). Clients who experience a period of depressive symptoms appear to be at increased risk of an episode of major depression or other depressive illnesses. Thus, it is important for the substance abuse counselor to monitor the client's depressive symptoms on a regular basis (see the screening and assessment section of this chapter, p. 20).

The Relationship Between Depressive Symptoms and the Toxic or Withdrawal Effects of Substances

Intoxication and/or withdrawal from certain substances can lead to depressive symptoms. The DSM-IV-TR provides a description of behavioral, physiological, and psychological symptoms related to each class of drug. If these symptoms are significant enough, they may be characterized as a substance-induced mood disorder (see Appendix D for a description of this disorder). These drug-induced symptoms can last as long as an individual continues to take substances and may or may not improve with abstinence. This may be because of toxic effects on the nervous system of chronic exposure to substances.

Depressive symptoms can linger for 3 to 6 months after abstinence and must be treated in counseling. Because appropriate treatment for depressive symptoms has been shown to improve substance-related outcomes (Dodge, Sindelar, & Sinha, 2005), addressing depressive symptoms must be of concern to you as a substance abuse treatment counselor. Depressive symptoms typically associated with common substances of abuse are detailed in Figure 1.3 (p. 8).

The Relationship Between Depressive Symptoms and Substance Use Disorders

Substance use disorders relate to depressive symptoms or a depressive disorder in a variety of ways. Having a substance use disorder increases the risk of experiencing depressive symptoms or a depressive disorder. Similarly, having a depressive disorder increases the odds of having a substance use disorder (Nunes, Rubin, Carpenter, & Hasin, 2006).

Depressive symptoms can precede, follow, or co-occur with substance abuse symptoms. In many cases, it is important to understand the evolution of these conjoint symptoms in each client's history. Depressive symptoms can result from the direct effects of alcohol or drugs on the central nervous system or from withdrawal of those drugs as described in Figure 1-3. Cocaine intoxication and withdrawal can produce

Figure 1.3
Depressive Symptoms Typically Caused by Substances of Abuse

Substance	Associated Depressive Symptoms		
	Intoxication	Withdrawal	Chronic Use
Alcohol		Depressed mood, anxiety, poor appetite, poor concentration, insomnia, restlessness, paranoia and psychosis	Depressed mood and other depressive symptoms
Opioids	Low energy, low appetite, poor concentration	Depressed mood, fatigue, low appetite, irritability, anxiety, insomnia, poor concentration	Depressed mood and other depressive symptoms
Cocaine and stimulants	Anxiety, low appetite, insomnia, paranoia and psychosis	Depressed mood, increased sleep, increased appetite, anhedonia, loss of interest, poor concentration, suicidal thoughts	Depressed mood and other depressive symptoms
Cannabis	Anxiety, apathy, increased appetite	Anxiety, irritability	Low motivation, apathy
Sedative-hypnotics	Fatigue, increased sleep, apathy	Anxiety, low mood, restlessness, paranoia and psychosis	Depressed mood, poor memory

symptoms that look like major depression, except that they typically reduce in intensity in a matter of days after abstinence is initiated (Husband, 1996). An individual with a substance use disorder may experience depressive symptoms as a result of the losses or life problems caused by the substance use over time. The person may have lost a job, an important relationship, or financial security, and feel depressed, yet not meet criteria for a depressive disorder.

Untreated depressive symptoms can influence the client's response to substance abuse treatment and the ability to remain substance free over time. For example, perhaps one of your clients who has recurrent depressive symptoms and cocaine dependence refuses to take her antidepressant medications as prescribed. She demonstrates a pattern of relapse to drug use when she uses cocaine to boost her mood during periods of depression. In his book *Darkness Visible: A Memoir of Madness* (1992), author William Styron provides an excellent and detailed description of how his depression significantly worsened after he stopped drinking alcohol. He felt that his alcoholism initially covered up his depression, which became intolerable after he quit drinking, causing him considerable anguish.

It is important to remember that both problems and their symptoms are primary illnesses and would probably occur without the influence of the other. In this context, an integrated treatment plan, addressing both disorders, is essential.

Sometimes, one disorder precedes the other. For example, people who are sober from alcohol or drugs for months or years can later develop an episode of depressive symptoms or major depression. Similarly, people recovering from a depressive disorder can develop alcohol or drug abuse or dependence years after the end of treatment or during a course of treatment. The important point to remember, regardless of which disorder came first, is that both substance abuse and depressive symptoms need to be treated concurrently.

A substance use disorder can contribute to a delay in seeking treatment among those with depressive symptoms. It can also interfere with a client's successful transition from inpatient care to ambulatory treatment.

Substance use can cover up depressive symptoms, making it hard to identify depression until a client stops using substances and remains sober for days, weeks, or longer. For example, Steve had been dependent on alcohol for 8 years and drank large quantities nearly every day. He also had depressive symptoms that preceded his alcoholism, but his alco-

hol use covered them up. Although Steve sought help for his depressive symptoms over the years, treatment was only partly effective because he continued drinking heavily and minimized his alcohol problem. After detoxification, when he began working on a program of recovery, Steve's depressive symptoms actually worsened. Since he was used to reducing his depressive symptoms with alcohol, his mood symptoms caused strong cravings and thoughts of using alcohol. It was clear that in order to help him stay sober, Steve needed evaluation and treatment for his depressive symptoms.

Effects of Substances on Recovery From Depressive Symptoms

Substance use, abuse, or dependence can cause depressive symptoms to worsen and complicate recovery from a depressive illness. These effects may also interfere with a client's response to medications or other therapeutic interventions. Helplessness and hopelessness are common experiences for clients with substance use disorders and those with depressive symptoms. Having both tends to compound these reactions.

Hopelessness and relapse to alcohol and drug use are interrelated. Hopelessness creates a psychological environment that supports drug relapse. At the same time, drug relapse may increase the experience of hopelessness. The combined effect of relapse and hopelessness is to make treatment more difficult. The client may be more resistant to following the treatment plan and may blame lack of improvement on such external factors as medications, the treatment program protocols, other clients in the program, or the counselor's skills.

Depression and hopelessness, combined with alcohol and/or drug use, may also increase the potential for violence to self or others. The client may be at higher risk for thinking about, planning, or acting on suicidal thoughts.

Suicidality Among Clients in Substance Abuse Treatment With Depressive Symptoms

Two populations with the highest rates of suicide are people who are depressed and people with a substance use disorder diagnosis (Center for Substance Abuse Treatment [CSAT], 2005c; Kessler, Berglund, Borges, Nock, & Wang, 2005). As a result, all clients with substance use problems and depressive symptoms should be screened for suicidality. TIP 42, *Substance Abuse Treatment for Persons With Co-Occurring Disorders* (CSAT, 2005c), provides detailed information appropriate for both screening and assessment of suicidality. There is no generally accepted and standardized instrument that can accurately measure suicide potential. **Suicide screening and assessment scales can be used as aids, but if a client shows signs of being at risk of suicide, these scales are not a substitute for a thorough clinical interview by a qualified mental health clinician, during which client and counselor can talk openly about suicidality.** Any client showing warning signs or risk factors for suicidality should be assessed by a mental health professional specifically trained in conducting suicidal risk evaluations (APA, 2000) (see also Decision Tree on When To Refer a Client, p. 37). Most clients with suicidal ideation want a path out of their pain without harming themselves. It is their current perception, however, that such a path isn't available to them.

Some of the common **myths** about suicidality include:

1. Clients will not make a suicide attempt if they promise the counselor to not harm themselves.

   FACT: A variety of circumstances can influence suicidal behavior. A promise by a client not to harm himself may not apply when a client is confronted with a variety of environmental, interpersonal, and psychological stressors. A "commitment to treatment" plan is generally considered more useful than a "no-suicide pact" (Rudd, 2006).

2. Talking about suicidal thoughts will put the idea in a client's head and make the problem worse.

   FACT: Most clients want to talk about their suicidal thoughts and plans with someone. Talking with a nonjudgmental, accepting person about suicide can offer relief (Gliatto & Rai, 1999).

3. Changing a client's perception of the events in her life will change her suicidality.

   FACT: Events are only one variable in an individual's suicidality. Other variables include the individual's interpersonal support system; psychological variables such as depressive symptoms, depressive illness, despair and emptiness; cultural values

and influences regarding suicidal behavior; and access to a method for suicide (Rudd, Joiner, & Rajab, 2001).

4. A client is not at risk of suicide unless he can describe a plan.

   FACT: People sometimes impulsively act on suicidal thoughts, without a well-defined plan (Rudd et al., 2001).

Some "do's" for working with clients who have suicidal thoughts or plans include:

1. Seek the clinical support and input of supervisors, consultants, and treatment team members.
2. Obtain the informed consent of the client to consult with a supervisor, appropriate mental health professionals, and referral resources about the client's care.
3. Listen to the client's experience and feelings without judgment.
4. Encourage clients to talk about their suicidal ideation, whether plans have been considered or made, and whether a method (a gun or medication, for instance) is available. This is important information to have when you consult with a supervisor or mental health professional.
5. Don't allow yourself to be sworn to secrecy about the client's suicidal thoughts or intent.
6. Engage the client in participating in a plan of care to intervene with suicidal thoughts and/or behaviors.
7. If possible, involve the client's family and significant others in supporting the client.
8. Have a clear understanding of the ethical, legal, and agency guidelines in working with clients who are suicidal. (See also the forthcoming TIP, *Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment*, and [CSAT, in development a].)

How Depressive Symptoms Affect Treatment Participation

Depression can affect almost any area of functioning. As a result, the client with depressive symptoms may have problems such as the following:

- Difficulty in concentrating and integrating materials, such as program rules and program assignments.
- Trouble keeping appointments.
- Lack of energy to participate in substance abuse treatment program activities such as group therapy, family therapy, 12-Step meetings, and recreational activities.
- Lack of perceived ability or motivation to change
- Belief that he or she is beyond help.
- Difficulty engaging in recovery activities because of social withdrawal.
- Being overwhelmed by feelings (sadness, anger, hopelessness).

As a substance abuse counselor, you want your clients to achieve abstinence and an improved quality of life. Addressing depressive symptoms is a part of reaching both those goals. Clients with depressive symptoms may have difficulty relating to other clients. They may see themselves as different and distance themselves from other clients and may not be interested in participating in group activities. Vignettes 2 and 4 in chapter 2 of this TIP demonstrate techniques for dealing with some of these challenges.

Because clients with depressive symptoms are more likely to relapse after treatment is completed (see *Managing Depressive Symptoms: A Review of the Literature, Part 3*, at www.kap.samhsa.gov), the work you do with clients to reduce depressive symptoms will yield added benefits in terms of supporting abstinence.

The Concept of Integrated Care for Substance Abuse and Depressive Symptoms

Integrated treatment for both problems is the standard of care for clients with substance abuse and depressive symptoms or any co-occurring mental disorder. Integrated interventions are specific treatment strategies or therapeutic techniques in which interventions for two or more co-occurring disorder diagnoses or symptoms are combined in a single session or interaction, in a series of interactions, or in multiple sessions over time (CSAT, 2005a). These can be acute interventions to establish safety, as well as ongoing efforts to foster recovery.

You can make a basic error if you treat clients as a collection of parts rather than as individuals who are trying to integrate all their experiences and feelings into a single understanding of themselves. An example of this is when the client's substance abuse and depressive symptoms are treated as though they are separate issues. While in some ways, these problems are indeed separate (e.g., each has its own history, symptoms, treatment approaches, and neither "goes away" just because the other is addressed), they cannot be separated because they exist in the same person at the same time.

The case example of Steve, provided earlier in this chapter, illustrated the problems encountered when depressive symptoms or substance abuse are treated independently. If counselors try to treat only the substance abuse, the depressive symptoms get in the way and vice versa.

It is also important to note that substance abuse and depressive symptoms may interact in various ways. For example, the personal exploration central to recovery from substance use disorder may bring to the surface memories or feelings that activate or exacerbate depressive symptoms. Loss of the "old friend" that substance abuse and associated lifestyles represent may cause grief. Similarly, depressive symptoms are known to be cues for craving (see *Managing Depressive Symptoms: A Review of the Literature, Part 3*, at www.kap.samhsa.gov) or may contribute to feelings that all change, including recovery, is impossible.

For all these reasons, care for the person with substance abuse problems and depressive symptoms must be integrated. This means treating each disorder as "primary" (i.e., having its own cause and course) but also treating each within the context of the other.

Further discussion of the concepts of integrated care can be found in TIP 42 (CSAT, 2005c).

Approaches and Psychosocial Interventions for Working With Depressive Symptoms

Many psychological therapies (e.g., cognitive–behavioral therapies [CBT], psychoeducation) help the client build adaptive strategies for coping with depressive symptoms. The literature reports that the therapies substance abuse counselors are generally trained in (such as CBT, supportive counseling, and psychoeducation), are effective in relieving depressive symptoms (Carroll, 1998). Counselors therefore do not need to learn a whole new skill set, but rather to translate what they already know to the language of depression. Some drug therapies (such as antidepressants) are effective in relieving depressive symptoms.

As stated above, depressive symptoms exist on a continuum. The difference between having depressive symptoms and having clinical depression can be the presence of a single symptom or the degree to which a specific symptom limits a person's ability to function. There is also no current evidence that the causes of depressive symptoms differ from those of significant depressive illness. Until further research is available, it is sensible to assume that those interventions and counseling approaches that work for depressive illnesses will likely be of help to persons with depressive symptoms.

Interventions Used in This TIP—Chapter 2 provides the application of a number of interventions for depression, including:

- Educating clients about depression and depression recovery.
- Integrating counseling for substance abuse and depressive symptoms.
- Understanding depression.
- Reframing negative thoughts.
- Testing negative beliefs against reality.
- Helping clients identify and change maladaptive behaviors.
- Developing coping strategies.
- Exploring and understanding emotions related to substance abuse and depression.
- Providing support and encouragement to the client.
- Motivating the client to change.

Many of these strategies are described in the work of Miller and Rollnick on motivational interviewing (2002). All these interventions seek to break the cycle of maladaptive thoughts, beliefs, behaviors, and emotional reactions that are characteristic of depression.

Brief descriptions of the major intervention techniques used in this TIP follow:

- *Behavioral interventions*—Behavioral interventions focus on helping clients change problematic behaviors or take on new behaviors that will benefit and sustain recovery. Behavioral interventions assume that as an individual changes behavior, more productive thinking and feelings will follow. For example, behavioral activation is an intervention that, by identifying behaviors that maintain or worsen depression and then scheduling rewarding activities, assists clients with depressive symptoms in overcoming inertia and avoidance despite their depressed mood or lack of motivation (Jacobson, Martell, & Dimidjian, 2001). When clients with depressive symptoms become more active, they focus less on painful feelings, and because of this respite, tend to feel more motivated and energetic. Behavioral activation using activity scheduling is an effective treatment for depression and should be of specific use in clients with depressive symptoms (Cuijpers, van Straten, & Warmerdam, 2007b).
- *Cognitive–behavioral therapy*—CBT integrates principles derived from both cognitive and behavioral theories. Cognitive theory suggests that cognitions or thoughts mediate between environmental demands and an individual's attempts to respond to them effectively. Behavioral theory suggests that changing behavior can be a powerful influence on both the acceptance of changes in cognitions about self or a situation and on the establishment of a newly learned pattern of cognitive–behavioral interactions. A large number of clinical trials have demonstrated that cognitive therapy is efficacious for depression (Dobson, 1989). Analyses of other controlled studies show that CBT has a significant impact on depressive symptoms (Cuijpers, Smit, & van Straten, 2007a). In practice, CBT makes use of a wide range of coping strategies, not all of which are cognitive in nature (e.g., having individuals change behaviors directly rather than focusing on change in thinking). CBT is often the basis of relapse prevention counseling in substance abuse treatment.
- *Supportive therapy*—Supportive psychotherapy, the most frequently used psychological treatment in the United States, uses direct measures to reduce or eliminate symptoms and to help the client maintain, restore, or improve self-esteem, adaptive skills, and psychological functioning. These positive changes in the client are a result of therapist interventions such as active expression of interest and empathy, offering appropriate praise and reassurance, a general focus on here-and-now relationships, modeling adaptive behavior and anticipatory guidance, and respect for defenses (Winston, 2004).
- *Expressive (affectively based) therapies*—Expressive therapies focus on assisting clients in experiencing and modulating feelings that have been disavowed or distorted. The goal of expressive or supportive/expressive therapy is to have feelings be a productive rather than limiting component of recovery and, by accessing feelings, to change cognitions, behaviors, and self-esteem.
- *Motivational interviewing*—The goal of motivational interviewing and related motivational strategies is to assist clients in mobilizing, seeking, and benefiting from a variety of change approaches, as well as to sustain the energy required to achieve lasting change.

Choosing Among Interventions—There is no cookbook that will tell you which interventions to use with a given client at a given point in his or her recovery. Rather, the interventions described above and demonstrated in chapter 2 constitute a toolkit on which you can draw.

Different substance abuse treatment counselors emphasize different interventions and approaches depending on their skills, preferences, and counseling styles. Effective counselors also adapt their toolkits to the specific needs of the client. If you are not comfortable with a given intervention, it is not likely to help your client. Thus, it may be best initially to use a limited number of techniques and expand your toolkit as you gain experience, confidence, and competence.

As discussed later in this chapter under Client-Centered, Integrated Treatment Planning (p. 22), your client's values and patterns of relating to others will also dictate the strategies you use. Specific elements of your client's culture may make some interventions inappropriate.

Evidence-Based Thinking—Some counselors may find it useful to think of their work in terms of "evidence-based thinking" (Hyde, Falls, Morris, & Schoenwald, 2003). Evidence-based thinking means picking the best clinical option available for a given client in a given context based on the best current information.

The information that is used in evidence-based thinking includes:

- Research and the experience and recommendations of clinical experts.
- Your past experience.
- Your personal preferences and style.
- Advice from your clinical supervisor.
- The needs, values, preferences, and characteristics of the client.
- Constraints such as the number of sessions you have available.

Evidence-based thinking mixes science and clinical experience with a large measure of common sense. Counselors who use evidence-based thinking are flexible—always looking out for changes in the client's needs, and constantly adjusting their approach to make use of new information.

Special Considerations Related to the Substance Abuse Treatment Setting in Which You Work

Most information presented in this TIP is applicable to any setting in which clients with substance abuse problems receive treatment. However, different kinds of substance abuse treatment settings may place limits on what you can do. The vignettes in chapter 2 take place in a variety of settings including inpatient, intensive outpatient (day treatment), and outpatient to demonstrate issues that may arise in each type of setting.

Sometimes, responding to the needs of clients with depressive symptoms may require a departure from the way your program normally provides services. For example, clients with depressive symptoms may require more individual attention, and some of these clients will have trouble participating in groups. If your program does not currently provide for extra individual sessions, new arrangements may need to be made. Similarly, some clients may initially feel too low or blue to participate in recreational activities, occupational therapy, or other program components. If participation is currently mandatory, some changes to accommodate people who are depressed might be considered.

As you learn from this TIP and gather ideas for working with clients with depressive symptoms, share your thoughts with your clinical supervisor, your treatment team members, and, where appropriate, with program administrators. See whether there is room for the changes you think are needed, and collaborate with supervisors and administrators to find the best ways to meet the needs of your clients with depressive symptoms. Refer them to Part 2 of this TIP, *Managing Depressive Symptoms: An Implementation Guide for Administrators*, for further information on changes in your substance abuse treatment program that may be important to meet client needs.

Special Considerations Related to the Cultures of Your Clients

Individuals from different cultures and ethnic groups will experience and report symptoms of depression differently. General observations can be made, but it is of the utmost importance that you seek to understand each individual with whom you work. Some ethnic groups speak of depressive symptoms in terms of physical symptoms (headache, fatigue, gastrointestinal discomfort) and therefore seek the assistance of a medical doctor. This is common among some Asians, Hispanics/Latinos, and some non-Hispanic whites (especially from families where emotions are denied or minimized).

Another phenomenon is that depression is collectively denied by an ethnic group or subculture and therefore is not discussed or reported. For instance, African-American women are often socialized to deny the existence of their own needs and feelings and do not acknowledge depression. They may say things like, "well, that's just the way life is; life is hard." These statements may reflect feelings of hopelessness and frustration associated with external situations such as financial stress, family dysfunction, and racism. However, these statements may also reflect the presence of undiagnosed depression. Additionally, having been raised to believe that one has "no needs," seeking the assistance of a treatment program (by choice or through mandate) is likely to evoke intense shame, increasing the difficulty in opening up and getting support. Lastly, if children are involved, women are, understandably, afraid to report difficulties for fear the local child protective services agency will become involved. All these issues can make engaging in treatment and trusting the counselor difficult (Jackson & Greene, 2000).

Some older Americans will talk of having had a "nervous breakdown," which for some is another word for depression. But for others, "nervous breakdown" may mean other psychiatric disorders, such as anxiety disorder or an exacerbation of schizophrenic illness. It is therefore important to explore not only the symptoms experienced in the "breakdown," but also the environment in which the "breakdown" occurred, how long the symptoms lasted, and what happened that resulted in the remission of symptoms.

Some cultures, particularly Latino and Caribbean cultures, talk in terms of nerves. An "ataque de nervios" has similarities to a panic attack but is often triggered by a significant loss or distress. The fear of recurrence that is characteristic of panic disorder may not be present. When some people talk about "nerves," it is likely that they are referring to thoughts and feelings associated with a mix of anxiety and depression. It should be emphasized that a person's belief about the cause of depression is key to helping the client address it.

An important precursor to cultural competence is self-knowledge: how have your beliefs about functional and dysfunctional behavior been shaped by your own culture? How have racism, discrimination, and cultural stereotyping affected you personally and professionally? How do your beliefs about other cultural groups affect your relationships with clients who belong to those groups?

Having knowledge of the culture of the clients served by your organization demonstrates respect for their experiences and ways of life. Particularly valuable in your interactions with clients whose culture differs from yours is a familiarity with immigration, acculturation, and assimilation issues; socioeconomic, religious or spiritual, and political influences; sex role expectations and family structure; and communication styles.

Culturally competent counselors are skilled in—

- Framing issues in culturally specific ways (e.g., "How does your family respond when you are sad?").
- Recognizing complexity in client issues based on cultural context (e.g., "How do your experiences leaving your homeland and coming to the United States affect your depression?").
- Making allowances for variations in relating to others and in the use of personal space (e.g., a client's preference for sitting beside a counselor rather than being separated by a table).
- Displaying sensitivity to culturally specific meanings of touch (e.g., hugging and holding hands).
- Exploring culturally based experiences of power and powerlessness (e.g., "How does feeling depressed affect how you see your status in your community?").
- Adjusting communication styles to accommodate the client's culture (e.g., permitting comfortable silence in conversations with American Indians).
- Interpreting emotional expressions in light of the client's culture (e.g., "How do people know when you're feeling depressed; what do you do?").
- Expanding roles and practices as needed (e.g., participating in cultural ceremonies, facilitating indigenous support systems and healing systems).

Clinical supervisors must distinguish cultural sensitivity and cultural competence among staff members. To have empathic regard for another's culture is one thing, but to have cultural competence to help the person grow within and/or beyond their cultural strengths and limits is another.

The DSM-IV-TR recognizes several culture-bound syndromes (APA, 2000) and lists several examples of how mental disorders may be manifested differently by individuals of different ethnic groups.

The work of Sue and Sue, *Counseling the Culturally Diverse: Theory and Practice* (2007), is a basic text on cultural competency and includes some discussion on the issues of substance abuse and depression.

Your Professional Role and Responsibilities in Relation to Clients With Depressive Symptoms

As a substance abuse counselor, your professional responsibilities include facilitating and guiding clients in their recoveries through the clinical evaluation of substance use and related issues, treatment planning, counseling (individual, group, and/or family), education, and relapse prevention. If you hold other credentials, you may have broader roles and responsibilities related to mental health issues.

If you are a clinical social worker, licensed professional counselor, licensed psychologist, psychiatric nurse, or physician, you may hold a national credential in

addiction disorders issued by your professional association. The specific duties you may undertake with a client depend on the licenses and/or certifications you hold. Licenses and certifications define the scope of practice for your discipline, and they differ by State and profession.

Figure 1.4 provides information on common certifications and licenses for substance abuse counselors and other related professionals, including information related to substance abuse and depressive symptoms. This table is intended as a guideline only. It is your responsibility, in collaboration with your clinical supervisor, to determine the exact nature and scope of services you can provide within the laws of your State and within your profession's ethical requirements for competency.

Figure 1.4
Scope of Practice

Discipline	Can Treat Substance Abuse	Can Diagnose Clinical Depression	Can Treat Clinical Depression	Can Address Depressive Symptoms
Substance Abuse Counselor	Yes	No	No*	Yes†
Clinical Social Worker	Yes	Yes	Yes	Yes
Licensed Psychologist	Yes	Yes	Yes	Yes
Psychiatrist	Yes	Yes	Yes	Yes

*There are possible exceptions to this general proscription against substance abuse counselors diagnosing and/or treating mental illness. In Texas, substance abuse counselors may treat for mental illnesses "associated with" substance use disorders if they have received an additional level of postlicensure training (Texas Department of State Health Services, 2004). In Nevada, counselors may provide services not directly related to counseling for substance abuse or problem gambling but must disclose to their clients both orally and in writing that the type of service they are providing is not within the scope of counseling for substance abuse (State of Nevada Board of Examiners for Alcohol, Drug and Gambling Counselors, 2003). In five States (Mississippi, Missouri, Oklahoma, Oregon, Virginia), legal research and Web site investigation failed to reveal whether diagnosis and treatment for mental disorders are authorized to be performed by substance abuse counselors.

†All currently recognized behavioral/mental disorders in the United States are included in the DSM-IV-TR. The determination that substance abuse counselors can treat for depressive symptoms is based on the fact that "depressive symptoms" do not constitute a behavioral or mental disorder because they are not included as disorders per se in the DSM-IV-TR, yet they are commonly associated with substance use disorders.

Ethical Considerations—As a provider of human services, you take on the responsibility of meeting the needs of your clients to the best of your abilities. This means providing those services for which you have been trained and which the law permits you to provide and not withholding these services from persons in need.

It is also your ethical responsibility to practice within the limits of your skills and the limits of the law. You (and your supervisor) must make an assessment of your skills, licensures, and certifications as they relate to the needs of the client who uses substances and has depressive symptoms. If, for any reason, you are not prepared by training, certification, licensure, or other reasons to meet the client's needs, it is your responsibility, along with your clinical supervisor, to make this clear to clients and to assist them in finding appropriate care. For more information see also chapter 2, Decision Tree 2, When To Refer a Client, p. 37.

Preparing Yourself To Work With Clients With Depressive Symptoms

Working with clients with depressive symptoms can be a frustrating and difficult experience for substance abuse counselors. However, helping someone emerge from personal darkness and hopelessness to the light of living well, renewed enjoyment of life, and hope for the future is also one of the most rewarding experiences for the counselor. This section discusses some of the challenges you will face in working with clients with depressive symptoms, and presents several techniques for preparing yourself to deal with these challenges. While the personal emotional reactions to clients with depressive symptoms can get in the way of effectively using the therapeutic techniques described in chapter 2, it should also be noted that understanding your emotional reaction to a particular client can assist you in helping your client. Your feelings toward the client may in fact reflect the client's mood and/or feelings about himself or herself. In

addition, acknowledging your own grief or depressive tendencies can help you form a more empathic connection with the client. Denying your emotional reactions to the client is likely to interfere with your role as a professional. Whatever your reactions, addressing them with your supervisor will help you sort out the reactions that are about you and those that are about the client.

Attitudes and Beliefs You May Bring to Your Work

Although you may have never dealt directly with depression in your clients, you have certainly encountered depressed clients in your work as a substance abuse counselor. As a result, you may have developed attitudes and beliefs that could interfere with your ability to effectively use the recommendations in this TIP. Some common attitudes and beliefs are given in Figure 1.5. The table contrasts these attitudes and beliefs with what is known about depression among people with substance use problems.

Figure 1.5
Common Attitudes and Beliefs About Depressive Symptoms

Attitude or Belief	What Is Known
If the client stops using psychoactive drugs, the depression will take care of itself.	Although this is sometimes true, it is frequently the case that the client's depressive symptoms may be a primary problem on par with his or her substance abuse. Thus, the depressive symptoms must be addressed directly.
This is not my job; I am a substance abuse counselor.	Your client's depressive symptoms may present roadblocks to recovery. You cannot do your job effectively if you ignore the depressive symptoms.
I don't have the skills to work with someone who is depressed.	Although working with a client with depressive symptoms does require some special skills, these skills can be learned and used effectively by substance abuse counselors.
I work with the 12 Steps. What has this got to do with them?	The 12 Steps and the 12 Traditions are powerful tools that ordinary people can use to make important changes in their own lives and in the lives of others. They are effective tools not just for recovery from substance abuse, but also can benefit the lives of people with a variety of other life problems. (More on this topic is in the section, The 12 Steps as a Tool, p. 28.)
Depression is a result of a lack of spirituality	Although some symptoms of depression (especially hopelessness and feelings of isolation) can be addressed by spiritual practices, for many individuals, spirituality alone is not enough. Specific treatment (e.g., talk therapy, group, and medication) is needed to relieve depression.

Transference and Countertransference

Transference (by the client) and countertransference (by the counselor) refer to the unconscious (underlying) use of past experience with similar individuals or in similar situations to shape reactions to a new person or social situation. Transference and countertransference occur in all types of counseling—including counseling for substance abuse and for mental health issues—as well as in our everyday reactions to others. The positive aspect of transference and countertransference is that it helps you generalize from your past to better manage the present. The downside is that rarely are these generalizations completely accurate. You may remind the client of a teacher he or she had in school, and his or her initial feelings about you and reactions to you may be shaped as much by these feelings as they are shaped by what you do and say.

Just as the client applies what he or she knows (or believes) about similar people in understanding you, so you apply your knowledge (or beliefs) about people similar to the client in understanding him or her. If

you are unaware that it is taking place, countertransference will almost always interfere with your work with the client. After all, the client is not your parent, son, or daughter, the kid you did not like in school, your scoutmaster, or someone you know who spent most of their life being depressed. Each client is a unique individual whose needs, beliefs, aspirations, fears, and desires you must come to understand.

Countertransference, if recognized, can be used productively in your work with the client. It can facilitate:

- Developing an empathic relationship with the client.
- Understanding the thoughts and feelings you have in reaction to the client.
- Understanding what your client is feeling by understanding your own reactions to your client ("Why am I feeling this way? Who am I to the client now?").
- Disentangling the web of your own feelings from those of the client.

It is difficult to manage countertransferential reactions by yourself, even with extensive experience as a counselor. As a result, clinical supervision is an essential component of the counseling process. It is particularly important when you have a strong reaction to a client (positive or negative) that could potentially interfere with treatment. Most people have had powerful experiences in the past both with people with substance abuse problems and people who are depressed. They may not be consciously aware of those experiences in the presence of a client today, but those experiences can (and probably do) affect how they approach the person in their office, how they view the client's potential for recovery, and how they feel about themselves in the client's presence.

Countertransferential Reactions As You Work With Clients With Depressive Symptoms

Clients with depressive symptoms commonly paint a negative picture of themselves, either in words (expressing feelings of worthlessness, hopelessness, inability to cope, lack of competence) or through appearance and demeanor (lack of attention to grooming, listlessness, difficulty communicating). It is understandable that some substance abuse counselors may have an initial negative reaction to the client—for example, "This person is a loser." Counselors working within the 12-Step tradition may refer to this as "taking the client's inventory." Rather than fall into the trap of blaming or judging, the substance abuse counselor can instead take a stance of curiosity and help clients verbalize their thoughts, feelings, and awareness. Such a stance can help in differentiating depressive symptoms from resistance and motivational problems. Additionally, as a counselor, you may fear that you are not equipped to help your client with depressive symptoms. Your own feelings of helplessness or inadequacy may also arise. Addressing these concerns in supervision will help you be more open and helpful to your client.

As a result of these feelings of helplessness or inadequacy, you may find yourself wanting to "fix" the client's problems. This, in turn, may lead to overly directive behavior (e.g., "do this, change that"), "cheerleading" (e.g., "things aren't really so bad"), or preaching. Wanting to "fix" the client's problems is not by itself a problem. After all, you are in this profession to help clients with recovery. However, it is important to find a balance between your desire to protect the client from further harm because of poor choices or maladaptive behavior and the client's need to develop autonomy, engage in his or her own recovery, and "walk the walk." Depending on the stage of recovery and specific needs of the client, what may be helpful in one stage could be enabling in another. For example, advice and reassurance may be helpful at one stage while at another it may interfere with autonomy (Rosenthal, 2008). Miller and Rollnick's (2002) motivational interviewing concept for wanting to "fix" the client is referred to as "the righting reflex," the urge to "right" the "wrong" experienced or expressed by the client.

Although these reactions are common and understandable, they will prevent you from entering the world of the client and establishing a therapeutic alliance (a joint agreement and rapport between the client and the counselor to work together toward the client's recovery). They may also reinforce the client's belief that he or she is worthless, beyond help, and different from "normal" people.

Recovery from depression takes time, and sometimes clients seem to be "stuck" in a set of beliefs (e.g., the situation is hopeless; they are unable to change) to which they will continually return. This can be a frustrating experience for you and you may find that it brings up feelings similar to those that arise when you are working with a client who keeps relapsing.

Just being with someone who is depressed can be draining and at times can feel depressing. The feelings of hopelessness, despair, anger, or sadness experienced by people with depressive symptoms can sometimes feel quite toxic, even to an experienced counselor. In addition, the life challenges faced by the depressed client can be very real and difficult as illustrated particularly in vignette 1 in Part 1, chapter 2.

Emotional reactions may be particularly strong when working with clients who are suicidal, and additional support and supervision are indicated when working with clients who are at risk of harming or killing themselves. This is particularly true if the counselor has had major life experiences with his own suicidal intent or suicidal efforts of significant others. Special approaches to counselor self-support, such as good clinical supervision, ability to leave work at work, and a healthy lifestyle away from work, are important for the counselor to maintain.

You may have had experience with your own depression (or experience with depression of significant others) that may bias and/or improve your capabilities in working with people with depressive symptoms. Much as with a person recovering from a substance use disorder working in the addictions field, it is important for you to keep your own experiences separate from your professional role with clients. Many counselors who are constantly exposed to the stresses of their clients in early recovery find that they benefit from supportive psychotherapy. Psychotherapy improves one's own life as well as one's ability to help others.

In summary, therapeutic work with people with depressive symptoms is similar to therapeutic work with people who have substance use disorders—not only are specific skills needed, but also self-awareness and an ability to differentiate your life experience and needs from those of the client. It is important not only to be aware of and empathic to the client's affects (i.e., sadness, anger, and anxiety), but also to be aware of how the client's affects influence you.

Therefore, it is critical that you seek quality clinical supervision on a regular basis that employs the best-practices available. More information on the benefits and resources available through clinical supervision will be available in the forthcoming TIP, *Supervision and the Professional Development of the Substance Abuse Counselor* (CSAT, in development c).

Treating the Whole Person

Central to the concept of integrated treatment is viewing the client as a whole person. Everyone places people and things in categories. This is a natural tendency for humans and serves the useful purpose of bringing some order to the world. In thinking about your clients, you probably use categories such as their drug of abuse, their gender, their age, and so on. Thus, one might say, "Matt is a 25-year-old man who abuses cocaine" or "Janice is a 45-year-old female who is alcohol dependent."

In reality, of course, Matt, Janice, and all your clients are complex individuals, each with a unique genetic makeup, a personal history, relationships with others, likes and dislikes, emotions, thoughts, attitudes, beliefs, hopes and desires, predispositions to think and behave in certain ways, and so on.

The norm of identifying oneself as an "alcoholic" or "addict" in 12-Step programs helps reduce isolation and shame and create a sense of belonging. Learning to "identify with the feelings," rather than comparing oneself to others also helps normalize experiences and offer hope. This is a very important component of the self-help community—one that should be supported by substance abuse counselors. However, in treatment programs, professionals have the opportunity to address individual differences and complexities and complement the group mentality of self-help to provide the best possible chance for recovery.

Treating the whole person means recognizing that particular symptoms, whether of substance abuse, depression, or some other issue, are part of a system of biology, thoughts, beliefs, emotions, spiritual, and behavioral predispositions that make up the totality of the client (see the example below). The symptom cannot be addressed in isolation. Rather, its relationship to and interactions with all the other attributes of the client must be understood.

Interrelationships and Interactions

Lisa has always struggled with her weight (biology). She believes that people do not like her because she is unattractive (negative belief). So she reduces her social contact (behavior), which in turn leads her to feel increasingly lonely (emotion). She deals with the loneliness by binge eating (behavior), which makes her feel hopeless about herself (emotion) and supports the belief that she is not attractive. So she further reduces her social contacts (behavior), which increases her experience of isolation.

The Perspective of the Client With Depressive Symptoms

While people with substance use disorders generally tend to have a perspective that incorporates some of the thinking styles discussed in this section, the discussion focuses on the perspectives of people with depressive symptoms. Persons with depressive symptoms tend to have a negative view of themselves, their surroundings, and their relationships, and lack hope that things will get better. These pessimistic and self-defeating thoughts about the self, one's experiences, and one's future form the "cognitive triad" of Beck's (1979) cognitive theory of depression. People with depressed mood tend to automatically interpret experience through a negative filter, making unrealistic negative attributions about self and others. The negative thoughts are automatic and are typically accepted without any awareness or scrutiny. For example, when people behave in ways that they experience as depressed, such as staying in bed, or not taking care of family responsibilities, their dysfunctional cognitive process reinforces negative attributions about the self such as, "I'm irresponsible" or "I'll never amount to anything."

The theory of depression from a cognitive–behavioral standpoint is that dysfunctional core beliefs and assumptions support distorted or maladaptive thinking, which then lead to altered affect and maladaptive behavior. So, changing the dysfunctional thinking should lead to improved mood and modification of beliefs and assumptions, to long-term improvement of mood with reduction in vulnerability to relapse.

The following examples of typical depressive thinking styles (adapted from Gilbert, 2000) provide insight into the experience of depression:

- *Jumping to conclusions*—People with depressive symptoms tend to jump to conclusions easily, particularly negative conclusions. For example, in vignette 2 in the next chapter, John's friends don't talk to him when he enters the room; he concludes that they don't think he's worth talking to. This is a negative self-attribution based in a dysfunctional belief.
- *Emotional reasoning*—Emotional reasoning is related to jumping to conclusions. People with depressive symptoms may assume that their emotions give them an accurate view of the world and do not test further. In the above example, John may not start up a conversation himself. He simply assumes his "gut reaction" is accurate.
- *Discounting the positive*—People with depressive symptoms tend to discount their positives; the glass is half-empty. Because of selective perception, they tend to not focus on what they do have, only what they don't have. As a result, they may feel deprived or disappointed. Even when people who are depressed achieve something, they tend to discount it with the negative self-attribution that "anyone could do that."
- *Disbelieving others*—It is very common for people with depressive symptoms to believe that others are being nice only because they want something, that they are being manipulative. People with depression often believe that individuals have one set of thoughts they express outwardly and a set of thoughts they keep private. They believe this in part because this is what they do (for instance, project happy feelings outward while feeling miserable inside). They worry that the private thoughts of people are very negative toward them—an example of negative attribution.
- *Black and white thinking*—Depressive symptoms makes it harder to think about life in complex ways. Thinking tends to become black and white and "either/or." Either one is a success or a failure; either this relationship is good or it is a complete failure.

When combined with the sadness, inability to derive pleasure from life, and feelings of isolation that are characteristic of depression, these thinking patterns can lead to a dark and hopeless view of the world. To work effectively with clients with depressive symptoms, you will need to enter that world with as much understanding, empathy, and compassion as possible.

Only then can you guide clients in ways that will assist them in emerging from depressive symptoms and open the way to recovery from substance abuse.

Important Ways in Which Clients Differ

Although each person is made up of a system of biology, thoughts, beliefs, emotions, and behavioral predispositions, specifics are what make us unique individuals. As has been discussed, depressed people tend to share certain characteristics in these spheres. However, there are some important differences of which you should be aware. The role of culture was discussed earlier. Following is a discussion of some other differences.

Attitudes toward substance abuse and mental health problems—People differ in their attitudes toward substance abuse and mental health problems and in seeking help for these problems. As noted in *Managing Depressive Symptoms: A Review of the Literature, Part 3*, many people still view depression and other mental health issues as something to be ashamed of, a sign of weakness, and/or something to hide from others. Many people believe that problems should stay within the family and should not be discussed with outsiders, such as counselors. This can be particularly true of ethnic groups that face discrimination and racism.

Some people believe that counselors who have different ethnic backgrounds or have not had the same experiences cannot help them. These attitudes are similar to the attitudes that some people have concerning their substance abuse. In spite of the reality that substance use and mental disorders are beyond the reach of simple willpower, vast numbers of people in our greater culture still think that you should "pull yourself up by your bootstraps." This widely held attitude is a common source of shame and stigma for our clients as they struggle with acknowledging substance abuse or depression. For some people, the 12 Steps can help them come to terms with their depression (see the section "The 12 Steps as a Tool"). For others, education about depression (as demonstrated in vignette 2 in chapter 2) may be needed to bring them to a point where depression can be acknowledged and addressed. A variation of this issue is when clients accept the idea that substance abuse or dependence is an illness, but feel that their depressive symptoms are a personal weakness.

Belief that substance abuse and mental health problems can be addressed—Although increasing numbers of Americans have come to view mental disorders as treatable, many still are skeptical of both "talk therapies" and medications. Your client with a substance use disorder may initially believe there is nothing you can do for his or her depressed feelings. As noted earlier, in some cases, you may hold this belief yourself. However, this TIP is predicated on the assumption that you can assist your clients with depressive symptoms during the course of their substance abuse treatment. Part of that help is communicating hope that things can get better.

Spirituality and religion—As a substance abuse counselor, you may understand the important role that spirituality plays in recovery. Spirituality and religion can be important resources for addressing depression for some people. Noted among the positive effects is the support provided by religious communities, the use of religious and spiritual concepts to help people understand and cope with life stresses, the strength some people draw from their religious or spiritual convictions, and the emphasis in many religions on moderation and healthy living.

On the other hand, some spiritual and religious beliefs and practices may contribute to increased feelings of guilt (especially pertaining to family conflict and child rearing), may discourage addressing interpersonal conflict directly, or may lead the depressed person to believe that he or she deserves to be depressed because of some transgression. In yet other cases, depression may be viewed as being caused by a character defect or seen as self-pity. People may even be discouraged from taking antidepressant medications. Clearly, with a good therapeutic alliance, you can explore your client's specific religious and spiritual beliefs so as to better understand the role of these beliefs in either facilitating or inhibiting recovery from depressive symptoms.

Clients with active substance use disorders frequently behave in ways that harm others. However, depressed clients tend to overinterpret the harm they have done to others. Because guilty feelings can drive relapse, in early recovery it is often best to guide the client away from contemplating the harm he or she

has done to others, until sobriety is well established. Later in recovery, when the client has better coping strategies, ethical guilt can begin to be approached in a calm and exploratory manner with the counselor. The client can then explore prior harmful behaviors, begin to address them with religious or spiritual involvement, and make amends through step-work or other means. However, guilt is also a symptom of depression and often clients suffer from inappropriate guilt, that is, the client assumes guilt inappropriately for imagined transgressions. Helping clients differentiate ethical guilt from inappropriate guilt can help alleviate suffering.

Learning styles—Like recovery from substance abuse, recovery from depressive symptoms requires learning new ways of viewing and dealing with self, others, and the world. For example, as part of their early work with you, it is important for the client with depressive symptoms to learn the facts about depression. Some of the interventions discussed earlier rely on your client's learning new ways of thinking and behaving. People differ in the ways they learn most effectively. Some people learn best by reading, some by listening, some by watching others, and some by doing. Some people prefer to get information as a series of bullet points, whereas others are most comfortable when points are made in a story or example. As a general rule, adult learning occurs most rapidly and effectively when some combination of these methods is used. Effective counseling requires that you discover the ways your client learns best.

Some people understand their own learning styles and will ask you to provide information in a specific form (e.g., they will ask for a pamphlet or ask you to give examples). However, many people cannot tell you how they learn best. Hence, you must try out different methods and be aware of whether or not the client is "with you." As time progresses, you will discover the methods that work best. Even when you have discovered the client's preferred mode of learning, it is best to use more than one method to reinforce the information you want the client to learn.

Screening and Assessment

Screening and assessment begin at the earliest point of contact with the client and continue throughout treatment. Information about a client's substance abuse and depressive symptoms should be monitored for positive changes as well as evidence that symptoms are getting worse. As noted earlier, screening and assessment should be integrated so that substance abuse and depressive symptoms are each explored within the context of the other.

Although making a diagnosis of mood disorder is outside the scope of practice for counselors, they should nonetheless learn the symptom sets (described in Appendix D of this TIP) so as to make an appropriate referral for assessment to someone who can diagnose and treat these disorders. Because of the interaction between depression and substance use disorders, it is especially important that a capable mental or behavioral health professional qualified in the State to diagnose and treat depresssion who also has training in substance use disorders make the diagnosis and direct treatment. Screening and assessment for substance abuse clients with depressive symptoms always needs to include screening for suicidality.

Screening

Screening is a planned and purposeful process that typically is brief and occurs soon after the client presents for services. Screening determines the likelihood that a client has co-occurring substance use and mental disorders or that his or her presenting signs, symptoms, or behaviors may be influenced by co-occurring issues such as depressive symptoms (CSAT, 2006). The purpose is to establish the need for an in-depth assessment.

Your job as a counselor is to watch the client for symptoms of depression, discuss them with your clinical supervisor when they appear, and, in concert with your supervisor, make a plan for how these symptoms will be addressed in treatment. The symptom list in Figure 1.1 (p. 5) provides a solid reference guide. Screening and assessment are discussed in chapter 4 of TIP 42 (CSAT, 2005b). Although screening instruments tend to be sensitive to the symptoms they track, one must rely on an expert clinical evaluation for clinical assessment and diagnosis.

Several screening tools can help determine the likelihood of the presence of depressive symptoms. Their selection depends on many factors and is part of the development of the screening and assessment process. One example is the Center for Epidemiologic Studies Depression Scale (CES-D), a 20-item form that can be completed by the client in a few minutes. It asks the

client to rate how frequently he or she had each symptom during the past week. The possible range of scores is 0 to 60. A copy of this instrument is in Appendix B of this TIP.

Another commonly used screening tool for depressive symptoms is the Beck Depression Inventory (BDI-II), a 21-item self-report of depressive symptoms. This widely used instrument is copyrighted by The Psychological Corporation and requires payment for its use. Information on BDI-II can be obtained from the publisher's Web site (www.harcourtassessment.com).

It is important to note that these instruments do not assess suicidality, even though suicidality is a depression symptom. Therefore, as stated above, suicidal thoughts, intentions, and behaviors must be screened for and assessed independently in the clinical interview.

In addition to client self-report, it is important to observe the behavior of the client: that is, to watch for changes in mood, affect, and behavior that the client may minimize or find hard to articulate. Keep track of the intensity and duration of symptoms. As noted earlier, depressive symptoms may be the prelude to a depressive disorder. Signs of deterioration should be reported immediately to your clinical supervisor, who will need this information to decide whether a formal assessment for depression is needed.

Assessment

Assessment "gathers information and engages in a process with the client that enables the provider to establish (or rule out) the presence or absence of a co-occurring disorder." It "determines the client's readiness for change, identifies client strengths or problem areas that may affect the processes of treatment and recovery, and engages the client in the development of an appropriate treatment relationship" (CSAT, 2006, p. 1). One outcome of the assessment may be the attribution of a DSM-IV-TR diagnosis, such as alcohol dependence or a depressive disorder. Another outcome is the initial treatment plan for the client.

Assessment for depressive symptoms may take place at intake in your program or may be the result of screening by the counselor. Assessments for depressive illness must be conducted by a mental health professional who has the required specialized training, skills, and licensure and/or certification. DSM-IV-TR diagnosis is accomplished by referral to a psychiatrist, licensed psychologist, licensed clinical social worker, or other qualified healthcare professional who is licensed by the State to diagnose mental disorders.

Certain assessment instruments can be obtained and administered only by a licensed psychologist. Your clinical supervisor or other staff associated with your program may be licensed mental health professionals who are qualified to assess and diagnose for depression. Therefore, "referral" does not necessarily mean to someone outside your agency. If a referral is to be made, appropriate program protocols should be observed. For example, you may need to refer through your clinical supervisor or your program administrator. It is also important to explain the purposes and processes of the referral to the client and to elicit cooperation in the referral and assessment process. Finally, it is important to gain written consent from clients to discuss their cases with other professionals, particularly in other programs.

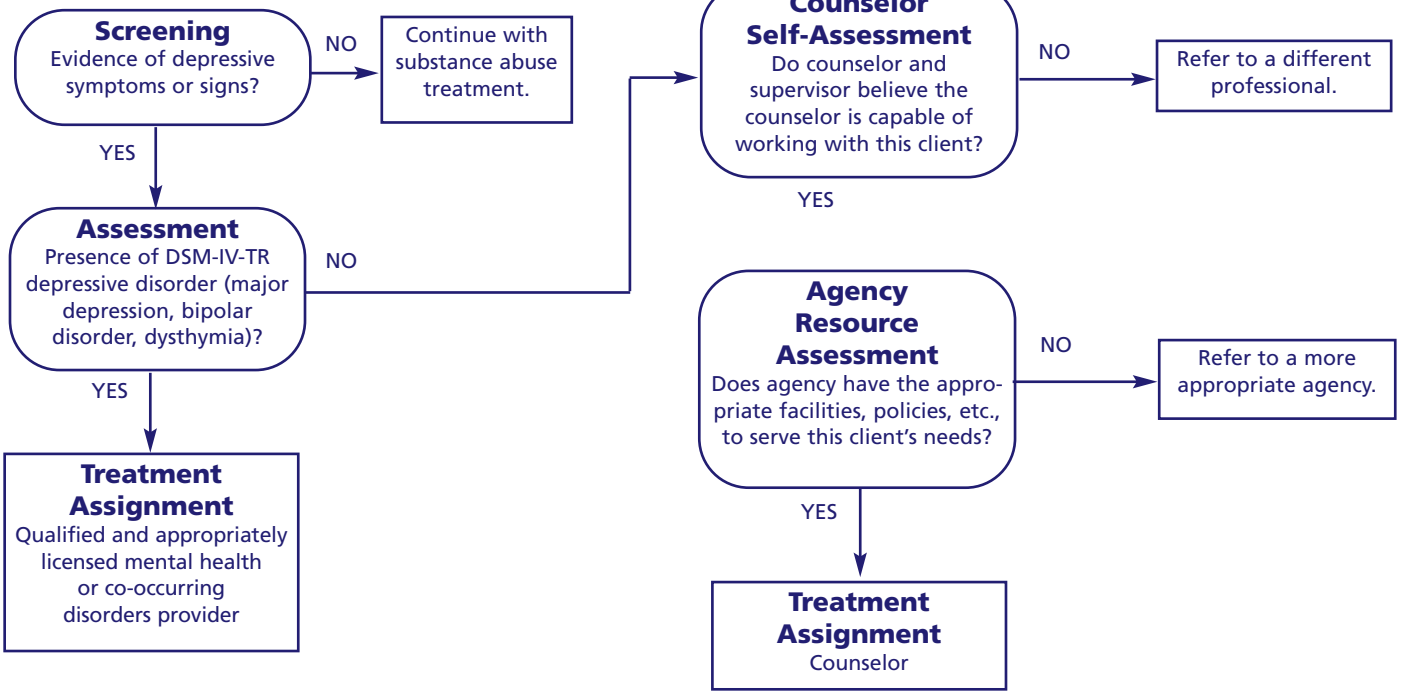
The American Society of Addiction Medicine's (ASAM's) patient placement criteria (PPC-2R; ASAM, 2001) address the decisionmaking process for how a client with a substance use disorder diagnosis with co-occurring depression (or other disorders) can be treated in existing substance abuse treatment programs. The ASAM criteria offer a model for assessing across several life areas, suggesting the severity of symptoms (in this case, depressive symptoms) and the appropriateness of fit with a program's services.

Note: The clients in the vignettes of chapter 2 have all been identified as experiencing depressive symptoms, not a DSM-IV-TR mood disorder, in their intake assessment or through a process of screening by their counselors and subsequent assessment by a qualified mental health professional.

Treatment Planning

As a substance abuse counselor, you may be legally entitled to work with clients who have depressive symptoms as defined earlier in this chapter. However, most States require additional training or credentials to provide treatment to clients with diagnosable depressive illness (see Figure 1.4, p. 15). Figure 1.6 provides guidance for determining who should work with a given client.

Figure 1.6
Decision Tree
How To Determine Who Should Work With a Specific Client



Client-Centered, Integrated Treatment Planning

A treatment plan for a person with substance use disorder and depressive symptoms should be client-centered and integrated. An excellent resource for integrated treatment planning is ASAM's PPC-2R (ASAM, 2001).

Client-Centered—There is no one right approach to care for the client with a substance use disorder who also has depressive symptoms. A client-centered treatment plan is based on a careful assessment inclusive of immediate needs, motivation for change, and readiness for change (see "Stages of Readiness for Change," p. 26). Cultural differences must be accommodated, respected, and incorporated into all aspects of treatment, but each individual must be viewed as a unique combination of culture, history, current situation, and stage of life.

Client-centered treatment planning is a process conducted in collaboration with the client. As the counselor, your job is to help the client explore various alternatives and educate the client about each option. Together you and the client can arrive at a mutually agreeable treatment plan. Helping a client explore potential risks and benefits, along with understanding the process for change and the effort that will be required, can help the client make informed choices.

Your success as a partner in the collaborative process of treatment planning will depend, in part, on your ability to enter the client's world and to assist the client in articulating concrete treatment goals and objectives. Your creativity and flexibility are as important in this process as your clinical skills and experiences.

Integration—Integrated treatment planning is fundamental to providing services to persons with co-occurring substance use and mental health problems (see the definition below). For this TIP, integrated treatment planning means that:

- You, the substance abuse counselor, take primary responsibility for helping the client work with both substance abuse issues and depressive symptoms (see Figure 1.6).
- Your treatment plan addresses the client's substance abuse, depressive symptoms, and issues that may arise through the interaction of the two (e.g., depressive symptoms as a cue for craving).

- The treatment plan includes specific client goals and objectives for substance abuse and for depressive symptoms.
- The treatment plan provides for monitoring progress in both areas.

Observe how the counselors in the vignettes in chapter 2 integrate their treatment of substance abuse and depressive symptoms, recognizing that the symptoms of one problem significantly alter the presentation of symptoms of the other problem. This is particularly true when the drug used by the client produces a depressive effect on the client's thinking and behavior.

Treatment Planning as an Ongoing Process

As the client progresses in treatment, new challenges will emerge, new issues may arise, and some initial plans will need to be abandoned. Clinical work requires the counselor to use not only continuous feedback in the form of objective clinical indicators of progress, but also subjective information from the client to guide the client's recovery at each stage.

As suggested earlier, a client with a substance use disorder who shows no signs of depressive symptoms at intake may begin to experience depressive symptoms as recovery proceeds. Similarly, a client whose depressive symptoms are currently mild may spiral downward into a clinically diagnosable depression during your work together. Finally, a client who initially shows depressive symptoms may rapidly feel better as he or she adjusts to the routine of the program.

The need to be on the lookout for such changes and the need for further assessment when symptoms appear or worsen were discussed earlier in this chapter. Such reassessment will sometimes require major alterations in the treatment plan. As with the initial treatment plan, revisions should be made in collaboration with the client.

The Role of Medications

A review of medical treatment for substance use and depressive disorders is beyond the scope of this manual. However, the treatment plan for a client with substance dependence and depression should always consider the use of appropriate psychoactive medication. Medication treatment will involve a psychiatrist, another physician, or another clinician licensed to prescribe in your State who should also make a careful diagnostic assessment. In the diagnostic assessment, it is important for such clinicians to establish whether depressive disorder is present, because the evidence suggests that a diagnosis of one of these depressive syndromes is important for antidepressant medications to be effective (Nunes and Levin, 2004; Nunes, Sullivan, & Levin, 2004). Without such a diagnosis, it is not clear whether depressive symptoms respond to antidepressant medication. Evidence from a meta-analysis of clinical trials of antidepressant medications for clients with alcohol or drug dependence (Nunes and Levin, 2004) showed that depression improved with a placebo for many clients, but all patients (including those on the placebo) received a manual-guided psychosocial intervention, such as relapse prevention or drug counseling.

Treatment

This section presents the principles, skills, techniques, and resources you can use in implementing these strategies with your clients.

Principles

Principles that you should apply in your work with clients with substance use disorders and depressive symptoms have been presented throughout this chapter. Figure 1.7 (p. 25) summarizes them for easy reference.

Skills and Techniques

A number of skills and techniques can be used while applying any of the treatment approaches and interventions discussed earlier. You probably use many of these already, but the brief descriptions below are a reminder of their importance.

The Therapeutic or Working Alliance—This refers to a mutual bond between the substance abuse counselor and the client. It includes elements of trust, rapport, and faith in the counselor's ability to help and the client's ability to change, and agreement on treatment tasks and goals. An early and strong therapeutic alliance is critical to successful treatment. Specific

Figure 1.7
Principles of Care

- Depressive symptoms must be expected among clients in substance abuse treatment, and this expectation should be incorporated into all aspects of screening, assessment, and treatment planning.
- Both substance abuse and depressive symptoms should be considered primary.
- Care for clients with substance use disorders and depressive symptoms should not be limited to a single "correct" model or approach.
- Empathy, respect, and belief in the individual's capacity for recovery are fundamental provider attitudes.
- Treatment should be individualized to accommodate the specific needs, personal goals, and cultural perspectives of unique individuals in different stages of change.
- Clients may at different times have more or less intense depressive symptoms or substance use disorder symptoms but need continuity of care.

Adapted from CSAT, 2005; Rosenthal, 1999

techniques that facilitate the development of a therapeutic or working alliance are:

- Maintaining a respectful, welcoming, accepting, warm, empathic, hope-inspiring, confident, nonjudgmental, trustworthy, and open stance.
- Setting appropriately frequent and consistent appointments.
- Listening reflectively (see Active Listening, below).
- Providing accurate feedback and interpretation.
- Expressing interest, empathy, and understanding.
- Actively addressing a misstep or conflict.
- Setting appropriate limits and boundaries.
- Being sensitive to the client's ethnic identity, cultural values, and beliefs.
- Being a good role model.

Motivational Techniques—Motivational techniques emphasize the client's responsibility to talk about ambivalence toward making a change, to voice personal goals and values, and to make choices among options for change. The counselor's stance is to understand and respond to the client's statements in a nonjudgmental way. For example, when working with a client who is not thinking about making a change, the counselor can help identify ways in which the client's current behaviors have created problems. When working with a client who is ambivalent about making a change, the counselor can seek to identify discrepancies between the client's current behavior and the client's values. When working with a client who is preparing to make a change, the counselor can identify not only potential barriers to change, but also the resources available to the client to overcome those barriers. Motivational techniques are client-centered and strengths-based and use acceptance, support, and understanding to help a client move from one stage of change to another. These techniques help clients resolve their reluctance and resistance as they learn alternative ways to satisfy their total well-being. (See Figure 2.2 in TIP 35 [CSAT, 1999] for more on strategies for enhancing motivation.)

Cognitive–Behavioral Techniques—Cognitive–behavioral techniques are directive and educational in nature and aim to help clients learn to think and act more adaptively and thus experience improvements in mood, motivation, and behavior. Clients with depressive symptoms are caught in a vicious cycle of negative expectations and attributions about themselves and others, and then make choices based on these assumptions that reinforce these dysfunctional beliefs. Clients can be taught to monitor and record instances of their negative thoughts and mental images so as to realize the connection between their thoughts, feelings, and behavior. Inaccurate thoughts associated with depressive symptoms can be identified and modified using the counselor's more objective understanding of the client's history, current experience, and future opportunities.

Clients also learn to make their problems seem less catastrophic by breaking them down into smaller, more manageable components. This reduces dysphoria and anxiety and builds self-efficacy. Assignments that have tasks of increasing difficulty help clients get moving and provide rewarding experiences that will directly refute their negative attributions. Over time, clients learn to recognize, assess, and change the underlying assumptions and maladaptive beliefs that have rendered them vulnerable to depressive symptoms.

Individualized Care—In programs treating large numbers of people with similar problems, there is a tendency to diminish the focus on individualized care. Everyone, in effect, gets the same treatment. Programs offering individualized care have flexible program policies that allow counselors to focus on

specific client needs and then target treatment to meet those specific needs. The concept of individualized care is particularly important for individuals with co-occurring disorders and other special needs. Individualized care allows treatment to be client centered, involving the client in treatment planning and sharing responsibility for treatment outcome.

Active Listening—Also called reflective listening, active listening involves listening attentively to client statements and reflecting them back in different words so that the client can confirm or clarify their meaning. Active listening allows the client with substance abuse problems who is depressed to hear what he or she is saying, thus encouraging self-exploration of problems and feelings. Active listening deepens the counselor's understanding of the client's statements and can be used to elicit a client's concerns about problems without asking questions that can activate resistance.

Empathy—Empathy is central to helping the client feel understood, accepted, and safe to explore painful emotions and experiences. People with substance use disorders and depressive symptoms often have trouble feeling understood or believing that someone else can understand their experiences. Empathy is communicated through verbal and nonverbal signals that say "I understand." In some sense, it is wrong to say that empathy is a skill or technique. Rather, it is best understood as a way of being or staying in tune with your client. Certainly, when counselors have had some of the same experiences as their clients (such as recovering from substance abuse or depression), the capacity for empathy is heightened. Just as in 12-Step programs where individuals are taught to identify with feelings rather than compare the particulars of a situation, counselors can empathize with clients' feelings because they know what it is like to experience pain and loss.

In some instances, having a similar background to a client can interfere with empathy because you think you know what the client is going through and therefore fail to listen effectively. Being empathic is more than simply relating to a client. Empathy includes having patience and being supportive and understanding. As always, appropriate supervision and self-reflection are key to being an effective counselor.

People sometimes confuse empathy with sympathy. Sympathy does not involve placing yourself in the client's shoes. Rather, sympathy is an expression of compassion, concern, or sorrow for the client's experience. A good distinction between sympathy and empathy is that sympathy is feeling *for* the client, while empathy is feeling *with* the client. It is common for inexperienced counselors to confuse sympathy and empathy, and often people with substance use disorders who are depressed look for sympathy in lieu of empathy. Sympathy can, at times, be helpful. However, when you are carried away by your sympathy for clients, you may feel the need to rescue, which can interfere with their self-healing. Figure 1.8 provides some useful contrasts between empathy and sympathy.

Resolving Conflicts—Maintaining a therapeutic alliance requires skill in resolving the conflicts that arise between client and counselor. (You will see an example of such a conflict in vignette 4 in chapter 2.) Resolving conflict requires:

- Addressing the problem practically in the context of the current situation.
- Clarifying misunderstandings.
- Accepting responsibility for missteps, when appropriate, especially with clients who have a history of trauma or racism (including discussing with your supervisor the appropriate way to admit mis-

Figure 1.8
Empathy and Sympathy

Empathy	Sympathy
Involves a heightened awareness of the experiences of the other (not necessarily suffering) as something to be understood and reflected back.	Involves a heightened awareness of the suffering or need of the other as something to be alleviated. The focus is the other person's well-being.
Behavior concerns knowing, conceptualizing, understanding.	Behavior concerns relating, acting for, alleviating (or mediating responses).
Empathy is effortful and depends both on experiential and imaginal capabilities.	Sympathy is relatively automatic and effortless.
The self reaches out to the other.	The self is moved by the other.
The self is the vehicle for understanding and never loses its identity.	The other is the vehicle for understanding, and some loss of identity may occur.

takes to clients without expressing excessive guilt).
- Expressing sincere regret at having unwittingly impugned, misled, or patronized the client.
- Supporting the client's ability to express disagreements in the context of an ongoing therapeutic relationship.
- Being flexible in one's position or on the current tasks when the client is becoming angry or distant (Winston, 2004).

Strengths Based—Strengths-based approaches focus on identifying, encouraging, and using the client's strengths as the foundation for the plan to create positive change. Many clients with substance use disorders and depressive symptoms find it difficult to believe they can begin or maintain behavioral change. Belief that one is able to change leads to the ability to sustain motivation for making a change. Strengths can be elicited by asking how the client has successfully coped with depressive symptoms in the past. Once strengths have been identified, affirmation can be used to enhance the client's belief in his or her capacity to bring about change.

Three areas of strength for most clients include the capacity for endurance (e.g., survival skills), personal growth (e.g., willingness to consider making a change) in unpleasant circumstances, and a concern for the welfare of others, for instance, family. Counselors should never underestimate how skilled some people are at not seeing their own strengths. You may be surprised with the resistance you encounter when trying to focus on client strengths.

Therapeutic Confrontation—At times, confrontation can be an appropriate technique to demonstrate to the client the reality of his or her minimizing, evasiveness, blaming, rationalizing, or denying behavior. However, you should use this technique only in the context of a strong awareness that the purpose is to help the client, not to express your frustration or anger. Without a strong therapeutic alliance, the client may feel attacked. However, with a strong alliance, the client will know that you are trying to be helpful. Whenever possible, it is important to ask for feedback regarding the confrontation so that you and the client can better understand the client's reaction. The key is to use confrontation without being punitive and to use empathic, supportive techniques without being overly responsible for the client's behavior (enabling) or fostering dependent behavior (Rosenthal & Westreich, 1999). Good confrontation has two faces: The external, more obvious confrontation is between counselor and client. The more subtle, less obvious is how the client takes in the external confrontation and is able to internalize it.

Stages of Readiness for Change

Clients will enter substance abuse treatment with different levels of motivation to change. Your task is to discover and design with clients a systematic and strategic plan to address their unique set of symptoms of substance abuse and depression. The same client may have one level of motivation to change substance use and another level of motivation to address depressive symptoms. Prochaska and DiClemente (1984) developed a widely used classification of stages of motivation:

- No perception of a problem and/or no interest in change (Precontemplation).
- Might be a problem, might consider change (Contemplation).
- Definitely a problem, getting ready to change (Preparation).
- Actively working on changing, even if slowly (Action).
- Has achieved stability and is trying to maintain it (Maintenance).

Questionnaires for assessing stage of motivation are available (see TIP 35 [CSAT, 1999]). Simple interviews can also be used to determine the client's view of a given problem, such as substance use or depressive symptoms.

For clients in the precontemplation or contemplation phases, the application of one or more of the motivational techniques described previously and illustrated in chapter 2 should be considered. For example, in vignette 4 in Part 1, chapter 2, the counselor uses motivational strategies to help Shirley move from contemplation to preparation.

Self-Efficacy

Self-esteem includes a person's beliefs and experiences of his or her inherent value in addition to the individual's actual competence or self-efficacy. It is important to explore clients' perceptions of their moti-

vation to change and of their belief in their ability to change. A person's belief about his or her ability to do something is related to the ability to actually do it. A client's belief that he or she cannot change (e.g., cannot feel better, cannot alter circumstances that are leading to depressed feelings) needs to be dealt with proactively. As illustrated in vignette 1 in chapter 2, useful techniques for building feelings of self-efficacy include:

- Partializing a large task into smaller, manageable tasks.
- Setting a modest, if less important, goal that is achievable rather than repeatedly trying and failing at something that is very important but not currently achievable.
- Mentally rehearsing a task and visualizing success.

Because depressive symptoms often include feelings of helplessness, self-efficacy issues may be particularly salient for clients who are experiencing these symptoms. Supportive techniques such as offering reassurance, encouragement, and appropriate praise for recovery-related accomplishments bolster self-esteem and help motivate further adaptive change in clients (Rosenthal, 2008).

The 12 Steps as a Tool

Many substance abuse counselors use the 12 Steps of Alcoholics Anonymous (AA) and similar organizations as part of their work with people who abuse substances. Many of the curative factors inherent in 12-Step programs also can be helpful to people with depressive symptoms.

Some of these factors include:

- The support, comfort, acceptance, and hope people find when they enter AA can directly confront some depressive symptoms of alienation, hopelessness, and despair.
- The 12 Steps themselves can be applied to many aspects of healing depressive symptoms. For instance, doing a self-inventory of limitations, as well as strengths and assets, taking action to address wrongs of the past, and the act of reaching out to others can both be curative steps.
- The slogans and "folk wisdom" of AA and similar 12-Step programs confront "stinking thinking" that keeps people with depressive symptoms trapped in a cycle of fear and hopelessness.
- Finally, the nonjudgmental acceptance of others in the program provides an environment in which depressed people can examine themselves in a more nonjudgmental and accepting manner.

Below are some examples of how the steps can be applied to depressive symptoms.

Step 1—We admitted we were powerless over alcohol [depressive symptoms]—that our lives had become unmanageable.

Many of the life circumstances that contribute to depressive symptoms are not under the control of the client. Loss of a loved one, victimization, trauma, and other negative life events happen in people's lives. Depressed people often blame themselves for these events. Understanding that one is or was powerless to prevent a loss, trauma, or other life event, can alleviate some of the guilt and shame that drive depressive feelings. For clients for whom depression has no clear external cause, an understanding that genetic vulnerability, brain chemistry and/or hormones may be involved can help them understand that nothing they have done has caused them to feel depressed.

Step 2—We came to believe that a Power greater than ourselves could restore us to sanity.

This step applies as much to depressive symptoms as to substance abuse. It is a source of hope and strength. For the depressed person, the concept of giving in to a greater power can provide a welcome relief from the sense of burden and worry that often accompanies depressive symptoms.

This step can also be used with persons who do not believe in or are hostile to the belief in a deity. Such people may accept that a higher power exists in all of us that can be unleashed by letting go of everyday concerns. This higher power inside is sometimes referred to as the "life force" or "vital force." In some belief systems, the vital force derives from an inextricable connection to the earth or to nature. In other belief systems, the higher power inside is viewed as the healing force by which the body corrects its own deficiencies.

Step 4—We made a searching and fearless moral inventory of ourselves.

Initially, the depressed person may find this step frightening. After all, the person with depressive symptoms often finds little to like about himself or

herself. However, as illustrated in vignette 2 of chapter 2, the counselor can guide the client through a reality-based inventory that challenges the belief that the client is bad or worthless. Having a nonjudgmental collaborator in that exploration not only challenges the client's negative self-evaluation, but also localizes certain beliefs and behaviors as falling within the client's purview. The client can begin to see that their choices and behaviors are a function of their depression.

These three steps are presented as examples. Other steps can be equally adapted to provide understanding, hope, and motivation for clients with depressive symptoms. On another level, the ability to adapt the 12 Steps to other life contexts (such as depression) shows that the client has been able to internalize and integrate the steps in a powerful way.

Treatment of Depressive Symptoms With Antidepressant Medications

If a patient has depressive symptoms or a depressive disorder that has not improved after entering substance abuse treatment, you should consider referral to a physician for evaluation for antidepressant medication. This assertion is supported by a meta-analysis of 14 placebo-controlled clinical trials of antidepressant medications in alcohol or drug dependent patients with depressive disorders (Nunes and Levin, 2004). Antidepressant medications were most likely to be effective in studies when patients were abstinent when diagnosed with depression. Hence, much the same as with medications for treatment of substance use disorders, treatment with antidepressants is not a panacea or a stand-alone treatment. If applied with appropriately diagnosed patients, antidepressant medications should improve mood, help reduce substance use, and facilitate the overall psychosocial treatment plan. Your collaboration with the medicating clinician is essential to support your client's recovery.

Bear in mind the following principles in regard to the treatment of your clients with medications for depression:

- Antidepressant medications rarely have abuse potential.
- Any given medication has about a 50 percent chance of working well, and a 50 percent chance of failing.
- No method or test will predict the best medication for a patient.
- It often takes at least 4 to 6 weeks of treatment and the achievement of an adequate dose before an antidepressant medication begins to work.
- Depression symptoms should be monitored regularly and systematically during antidepressant treatment.
- If one medication fails to result in a significant improvement in depression symptoms after an adequate trial (generally 6 weeks of treatment at an adequate dose), then a different medication should be tried by the prescribing clinician.
- Counselors should be alert to possible adverse interactions between an antidepressant medication and the substances a patient is abusing (such as the potential for increased sedation or intoxication).

Continuing Care and Treatment Termination

In most cases, your work with a client on his or her depressive symptoms will be time-limited. There are some special considerations related to treatment termination with a (formerly) depressed client as well as some special considerations for continuing care.

Perhaps to a greater extent than with your clients who are not depressed, you will have engaged in a client-counselor relationship involving emotional sharing, support, and encouragement. As demonstrated in vignette 3 in chapter 2, the client may have shared experiences with you that he or she has never shared with anyone else. For these reasons, the client (and you) may experience sadness at the prospect of saying goodbye. It is especially important that you help the (formerly) depressed client view this sadness as a normal grief process rather than as a return of depressive symptoms. Indeed, distinguishing appropriate sadness from depression is one of the lessons you hope your client has learned in your time together.

Other considerations related to treatment termination are discussed below.

Reactivation

For some clients, the termination experience will mirror or reactivate experiences that were fundamental to their depressive symptoms (abandonment or feeling alone or without support). These feelings can be addressed directly using the skills the client has learned in counseling. They can also serve as practice in dealing with future situations that may cause depressive feelings to surface.

Preparation

This means preparation both for the treatment termination experience and for "life after counseling." Part of the preparation for life after counseling is avoiding early termination when the client begins to feel better. It is important for the client to understand that ups and downs are normal and that these are likely to occur throughout life. Learning the differences between a short remission and a more stable adjustment will be key to assisting the client in deciding when termination is appropriate. Sometimes, a "partial termination" can be accomplished by increasing the interval between sessions or by a trial period without therapy. If it is not possible to continue counseling, even though depressive symptoms continue, make every effort to assist the client in arranging other services that will help with the depressive symptoms.

Near the end of treatment, you should consider anticipatory guidance with the client for a host of situations. Anticipatory guidance is a core supportive psychotherapy technique, but it is consistent with CBT in that it rehearses what the client should do in high-risk situations or in situations where the client used to have your help to work things out. The counselor reviews the accomplishments achieved and uses anticipatory guidance to outline issues to explore in the future. Clients will have a range of feelings about the end of treatment and about the counselor after treatment, so it is also useful to help the client anticipate how he or she will deal with them (Rosenthal, 2008).

Because depressive symptoms can recur, it is necessary at some point to educate the client about this possibility. Just as people with substance use disorder lapse while in recovery, so people with depressive symptoms re-experience feelings of despair. Clients should be educated about this possibility, the likelihood that they may need to seek services again, and the fact that recurrence is not an indicator that they have "done something wrong."

Your Reaction to Treatment Termination

As already noted, you may experience sadness at the prospect of termination with your client. This sadness is a normal result of the therapeutic alliance you have forged. Another result of this alliance may be an investment in the client's future adjustment. After all, you have worked very hard to gain the client's trust and to use that trust productively in treatment. Although counselors want their work to be successful, the client's future is the client's responsibility. For you, the task is now to let go.

Continuing Care Plans

The symptoms of depression, like those of many other illnesses, come and go. The absence of symptoms doesn't mean the tendency toward depressive symptoms is necessarily gone. In addition, the potential for relapse with depressive symptoms is quite high, and significant improvement and remission of symptoms do not mean that ongoing care and monitoring should be discarded. Clients should be educated about the nature of depressive illnesses, relapse symptoms, and procedure to follow if symptoms do reappear. It is important for clients leaving treatment to know that they can telephone you or the agency if symptoms reappear, either to reactivate treatment or for referral. Finally, it is important for clients to understand that reoccurrence of depressive symptoms does not mean failure on their part, nor does it mean that the onset of another depressive episode has to be as difficult and painful as previous episodes. Like most other illnesses, if caught early, depressive symptoms can be treated more efficaciously and effectively than if symptoms linger for an extended period.

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), nonpossessive 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.

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	• 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	• Maintaining a nonjudgmental attitude toward the client • Considering what is important to the client
Sensitivity	• 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	• 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	• 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	• 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	• 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.

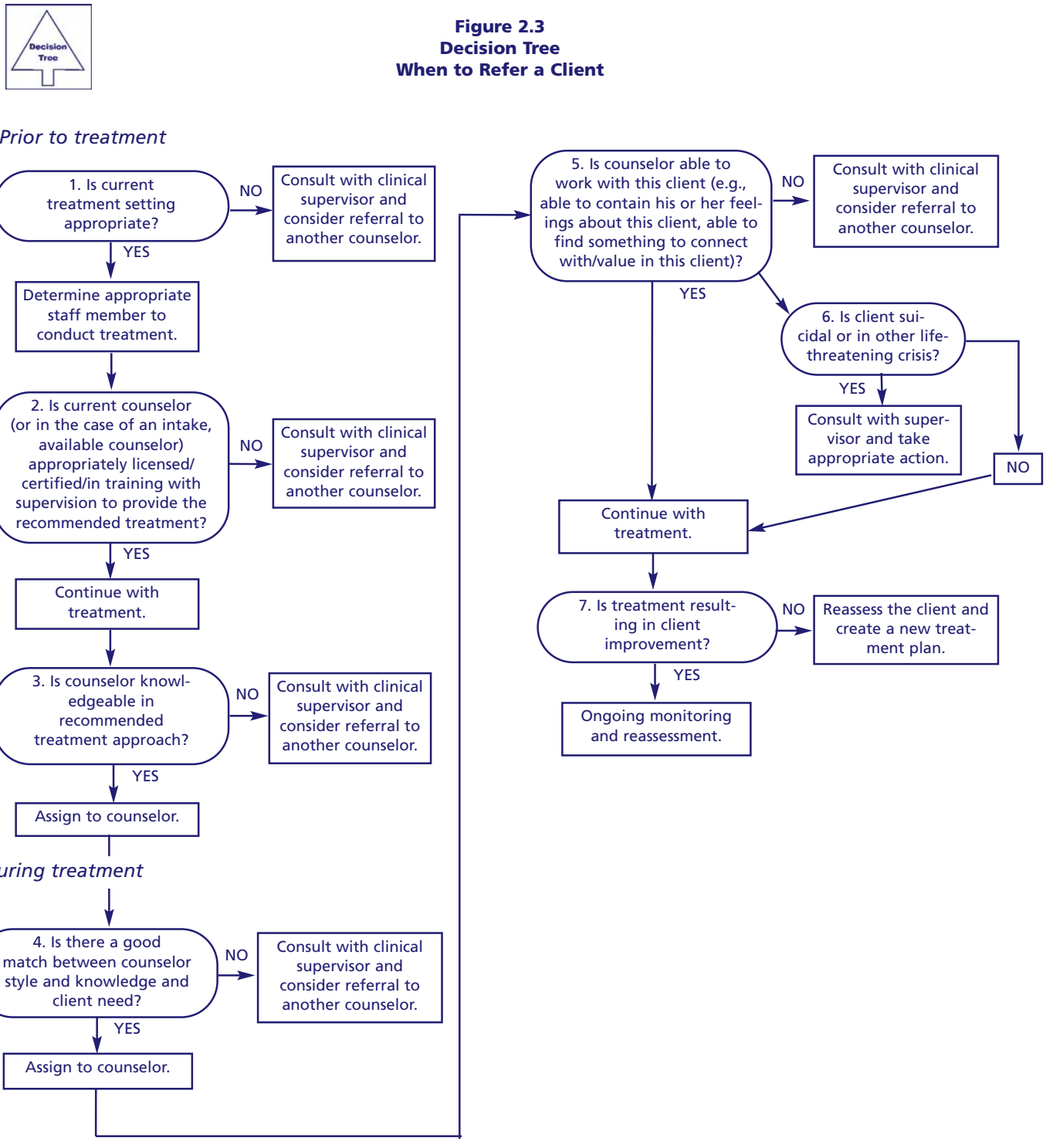
- ***"How-to" boxes*** contain information on how to implement a specific intervention.

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 clini-

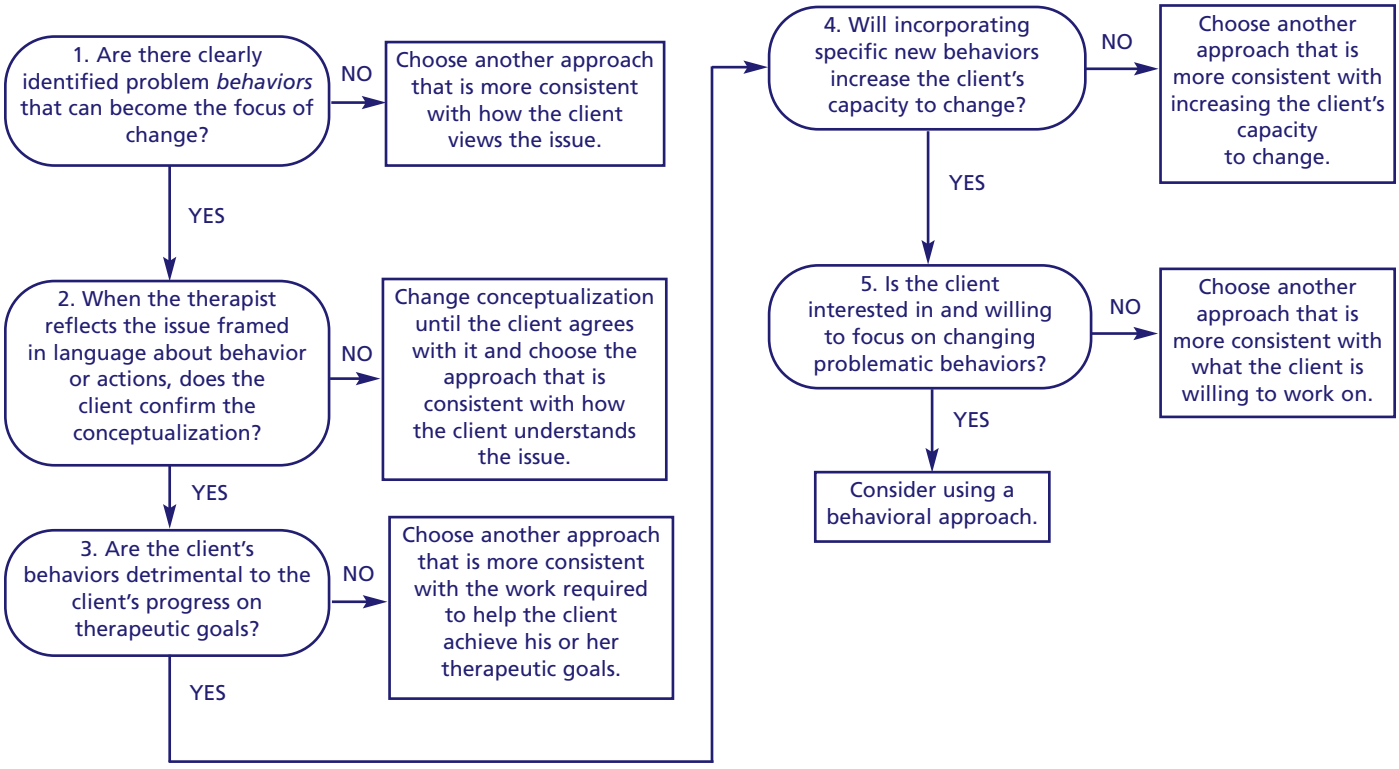
cian may not be appropriate for you to use, depending on your training, certifications, and licenses. It is your responsibility to determine what services are legally and ethically appropriate for you to provide (see Figure 1.4, Scope of Practice, p. 15).

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.

[*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.

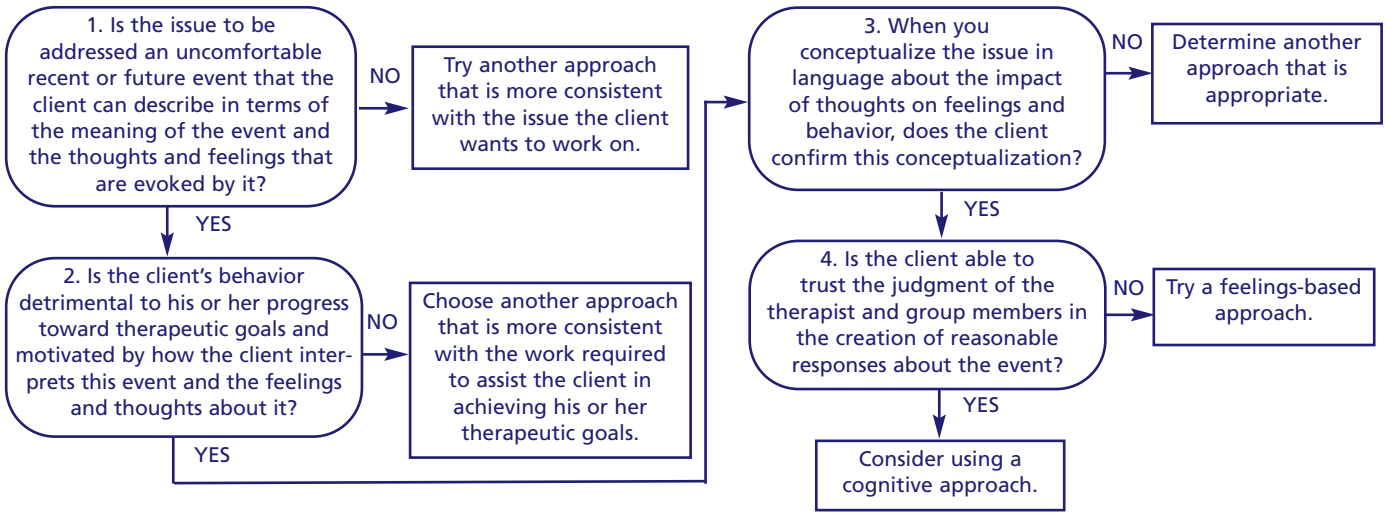
Cognitive therapy techniques are based on the premise that how you interpret your experiences in life determines the way you feel and behave. The patterns of thought typical of people who are experiencing depressive symptoms include negative thoughts about self (e.g., worthlessness), negative thoughts 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.

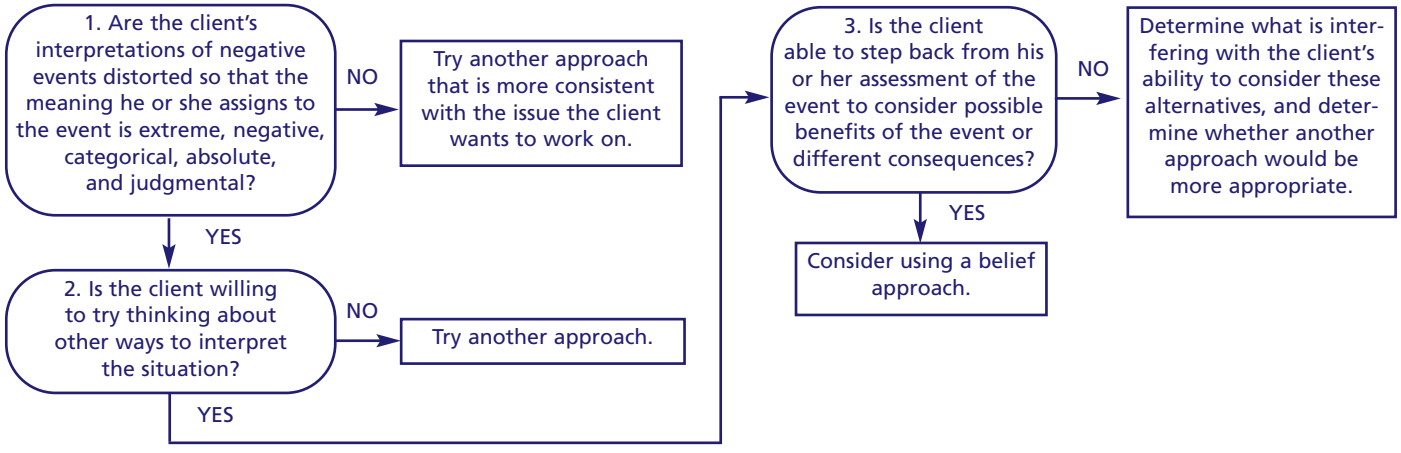
Vignette 3—Interventions With Core Beliefs

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 Marceline, 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 dsythymia 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 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

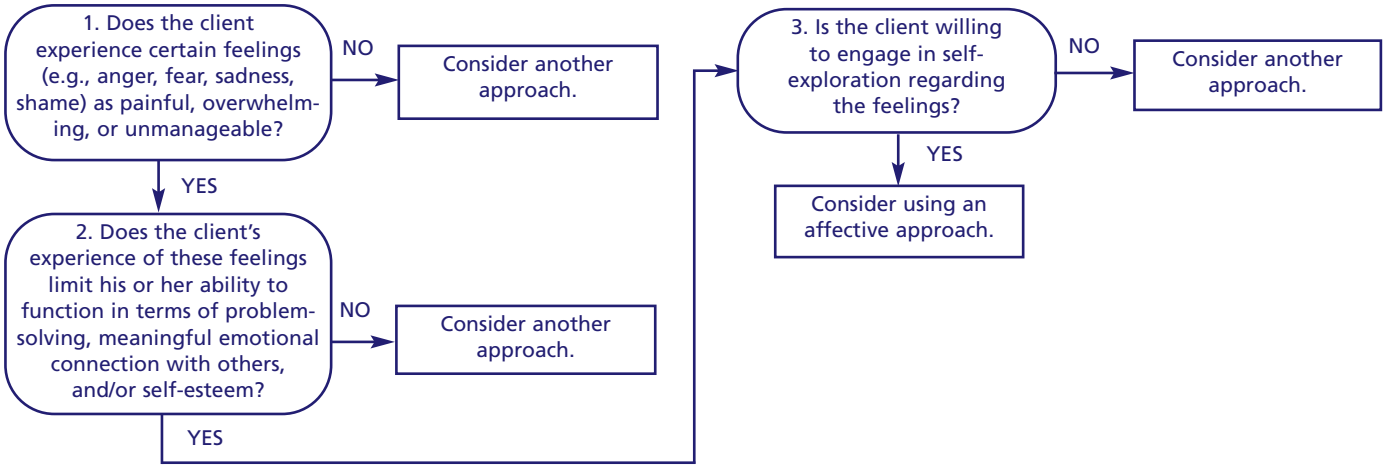
Feeling or affective-based therapies focus on feelings as a primary method of helping people change. These approaches are particularly appropriate when there are powerful primary feelings such as anger, fear, sadness, or shame that limit the individual's opportunity to solve problems, make meaningful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

Part 2

Managing Depressive Symptoms:

An Implementation Guide for Administrators

Chapter 1

Introduction

This Treatment Improvement Protocol (TIP) is designed to assist not only **substance abuse counselors** in working with clients who are experiencing **depressive symptoms** (see Figure. 1.1), but also clinical supervisors and **administrators** who support the work of the counselors. Depressive symptoms are common among clients in substance abuse treatment (Grant, Stinson, Dawson, Chou, Dufour, Compton, et al., 2007). When depressive symptoms occur, they can complicate substance abuse treatment and interfere with recovery.

Figure 1.1

Depressive Symptoms and Related Feelings and Behaviors

The term "depressive symptoms" refers to symptoms experienced by people who, although failing to meet DSM-IV-TR diagnostic criteria for a mood disorder, experience sadness, depressed mood, "the blues," or other related feelings and behaviors:

- Loss of interest in most activities
- Significant unintentional change in weight or appetite
- Sleep disturbances
- Decreased energy, chronic fatigue or tiredness, feeling exhausted
- Feelings of excessive guilt
- Feelings of low self-esteem, low self-confidence, or worthlessness
- Feelings of despair or hopelessness (pervasive pessimism about the future)
- Avoidance of normal familial and social contacts
- Frequent agitation, restlessness
- Psychologically or emotionally detached
- Feelings of irritability or frustration
- Decrease in activity, effectiveness, or productivity
- Difficulty in thinking (poor concentration, poor memory, or indecisiveness)
- Excessive or inappropriate worries
- Being easily moved to tears
- Anticipation of the worst
- Thoughts of suicide

The methods and techniques presented in this TIP are appropriate for clients in all stages of recovery. However, the focus of this TIP is on early recovery—that is, the first few months of treatment, when depressive symptoms are particularly common.

This TIP is *not* about treating any mood disorder that is defined in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, Text Revision (DSM-IV-TR; APA, 2000). Clients with diagnosed mood disorders (e.g., major depression, dysthymia, cyclothymia, bipolar disorder) need specialized treatment from a trained and licensed mental health professional. However, when treating the substance abuse issues of clients who have mood disorders, the substance abuse counselors' role is to (1) address how the depressive symptoms of the mood disorder interact with the substance abuse recovery treatment, and (2) develop a collaborative treatment relationship with the trained and licensed mental health professional who is directing the treatment for the mood disorders.

Why SAMHSA Created an Implementation Guide as Part of This TIP

Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery, Part 1, provides the tools your counselors need to address depressive symptoms with clients. However, an extensive literature review suggests that without specific attention to implementation issues, these tools are likely to go unused or to be used ineffectively (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). This *Guide* will help you ensure that the ideas in Part 1 are put into practice in your program or agency. Implementation will require the active support of executive administration and the expertise of clinical supervisors.

Consensus Panel Recommendations for Administrators

Substance abuse counselors should be prepared to help clients manage their depressive symptoms because these symptoms can complicate treatment and recovery from substance use disorders. Administrators play an important role in ensuring that their programs incorporate this aspect of treatment. In particular, the Consensus Panel recommends the following:

- All substance abuse treatment programs should integrate screening and management of depressive symptoms into existing substance abuse treatment.
- Programs need to develop the capacity to differentiate clients with depressive symptoms from those with depressive illness and have resources in place to address the needs of both groups.
- Programs have a responsibility to develop a referral network that is capable of evaluating clients with depressive symptoms and receiving clients whose depressive symptoms cannot be managed in the substance abuse treatment setting.
- Adequate policies and procedures should be in place to serve clients with suicidal thoughts or behaviors.
- In clinical supervision, an emphasis should be placed on improving counselors' ability to recognize and manage clients' depressive symptoms.

Why Address Depressive Symptoms?

The Effects of Depressive Symptoms on Recovery

Clients with depressive symptoms may experience challenges to successful treatment above and beyond those experienced by clients who are not depressed (Conner, Sorensen, & Leonard, 2005; Curran, Flynn, Kirchner, & Booth, 2000; Dodge, Sindelar, & Sinha, 2005; Greenfield, Weiss, Muenz, Vagge, Kelly, Bello, et al., 1998; Strowig, 2000).

The client with depressive symptoms may have difficulty in any or all of the following areas:

- Ability to learn program rules or to follow instructions.
- Ability to keep appointments.
- Energy to participate in or maintain interest in program activities.
- Motivation for change.
- Ability to make appropriate decisions about treatment needs and goals.
- Belief that he or she can be helped.
- Responsiveness to reinforcements.
- Ability to handle feelings.
- Ability to handle relations with other clients.
- Ability to attend to (and not disrupt) group activities.
- Ability to stay substance-free after treatment is completed.

In summary, depressive symptoms may pose significant impediments to recovery. Addressing these symptoms is a necessary part of treating the whole person and may be a concern for meeting the client's recovery goals.

Depressive symptoms may easily be mistaken for resistance to treatment. It is essential that staff be able to discriminate between depression and treatment resistance. Depressed clients may well wish to be in recovery but lack the motivation and energy to take on the challenging tasks posed by participation in recovery programs.

The Benefits to Your Program of Addressing Depressive Symptoms

Research clearly demonstrates that depressive symptoms can be reduced through treatment. Addressing these symptoms may improve substance abuse treatment outcomes and long-term abstinence outcomes (Brown, Evans, Miller, Burgess, & Mueller, 1997; Ramsey, Brown, Stuart, Burgess, & Miller, 2002).

Treating the symptoms of depression:

- Enhances the treatment experience for both the person with depressive symptoms and those around him or her.
- Increases retention rates.
- Leads to greater reductions in substance use.

- Reduces the probability of relapse.
- Increases engagement rates in aftercare services.

In addition to these benefits for the client, addressing depressive symptoms as part of your agency or program may lead to:

- Increased clinical competence of staff.
- Increase in appropriate referrals for psychological and psychiatric evaluations for depression and depressive symptoms.
- Increased staff retention, higher levels of staff satisfaction, reduced risk of burnout, decreased staff stress, and reduced turnover.
- Improved risk management (e.g., less suicidal ideation and suicidal behavior) and reduced liability.
- Access to new revenue streams.

Addressing co-occurring substance use and mental disorders is a key priority for the Federal government, State governments, insurance companies, credentialing boards, and accrediting organizations. By starting now to address depressive symptoms in your agency or programs, you will be better positioned in the future to compete in the substance abuse treatment marketplace.

Ideally, your agency can become part of the larger community of research-practitioners who seek the best ways to help clients more quickly experience a higher quality of recovery. By joining with other agencies in your network, you can coordinate treatment practices and perhaps collaboratively obtain research grants. Some of the best practices are unresearched because agencies do not appreciate the value of their unique treatment approach.

Thinking About Organizational Change

If you have decided to implement some or all of the recommendations in *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery, Part 1,* you, your staff, your clients, and the other agencies and organizations with which you interact may require the development of new treatment protocols and policies, as well as new clinical knowledge, attitudes, and skills. These changes can be rewarding and/or frustrating, but will be beneficial to client well-being in the long run.

Every organization is a social system with its own unique culture. There are actually two cultures to each organization—the formal and the informal—that involve separate communication channels. The ideal is to have these cultures as congruent as possible. They affect decisions, relationships, and common (or conflicting) values and beliefs. Any change in services or approaches to clients will call for a significant change in the organization's culture.

Change in the corporate culture calls for leadership. Management at all levels and in all departments—not just clinical services—must be involved. Ancillary and support personnel also will be affected and need to be part of the process.

The similarities between recovery in an individual and change in an organization are rather striking. In fact, the organizational change process is highly analogous to the clinical processes of assessment, client-centered treatment planning, treatment delivery, and continuing care.

As with recovery, careful assessment is central to organizational change. About half of Part 2, chapter 2 of this TIP concerns assessment issues. As you will see in that discussion, the current status of the organization relative to targeted change goals needs to be assessed. Current practices, staff and administrator competencies, policies and procedures, facilities, and so on will need to be evaluated (see the section "Maximizing the Fit," p. 106). These are similar to client assessments that determine the nature and scope of a client's issues and challenges as well as their strengths and assets.

A program's readiness for change needs to be examined. Sometimes, the best decision is to delay attempting any change and work only on organizational climate and readiness. Introducing change before the groundwork has been laid can foreclose or impede later change opportunities when the climate improves. An excellent resource for organizational assessment for change is the Program Change Model (Simpson, 2002) and its accompanying survey, the Organizational Readiness for Change (Texas Christian University, Institute of Behavioral

Research, 2002). This model addresses strategies and tools for assessing institutional and personal readiness and outlines the stages of the transfer process that administrators may find helpful.

The four stages are:
1. Exposure through training
2. Adoption through leadership decision making
3. Implementation through exploratory use
4. Practice through routine use.

In addition, your assessment should consider your organization's past experiences with change initiatives (i.e., whether they were positive or negative). Just as a bad experience in a previous treatment program may color a client's perception of a new program, old experiences with organizational change may affect attitudes toward new efforts. Thus, a thorough review of organizational history of change is critical to planning new organizational change. The response to change of staff members is equally important to predicting successful outcome of implementation.

As in treatment, assessment is not a one-time activity. Rather, it is an ongoing process that includes regular feedback and adjustment of your plans for organizational change and your approaches to facilitating change. A plan for organizational change is similar to a client-centered treatment plan. First, your plan must be tailored to the specific needs of your organization. Your assessment information helps you determine where your organization needs to go, how to get there, and the pace at which change can occur. Simply following the plan used by another organization makes no more sense than having the identical treatment plan for all of your clients. The choice to implement a component on depressive symptoms presumably is part of a larger mission and vision to provide treatment for a wider range of affective symptoms (such as anger, anxiety, shame, guilt) that undermine progress toward personal and social well-being.

In as many ways as possible, the change plan should be linked to your best understanding of what key stakeholders (e.g., boards, staff, funders, clients, communities, 12-Step groups) want and value. If, for example, your staff desires professional growth opportunities, change aimed at addressing the needs of clients with depressive symptoms can be linked to expanding staff capabilities in mental health issues. Similarly, your board's concern with expansion might be tied to the need for increased capacity if the organization is to address the depressive symptoms of its clients.

The development of the change plan should involve as many clients, stakeholders, and community resources as possible. There are a number of reasons this is the case. First and obviously, clients, staff, and other stakeholders function best when they feel involved in shaping their worlds. They feel that they have a measure of control and understand what is going to happen and what is expected of them. Equally important, stakeholders (especially staff) have a key role in determining how to make the recommendations in *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery, Part 1* work best in your agency or program.

Finally, no stakeholder is more important than the clinical supervisor who is commissioned to implement the clinical mission and vision of the administrators. The clinical supervisor is challenged to help counselors maintain a high level of best-practices, to oversee the application of these practices, and to conduct process and program evaluation for quality control. Below is a discussion of how clinical supervisors serve as the critical link between direct service staff and administration, and the role of clinical supervisors in implementing organizational change.

Principles for implementing the change plan are directly analogous to principles of treatment and recovery in that both are achieved in steps, making it a process rather than an outcome. The following principles of managing change are directly adapted from principles of care presented in chapter 1 of *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery, Part 1*:

1. *There is no single model or approach to implementing a program of organizational change.* A preconception about how change should occur or inflexibility during the change process is all but certain to be counterproductive, if not fatal, to meeting a client's treatment goals or a program's change goals. Constant vigilance and course corrections will be needed. Corrections should be made in consultation with the same stakeholders who developed the original change plan.

2. *A belief in your organization's ability to accomplish the change plan is fundamental.* As with counselors, an administrator's belief that change can happen (and the ability to communicate that belief) is a central component of the change process.

3. *The change program should be individualized to accommodate the specific needs, goals, culture, and readiness to change of your organization.* **It is critical to adapt and "personalize" the plan to fit specific organizational needs and culture.**

At least in the first few years after the implementation of an organizational change plan, maintenance of these changes cannot be assumed. Continuing care of your organization's new accomplishments is critical to their long-term survival. Like treatment and recovery, this is often neglected and can lead to relapse.

Continuing care is needed for several reasons. First, newly learned practices and procedures are fragile and will tend to drift. Organizational change almost always brings about some degree of personnel change. Planning for the selection and integration of new employees, the factors that need to be considered, and the method by which integration will be accomplished all need to be part of the developmental process. Equally important, new and unforeseen barriers may arise that need to be addressed. As time passes, more and more of these challenges will have been encountered and overcome. In the early stages, however, there will be some unanticipated challenges. Regular supervision and training boosters are the best insurance that behavior change will last over time.

Eventually, the changes you implement will become a regular feature of your agency's operation. This process is called institutionalization; it will have occurred when no one seems to really remember what things were like before the change took place. Rather, the new practices you introduced have become the everyday practices of your agency. Even when institutionalization occurs, however, a commitment to continuous quality improvement will help ensure your program's ability to respond to ongoing changes in the needs of your client population and community.

The Challenge of Implementing New Clinical Practices

It is sometimes assumed that good ideas are self-implementing. After all, you may pride yourself on being a rational person who does not need to be persuaded to adopt a good idea when you see one. This is all the more true in your role as a helping professional. You want the best for your clients and actively seek new ideas that will help you help them. However, recognizing a good idea and implementing it in practice are two very different things. In fact, many good ideas for practice improvement are never widely implemented (e.g., Woolf, DiGuiseppi, Atkins, & Kamerow, 1996).

Some of the usual challenges you may hear are:

- "This is not what worked for me."
- "This is not how I was taught to do it."
- "Depression is part of withdrawal; it will go away on its own after a while."
- "We need to stick to basics."
- "I'm doing it just fine, thank you very much."
- "You keep adding things to do. What are you going to take away?"
- "You're the expert: tell me what to do."
- "This won't work for this client."
- "I couldn't make supervision because I had to see a client."

As a general rule, failure to implement new clinical practices has little to do with resistance to change on the part of counselors or administrators. Failure to implement can be a result of issues such as inadequate modeling from administration, lack of follow-through, inadequate training, and many others. Even the best counselors and administrators are highly constrained by the contexts in which they work.

Accordingly, implementation success requires administrators to:

- Be proactive in making the new practice fit the context.
- Create an organizational climate that encourages and supports implementation.

These two tasks are related, and accomplishing one requires accomplishing the other. For example, fitting new practices to your context requires a thorough review of your agency's current operations. Such self-examination, in turn, helps create an organizational climate of openness to new ideas and experimentation. Before implementation begins, it is important to create positive expectations among staff. Investing the time to educate and express support for the specific implementations can go a long way in staff acceptance of change, especially in the early stages.

So often, executive staff face more immediate resistance or ambivalence because the initial groundwork was not done. Moreover, administrators have likely considered the change ideas for some time and expect staff to be at a similar level of enthusiasm and commitment to the proposal.

Change is easier to make when those involved:

- Understand why the change is needed and the benefits they will realize.
- See how the new ways will integrate into and honor what has been done previously.
- Are given motivation strategies for providing ideas and offers of assistance in implementation.

Maximizing the Fit

For a clinical innovation to take hold, it must fit with: (1) key characteristics of your target population and community (e.g., values, expectations); (2) the skills, licensures, certifications, and team structures of your staff; (3) your program or agency's facilities and resources; (4) your policies and practices; (5) local, State, and Federal regulations; (6) available interagency networks (e.g., needed outside resources, memoranda of understanding); and (7) your reimbursement procedures. Certain kinds of mismatches will be fatal to implementing change. For example, no one would expect successful implementation of an innovation when staff lack the skills to perform it. However, a lack of appropriate space or needed audiovisual equipment can stall an innovation in its tracks. As with many endeavors, the details are critical.

It is likely that adjustments will be needed both in your agency's or program's context and in the ways that the recommendations presented in Part 1 are implemented. Part 2, chapter 2 of this TIP provides procedures, checklists, and other tools for assessing the fit between the recommendations provided in Part 1 and your program or agency's current context, procedures, and so on. Useful though these materials are, your ultimate success in "maximizing the fit" will depend on your creativity, problem solving skills, and patience in applying them.

In the early stages of implementing the recommendations in Part 1, organizations will profit from a climate that promotes:

- A willingness to take risks and try unconventional approaches.
- A willingness to tolerate some ambiguity as the fit between new practices and context evolves.
- An ability to recognize false starts and to abandon approaches that are not working.
- Appreciation and reward for ideas and implementation.

As noted earlier, the later stages of implementation will be facilitated by:

- A commitment to continuous quality improvement.
- The development of structures that support and reinforce the change (e.g., standardized training for new staff, regular boosters, and supervision for all staff).
- Expressions of organizational pride in accomplishment.
- Institutionalization (in which new practices become everyday practices).

Clinical supervision is the keystone of implementation of new clinical procedures and processes. Supervision should be more instructive and less crisis driven—more proactive and less reactive—by using such strategies and resources as:

- Innovative supervision methods, including live, in-session supervision, role playing, taping, and group and peer supervision.
- Regularly scheduled, ongoing clinical supervision
- Checklists and fidelity scales.
- Quality skills training.
- Counselor mentoring.

The Role of the Administrator in Introducing and Supporting New Clinical Practices

Chapter 2 of this *Guide* presents the tasks you will need to accomplish in order to implement the changes elaborated in *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery, Part 1*. Important as these tasks are, they cannot themselves ensure the successful implementation of the Part 1 recommendations. Rather, successful implementation will ultimately depend on the leadership you provide.

Leadership is critical for implementing an organizational change. First and foremost, leadership means *commitment*. If you and your administrative colleagues are not fully committed to improving services for clients with depressive symptoms, meaningful and lasting change is unlikely to take hold. In many ways, attempting change without the commitment of organizational leaders can be worse than no attempt to change at all. The perception that leaders are only giving lip-service to a new idea will eventually become clear to staff. This perception will undermine the current attempts at innovation and may lead to a staff that is reluctant to try new ideas.

Second, leadership means having a *vision* of how the organization will change. This vision should include explicit goals and a clear statement of how conflicts with other organizational goals will be resolved. However, a vision is more than a list of goals. It is a picture of how the organization will look when change has been accomplished—a picture you must paint with words in vivid detail for your staff. Developing this vision and the means to communicate it throughout the organization requires considerable effort.

Leadership should include highly skilled and competent clinicians trained in mental health and substance use disorder treatment who can direct and supervise services for clients with co-occurring depressive symptoms and substance use disorders. These clinicians should know and appreciate the specific roles that can be played by licensed or certified addiction counselors, licensed social workers, psychologists, physicians, and other mental health and substance abuse professionals. They should also have an appreciation for the role depressive symptoms can play in interfering with substance abuse treatment. When such resources are not available on staff, a clinician should be available on a consultant basis.

Since working with clients with depressive symptoms means that programs must be prepared to address the needs of clients with co-occurring disorders, staff have a right to expect that program leadership will be knowledgeable and conversant on the impact of addressing co-occurring disorders and offer a vision of what this means to the program.

Third, leadership means *inspiring* your organization. Inspirational leaders communicate confidence in the organization's ability to change, enthusiasm for change, optimism about the change process, and an unwillingness to accept failure. This needs to be communicated to all stakeholders including current and potential clients, funders, board members, staff, community leaders, community 12-Step participants and programs, and sister agencies**.** Inspiration not only is a process of oral and written communication, but also involves modeling the attitudes and values you want staff and other stakeholders to adopt, including those discussed earlier (e.g., risk taking, tolerance of ambiguity, and willingness to start over when approaches are not working). Inspiration also involves getting your hands dirty. Nothing inspires staff members more than seeing their leaders struggle alongside them in the day-to-day tasks of making new ideas work.

Finally, leadership means an ongoing and honest *appraisal* of progress. As noted in *Managing Depressive Symptoms: A Review of the Literature, Part 3* (www.kap.samhsa.gov) and discussed further below, implementing the recommendations from Part 1 will require ongoing assessments of progress, including regular formative evaluation of process and outcomes. Periodic reports on how the organization is doing can and should be developed from the assessments and evaluations. These reports should be shared with staff as should plans for corrective action when needed. The most effective leaders frame both good and bad news in a positive light. One way to do this is to emphasize the learning value of challenges and setbacks and to remind staff that it is the organization as a whole, rather than any individual, that is responsible for making change happen. This means that "we succeeded" or "we still have room to improve" is always the preferred way to communicate successes and failures.

Chapter 2

Introduction

There is no simple formula for implementing the clinical recommendations presented in *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery, Part 1*. Like any tool, the resources presented in this chapter will be effective only when used by people who have a clear vision of what they wish to accomplish and who actively determine and understand the processes by which they will get there.

The resources presented in this chapter have been organized into those related to organizational assessment and those related to planning and implementing organizational change. The change process in your agency or program will require creative and thoughtful adaptation and application of these resources to your specific needs and circumstances. They should be viewed as points of departure only. You should revise or otherwise modify the materials as needed for your organization.

The *Change Book* (Addiction Technology Transfer Center Network [ATTC], 2004), provides the basis for the organizational change process presented in this chapter. Additionally, you may wish to consult *Implementation Research: A Synthesis of the Literature* (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). This is a highly readable and very useful summary of the scientific basis for various implementation practices. Some of the main ideas in chapter 1 derive from this synthesis.

You may also wish to consult with colleagues who have managed organizational change in organizations similar to yours. At this point in the development of implementation strategies for human services, many excellent ideas are still to be found outside the published literature. Your colleagues may have insights or ideas that are equal to or more applicable than those presented in this *Guide*.

Finally, a point made in chapter 1 is worth repeating: Managing organizational change is very similar to working with a client in a clinical setting. Your understanding of the recovery process and of the counselor's attributes and techniques that facilitate recovery is an invaluable resource as you apply the tools presented in this chapter.

Assessment and Planning Before Implementation

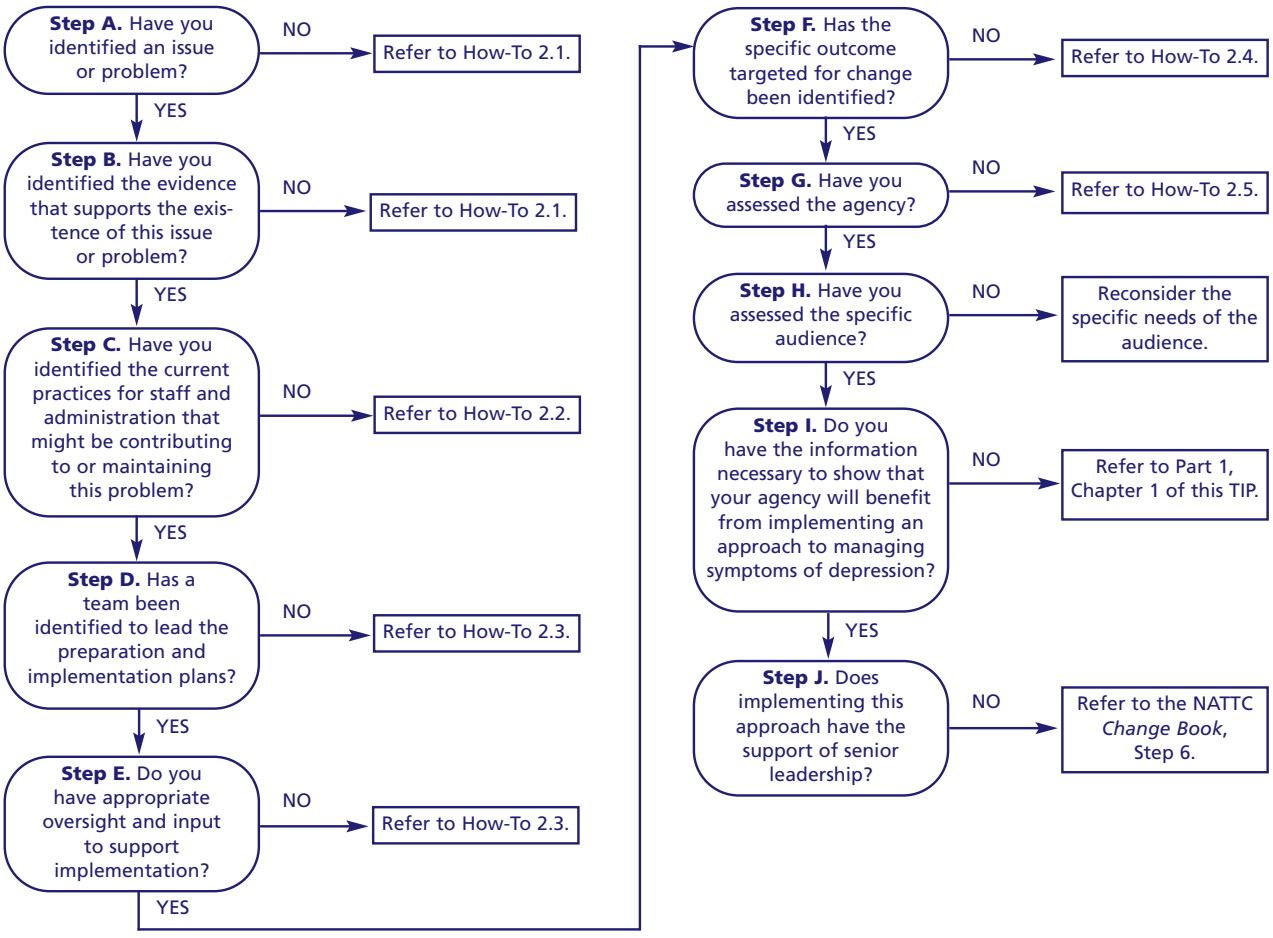
How Do You Decide Whether To Implement a Policy for Managing Depressive Symptoms?

To determine whether it makes sense for your agency to implement the recommendations made in *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery, Part 1*, refer to Figure 2.1.

How Do You Identify the Issue or Need?

The following How-To components provide ways to operationalize the steps presented in Figure 2.1.

Figure 2.1
Decision Tree
How To Decide Whether To Implement a Policy for Managing Depressive Symptoms



How-To 2.1: How to Identify the Issue or Need (Figure 2.1, Steps A and B)

Research suggests that the following issues or problems may be relevant to your agency's treatment outcomes. Think about the three levels where change can occur (i.e., program/organizational, practitioner/counselor, and client/patient) when considering the following steps. Also, begin thinking about the part of the agency where you may want to implement changes first (for more information, see also the section How Do You Decide Where To Start?, p. 113).

1. Depressive symptoms are common in clients presenting for substance abuse treatment. Determine whether clients with depressive symptoms are being identified and effectively treated in your agency (see How-To 2.2).

2. People who present with depressive symptoms may take longer to benefit from treatment. Determine whether this is an issue for your agency. Does your program offer the option of longer treatment stays to clients with depressive symptoms? If not, how is this need addressed? What practices may need to be changed?

3. Untreated depressive symptoms result in poorer substance abuse treatment outcomes. Determine whether a goal for your agency is to improve retention rates of clients with depressive symptoms. Determine whether a goal for your agency is to more effectively reduce the number of depressive symptoms experienced by the clients.

One aspect of the identification process is to assess the organizational capability of the agency to implement or augment a program for services to clients with depressive symptoms.

How Do You Assess the Capability of the Agency To Provide Services to Clients with Depressive Symptoms?

People with symptoms of depression may see themselves as worthless, the world as hostile, and their future as hopeless. Is this addressed in your treatment program? For example, are people not making the transition from detoxification to treatment because they are depressed and their depression is not being addressed while they are there? Are people not staying in treatment because they are not confident that their treatment plan will help them manage their symptoms of depression along with their substance use disorders? Assess the current capability of your agency or program to work with people with symptoms of depression (see How-To 2.2 below).

How-To 2.2: How To Assess Current Capability To Manage Depressive Symptoms (Figure 2.1, Step C)

For each program setting consider the following questions:

1. Are the treatment teams (e.g., psychiatrist, nurse, licensed master's level clinicians, certified substance abuse counselors, clinicians, and counselors in training) multidisciplinary?

2. Are symptoms of depression identified and adequately addressed in treatment plans?

3. Are appropriate interventions planned to treat symptoms of depression?

4. Are the interventions already in use effective with the program's clientele?

5. Does the supervisory staff have the knowledge, skills, and attitudes necessary to supervise or coach the line staff applying the interventions?

6. Does the program have referral or consultation relationships with trained and licensed mental health professionals or mental health programs?

Note: For more information on assessing current capability, see Sample Policies 1–6 and Checklists 1–4.

How Do You Organize a Team To Address the Problem?

Once you have identified an issue or problem, you need to create a work group to address the problem (see How-To 2.3).

How-To 2.3: How To Organize a Team To Address the Problem (Figure 2.1, Steps D and E)

1. Identify one person to lead the effort. This person must have the backing of senior administration and the respect of direct treatment staff.
2. Obtain the commitment of the chief executive officer of the agency to articulate the vision for implementation throughout the agency, with all stakeholders, and to the public.
3. Convene an implementation work group consisting of key leaders from different stakeholder groups: consumer leaders, family leaders, team leaders, clinical leaders, and program and administrative leaders. Some stakeholders will serve as ongoing members of the work group while information from others may be solicited through focus groups. If your program has a residential or inpatient component, be sure to include an individual from the night staff (i.e. aide, tech, night nurse). This staff will actually have more conversations with patients than most clinical staff and are in a position to support this program through their observations and understanding.
4. Identify the program oversight committee to which the work group will report. For example, if your agency has a quality improvement committee, the work group may report its findings, recommendations, strategic plans, and modifications to that committee. This is one way to initiate and sustain implementation.

How Do You Identify a Specific Outcome To Target for Change?

Once you've identified a work group to address the problem, you need to identify a specific outcome to be targeted for change (see How-To 2.4).

How-To 2.4: How To Identify a Specific Outcome To Target for Change (Figure 2.1, Step F)

1. Begin with the issue or problem identified in Step A of Figure 2.1, and determine a specific variable that can be measured that is directly related to improving the management of depressive symptoms. For example, "decrease client experience of depressive symptoms."
2. Identify a way to measure "client experience of depressive symptoms." For example, the Center for Epidemiologic Studies Depression Scale (see Part 1) could be administered to agency clients to determine the prevalence of depressive symptoms.
3. Measure a baseline prior to implementing the intervention. For example, determine how many clients experience depressive symptoms while in

treatment at your agency. How many clients are still experiencing depressive symptoms when they leave treatment? Do the clients who experience depressive symptoms tend to leave treatment earlier than the clients who do not report depressive symptoms? Do they tend to have more difficulty maintaining abstinence?

4. Identify which outcome you are most interested in measuring to determine whether implementing the intervention is working.

How Do You Decide Where To Start?

Once you've identified a specific outcome to target for change, you will want the work group to assess the agency and the staff (both frontline and supervisory) to be targeted by the implementation. You will have an easier time implementing your plan if you start with a small program where staff members already work well with one another and believe in the new techniques. Staff members on closely knit teams work with one another's strengths and will have an easier time assigning responsibilities when it comes time to implement the practice. Alternatively, you may choose a small, core group of staff members who are ready to try the new techniques and are prepared to be part of the implementation process (i.e., target early adopters across programs). These will be the first staff members trained and coached in using these techniques.

Other advantages to starting small include:
1. It is easier to track the success of the implementation.
2. It is easier to identify and make any modifications to the techniques that may be necessary to accommodate the agency's clientele.
3. The core group members will talk about the success they are having with the techniques and get other staff interested in learning and using the techniques.

For more information on assessing your agency's readiness for implementation, see How-To 2.5.

How Do You Assess the Agency's Organizational Readiness for Implementation?

How-To 2.5: How To Assess the Agency's Organizational Readiness for Implementation (Figure 2.1, Step G)

1. The committee assesses the agency's organizational readiness by first determining whether implementing practices to improve the management of depressive symptoms in the agency's clientele are consistent with the agency's mission statement. (See also the section Modifying Existing Policies, p 114).
2. The committee determines the obstacles to implementation:
   a. Rate of staff turnover in the agency including average longevity of clinical and support staff.
   b. Inadequate funding for training, technical assistance, and outcome measurement.
   c. Policies and procedures that would have to be changed (see Sample Policies 1–6, pp. 115–119).

d. Agency facilities and resources.

e. Federal, State, and local regulations that affect the decision to implement this intervention (see the section Addressing Relevant Regulations).

3. The committee determines the opportunities created by implementing this intervention:

   a. Increased funding.

   b. Increased collaboration with other agencies.

   c. Improved community relations and marketing opportunities.

4. The committee determines the organization's stage of change (see also the ATTC Change Book, pp. 33–34).

5. The committee determines where the resources will come from to provide support for the change initiative (ATTC Change Book, p. 29).

6. The committee determines what adoption of this change will mean at all levels of the organization and what the benefits are for administrators, supervisors, and counselors (ATTC Change Book, p. 29).

7. The committee determines what is already happening that might lay the foundation for the desired change (ATTC Change Book, p. 29).

Addressing Policies and Procedures

Planning and implementing a new program component almost always impacts existing policy and procedure. These items need to be reviewed and adapted to be sure they are in conformance with the new program.

Implementing organizational change requires a multilayered approach to establishing communication and commitment across departments and program areas. As described in earlier sections, the commitment of the organizational leader is of utmost importance. Nonetheless, this leadership commitment alone is not adequate to ensure that changes are adopted and sustained over time. Mechanisms to institutionalize these changes must be established. Policies and procedures constitute one of the most common approaches to institutionalizing organizational practices. Although varying in format and structure as a result of regulatory and organizational diversity, policies and procedures serve as the foundation of organizational practice.

This section provides six samples of the critical policies and procedures related to addressing depressive symptoms within substance abuse treatment agencies. In each topic area, a policy statement and set of procedures related to the topic are presented. These sample policies can be used as presented, combined into one or more comprehensive policies, or integrated into the organization's existing policies.

Modifying Existing Policies

In addition to adopting policies on managing depressive symptoms, provider agencies might consider modifying other policies and program descriptions to provide continuity of care for individuals experiencing depressive symptoms.

For example, each substance abuse treatment program will develop its own approach to screening and monitoring the depressive symptoms of its clients based on (a) the characteristics of its clientele, (b) its resources, espe-

cially its staff training and background, (c) legal and reimbursement considerations, and (d) a host of possible idiosyncratic factors (e.g., specific arrangements worked out with referral resources or consultants, participation in clinical trials, or other external influences). Your professional input into developing the necessary policies and procedures is essential, and at a minimum there should be a protocol that stipulates:

- What standard questions a client is asked.
- When these questions are asked (by interview and/or self-report mechanisms) and when repeated (especially what observations or events might trigger rescreening).
- Who can ask these questions and what training is provided or needed regarding the questions and the overall process, procedures, and policies.
- Exactly how scoring or assessment of the clients' responses will be done, including exact guidelines for the follow up triggered by different levels of severity or acuity indicated by various responses.
- Where these policies and procedures fit within the agency's policies and procedures and what chain of command and communication exist, especially for emergency situations that might arise.

The Mission Statement

Descriptions of the mission or treatment philosophy should be modified to include a description of the importance of addressing co-occurring problems (including depressive symptoms) during the course of treatment, the importance of client-centered care, and the need to educate the client about the relationship between substance abuse and depressive symptoms.

Program Descriptions

In addition, program descriptions should have welcoming statements for clients who have co-occurring substance abuse and depressive symptoms and identify client-focused treatment planning that is responsive to individuals who have substance abuse and depressive symptoms. An example of such an approach might be that alternative and/or complementary individualized activities are available in addition to group activities for individuals who may benefit from them. Each program should include a vehicle for communicating with all clients about the relationship between substance abuse and depressive symptoms.

Sample Policy 1
Topic: Clinical staff training and competency.
Policy Statement: All clinical staff will demonstrate basic competency in screening clients with substance use disorders for depressive symptoms.
Procedures: 1. All clinical and support staff will participate in a 3–5 hour training session covering depressive symptoms, their impact on substance abuse treatment retention and outcomes, and criteria and procedures for referring individuals to services aimed at managing depressive symptoms. 2. The clinical supervisor of new employees will provide site-specific information on the procedures for screening and referring individuals who are experiencing depressive symptoms. 3. Clinical competency checklists completed at hire and annually thereafter will ensure that all clinical staff members have a basic knowledge of the benefits of managing depressive symptoms, an understanding of strategies for assessing the significance of depressive symptoms, and an awareness of appropriate referral procedures.

Sample Policy 2

Topic: Recruitment, training, and supervision of clinical staff treating depressive symptoms in clients.

Policy Statement: Counselors interested in providing services for managing depressive symptoms and who possess the relevant basic counseling skills, knowledge, and attitudes (see Checklist 2, p. 122) will be recruited, trained, and supervised to deliver these interventions.

Procedures:

1. At least one clinical position in each program or modality of care will be designated to provide services to manage depressive symptoms.
2. Individuals exhibiting the attitudes, knowledge, skills, and job performance required to provide interventions to manage depressive symptoms will be identified by their clinical supervisor and designated to provide these services.
3. The counselors identified to provide interventions to manage depressive symptoms will receive 2 weeks of initial training and 1 week of additional training each year in the following areas:
   - Screening and assessment of depressive symptoms.
   - Managing depression in the context of cultural diversity.
   - Client-centered care.
   - Motivational interviewing.
   - Building self-efficacy.
   - Cognitive–behavioral approaches.
   - Therapeutic alliance.
   - Personal boundaries and professional ethics.
   - Termination and discharge planning.
4. Counselors managing depressive symptoms will receive clinical supervision twice monthly that includes direct observation or review of tapes of individual sessions with clients with depressive symptoms.
5. Counselors managing depressive symptoms will meet quarterly to provide peer support, supervision, and share resources related to the management of clients with depressive symptoms.

Sample Policy 3

Topic: Screening and referral of clients with substance use disorders and depressive symptoms.

Policy Statement: All clients will be screened for depressive symptoms and referred as needed.

Procedures:

1. During the intake process, all clients will be screened for the following nine depressive symptoms:
   - Loss of interest in most activities.
   - Significant unintentional change in weight or appetite.
   - Sleep disturbances.
   - Decreased energy, chronic fatigue or tiredness, feeling exhausted.
   - Feelings of excessive guilt.
   - Feelings of low self-esteem, low self-confidence, or worthlessness.
   - Feelings of despair or hopelessness (pervasive pessimism about the future).
   - Avoidance of normal familial and social contacts.
   - Frequent agitation, restlessness.
   - Psychologically or emotionally detached.
   - Feelings of irritability or frustration.
   - Decrease in activity, effectiveness, or productivity.
   - Difficulty in thinking (poor concentration, poor memory, or indecisiveness).
   - Excessive or inappropriate worries.
   - Being easily moved to tears.
   - Anticipation of the worst.
   - Thoughts of suicide.
2. Staff will be trained in using specific depression screening tools such as the CES-D scale.
3. Individuals demonstrating depressive symptoms will be referred for assessment by a State-qualified mental health professional (QMHP) or substance abuse specialist.
4. Clients who are determined by a QMHP to have a DSM-IV-TR mental health diagnosis will be referred for mental health treatment to be delivered by a QMHP. Collaborative relationships with mental health treatment providers will be developed.
5. If no current mental health diagnosis is identified by the QMHP but depressive symptoms exist, the client will be referred to a counselor competent in managing depressive symptoms (see Sample Policy 2).
6. The counselor managing depressive symptoms will screen for changes in the symptoms of depression at each session and, if the client is exhibiting more than two symptoms or current suicidal ideations, the counselor will immediately contact his or her clinical supervisor to determine whether the individual should be reassessed by a QMHP.
7. All screening results, consultation sessions with the clinical supervisor, and referrals (and ongoing communications) to a QMHP will be documented in the client's record.
8. The counselor providing services for depressive symptoms will provide the client with an emergency contact list that includes agency personnel and emergency mental health providers. The client can refer to this list if his or her symptoms worsen outside business hours or when substance abuse counselors are not available.

Sample Policy 4

Topic: Treatment planning, service recording, discharge planning, and continuity of care.

Policy Statement: Management of depressive symptoms will be integrated with substance abuse services, be properly documented, and include appropriate discharge and transfer planning related to depressive symptoms.

Procedures:

1. Screening for depressive symptoms and strategies for managing depressive symptoms will be included in the client's treatment plan.
2. Treatment plans for depressive symptoms, along with other substance use problems, will be jointly developed by the multidisciplinary team and the client within and/or across programs.
3. To minimize client confusion, the client will be provided with information about the roles and responsibilities of those delivering care.
4. If the counselor providing services for depressive symptoms is not the client's primary substance abuse counselor, the counselor providing services for depressive symptoms will attend all treatment planning sessions for the client along with the other members of the multidisciplinary team.
5. Treatment plans will include referral to other community resources and peer support activities that may increase the client's self-efficacy and reduce depressive symptoms.
6. Multidisciplinary treatment update sessions that include all professionals involved with the client's care will be held every 7 days for short-term residential treatment and every 30 days for long-term residential treatment and outpatient settings. (The frequency of treatment plan updates should be consistent with State and organizational standards and will vary by modality of care and regulatory agency.)
7. Services delivered by the counselor treating depressive symptoms will be recorded in the client's record at each contact and will be available to other members of the treatment team.
8. Major changes in the client's condition will be communicated between the substance abuse counselor and the multidisciplinary team providing services for depressive symptoms.
9. The checklist of depressive symptoms (see Sample Policy 3) will be completed at the last session before termination to assist in developing the discharge plan and to be used by the quality assurance department for outcome monitoring.
10. Discharge and transfer planning will include recommendations for the client about self-care and professional care for depression.

Sample Policy 5

Topic: Counselor performance appraisal..

Policy Statement: Counselors capable of providing services for depressive symptoms will have job descriptions that include a high level of specific performance expectations related to provision of services for these clients.

Procedures:

1. Job descriptions for counselors providing services for depressive symptoms will include modified caseload and productivity expectations for the modality of care in which the counselor works.
2. Performance appraisal of counselors providing services for depressive symptoms will include demonstration of core competencies related to managing depressive symptoms.
3. Annual training requirements will be outlined in the job descriptions of counselors identified to provide services for depressive symptoms.
4. Client satisfaction surveys and outcome reports will be discussed in annual performance evaluations with counselors managing depression symptoms.

Sample Policy 6
Topic: Evaluation of service effectiveness and quality assurance.
Policy Statement: Services for managing depressive symptoms will be reported annually through the agency's quality assurance system along with indicators of effectiveness based on client outcomes.
Procedures: 1. The agency's quality assurance program will include monitoring the implementation of policies related to screening and assessment of depressive symptoms, QMHP referral procedures, documentation and treatment planning, and supervision of counselors providing services for depressive symptoms. 2. Data from admission and discharge screening of clients with depressive symptoms (see Sample Policy 3) will be aggregated by the quality assurance coordinator for annual reporting to the agency. 3. The following overall agency performance outcomes will be reviewed annually by the management team: a. The proportion of clients dropping out of treatment before the third session (it will be important to have information on the dropout rate before implementation of services for depressive symptoms to assess the impact of these services on treatment engagement and retention). b. The proportion of clients evidencing two or more depressive symptoms at admission and discharge. c. The proportion of clients referred to a QMHP. d. The number of clients receiving services for depressive symptoms. e. The proportion of all clients experiencing a relapse during treatment and for the subgroup of those with depressive symptoms.

Addressing Relevant Regulations

Another aspect of assessing the agency is to determine whether implementing the intervention will conflict with existing governmental or accreditation regulations and standards. For example, you will want to review the licensing regulations for the substance abuse treatment counselors and the Federal, State, and local regulations that apply to the agency's operation.

The assessment of the agency includes ensuring that the agency, program, and staff are licensed to provide the interventions in *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery, Part 1*. Before implementing any intervention, ensure that all appropriate policies and procedures are in place and that these interventions fall within the scope of acceptable practice for the applicable Federal, State, and local regulations for your agency, program, and staff. It is also important to note that more and more often, licensed and certified substance abuse counselors have advanced degrees in professions (such as social work, counseling, and psychology) that do allow them to diagnose and treat mental disorders concomitant with the client's substance abuse treatment. Rules and regulations governing the practices of substance abuse counselors are evolving and subject to change by State legislatures (see Part 1 Chapter 1 of this TIP).

Addressing Staff Competence

Where Is the Clinical Expertise in Your Agency?

Change in clinical practice is best facilitated by assessing the skills of well-trained and experienced clinicians and targeting them for training and/or enlisting them in helping less skilled counselors facilitate change. Two clinical management structures are described here—multidisciplinary teams and traditional clinical supervisors.

Multidisciplinary teams are one effective way to ensure that the expertise for providing treatment for co-occurring substance use and mental disorders is available in your agency. If you have multidisciplinary teams in your program, the teams assume the responsibility of tailoring interventions to an individual client's needs in a way that addresses co-occurring disorders seamlessly. The multidisciplinary teams provide ongoing support, education, and treatment planning assistance for all staff. Teamwork creates an enriched environment for implementing techniques for managing co-occurring disorders. An advanced level of capability for managing depressive symptoms in clients with substance use disorders occurs when the more experienced and skilled members of the team have the knowledge, skills, and attitudes required to apply an intervention and to supervise and coach application of an intervention for other counselors.

Many substance abuse treatment agencies do not have multidisciplinary teams and instead rely on the expertise of *clinical supervisors* to evaluate and support the work of line staff. Clinical supervisors must have the knowledge, skills, and abilities required to apply an intervention and be able to demonstrate the intervention before they can coach others to perform it. The supervisors must also have the time to supervise and coach the staff. If this describes the supervisors in the setting where you work, you have an intermediate capability to manage depressive symptoms. If the supervisors have not yet reached this level, then you have a beginning capability for working with co-occurring disorders and must develop a plan to build the resources necessary to increase capacity.

The Frontline Staff and Clinical Supervisors

Once you've assessed the agency, you may want to assess the staff who will actually implement the change (see How-To 2.6).

How-To 2.6: How To Assess the Frontline Staff and Clinical Supervisors To Be Targeted (Figure 2.1, Step H)

The committee determines the specific program and staff members who will be the first to implement change.

1. Are there incentives to change (ATTC Change Book, p. 29)?
2. What are the barriers to change (ATTC Change Book, p. 29)?
3. At what stage of change is the program staff (ATTC Change Book, p. 29)?
4. How will staff practice be affected (ATTC Change Book, p. 29)?
5. What additional support will staff need (ATTC Change Book, p. 29)?
6. Does staff have the prerequisite knowledge, attitudes, and skills?
7. What training and continuing resources are necessary to provide the core intervention components?

See also Sample Policies 1–6 (pp. 115–119) and Checklists 1–4 (pp. 121–124) for additional information to be used in assessing staff readiness.

Staff Qualifications and Competencies

As a part of implementation, a number of process-oriented tasks should be completed, including an assessment of initial staff competence, education and training, development of skills and resources, and supervision. These considerations are relevant not only to the counselors' ability to deliver the services but also to clinical supervisors, other clinical staff, and support staff responsible for recording and billing services. These more peripherally involved staff are often critical to the success of the program and can help shape the public image of the program and sustainability of the service.

Compared with those providing support services, however, the required level of knowledge and skill is significantly different for those directly involved in clinical care. For this reason, the attitudes, knowledge, and skills required to manage depressive symptoms are separated into four categories: administrative and support staff, all clinical staff, counselors designated to manage depressive symptoms, and their clinical supervisors. The four checklists that follow (pp. 121–124) serve two purposes. First, they can be used to assess staff and organizational readiness to implement or sustain the specialized services for managing depressive symptoms. Second, they can be used to identify gaps in training and supervision to be addressed with individuals or groups. See also TAP 21-A, *Competencies for Substance Abuse Treatment Clinical Supervisors* (CSAT, 2007).

Checklist 1: Characteristics and Competencies of Administrative and Support Staff

Attitudes

____ Integration of substance abuse and management of depressive symptoms is important for promotion of the agency mission.
____ Depressive symptoms constitute valid and important experiences of clients with substance use disorders that deserve and require specialized attention.

Knowledge

____ Understands the relationship between depressive symptoms and substance abuse treatment effectiveness.
____ Understands how provision of services for depressive symptoms fits in the mission and goals of the organization.
____ Is familiar with the policies and procedures related to recording and billing services for depressive symptoms.
____ Understands the distinction between DSM-IV-TR diagnoses and the depressive symptoms treatable by substance abuse counselors.
____ Knows the agency's policies and procedures on treating depressive symptoms as they relate to the specific position (e.g., administrative staff in clinical records are familiar with documentation requirements for these services, and the finance staff are knowledgeable about how services are defined for billing purposes).
____ Understands the role of self-help groups in recovery and how those groups can support the goals of the program in working with substance abuse clients with depressive symptoms.

Skills

____ Communicates to the public the role of specialized services for managing depressive symptoms in clients with substance use disorders. Individuals answering telephones or preparing written materials describing agency services can describe the services accurately to outside agencies and to clients. They understand and can communicate the distinction between the mental health diagnosis of depression and depressive symptoms treated by substance abuse counselors.
____ Is able to conduct essential aspects of job duties related to service delivery. Individuals billing for services understand the distinction between mental health diagnoses and depressive symptoms to ensure clear communication with funding agencies.

Checklist 2: Characteristics and Competencies of All Clinical Staff

Attitudes

____ Integration of services for substance abuse and depressive symptoms is important for promotion of the agency mission.
____ Depressive symptoms constitute valid and important experiences of clients with substance use disorders that deserve and require specialized attention.
____ Integration of services for clients with substance use disorders and depressive symptoms is important.
____ Clients have a central role in creating and shaping their treatment goals.
____ Substance abuse and depressive symptoms can be both interrelated and independent; resolving one set of concerns may not lead to resolution of the other set of concerns without specialized treatment.
____ There is no one "right" approach to managing depressive symptoms in clients with substance use disorders.
____ Individual sessions can be particularly valuable for clients with depressive symptoms and can provide an effective adjunct to group treatment.

Knowledge

____ Understands the relationship between depressive symptoms and substance abuse treatment effectiveness.
____ Understands how provision of services for depressive symptoms fits in the mission and goals of the organization.
____ Understands the distinction between DSM-IV-TR diagnoses and the depressive symptoms managed by substance abuse counselors.
____ Knows the agency's policies and procedures on managing depressive symptoms.
____ Understands the interrelationship between depressive symptoms and substance abuse.

Skills

____ Communicates to the public the role of managing depressive symptoms of clients with substance use disorders.
____ Identifies the depressive symptoms listed in the screening policy and procedure (see Sample Policy 3).
____ Properly administers a depression symptom screening measure.
____ Conducts basic client education session on the relationship between depressive symptoms and substance abuse.
____ Collaborates with other team members on treatment and discharge planning.
____ Conducts a suicide risk screening.

Checklist 3: Characteristics and Competencies of Counselors Identified To Manage Depressive Symptoms

Attitudes

____ Integration of services for substance abuse and depressive symptoms is important for promotion of the agency mission.
____ Depressive symptoms constitute valid and important experiences of clients with substance use disorders that deserve and require specialized attention.
____ Integration of services for clients with substance use disorders and depressive symptoms is important.
____ Clients have a central role in creating and shaping their treatment goals.
____ Substance abuse and depressive symptoms can be both interrelated and independent; resolving one set of concerns may not lead to resolution of the other set of concerns without specialized treatment.
____ There is no one "right" approach to managing depressive symptoms in clients with substance use disorders.
____ Individual sessions can be particularly valuable for clients with depressive symptoms and can provide an effective adjunct to group treatment.
____ Resistance to change from clients is surmountable within the influence of the counseling relationship.
____ The client is an integrated whole rather than one or more diagnoses or sets of symptoms.
____ A desire exists to deliver services to clients with substance use disorders experiencing depressive symptoms.

Checklist 3: Characteristics and Competencies of Counselors Identified To Manage Depressive Symptoms (continued)

Knowledge

____ Understands the relationship between depressive symptoms and substance abuse treatment effectiveness.
____ Understands how provision of services for depressive symptoms fits into the mission and goals of the organization.
____ Understands the distinction between DSM-IV-TR depression diagnoses and the depressive symptoms treated by substance abuse counselors.
____ Demonstrates a nuanced understanding of the relationship between substance abuse and depressive symptoms.
____ Understands the distinctions among screening, assessment, and diagnosis of mental health problems.
____ Knows the common approaches to the management of depressive symptoms in substance abuse treatment settings including motivational interviewing, cognitive–behavioral, and supportive-expressive approaches.
____ Understands how substance abuse and depression present in ethnic and other cultural groups encountered in the agency.
____ Knows community resources (particularly mental health and peer support).
____ Understands how 12-Step and other mutual-help support programs can support resolution of depressive symptoms.
____ Is aware of the role of transference and countertransference in the counseling relationship.
____ Understands the role of religion and spirituality in promoting recovery for some clients.

Skills

____ Communicates to the public the role of managing depressive symptoms of clients with substance use disorders.
____ Identifies the depressive symptoms listed in the screening policy and procedure (see Sample Policy 3).
____ Properly administers a depression symptom screening measure.
____ Conducts basic client education session on the relationship between depressive symptoms and substance abuse.
____ Collaborates with other team members on treatment and discharge planning.
____ Conducts a suicide risk screening.
____ Communicates to the public the role of services for depressive symptoms of clients with substance use disorders.
____ Identifies the depressive symptoms listed in the screening policy and procedure (see Sample Policy 3).
____ Properly administers a depression symptom screening measure.
____ Conducts a client education session on the relationship between substance abuse and depressive symptoms.
____ Collaborates with other team members on treatment and discharge planning.
____ Conducts a suicide risk screening.
____ Exhibits evidence-based thinking (tailoring approach to service based on clinical experience, client characteristics, knowledge of field, consultation with supervisor, constraints, and resources available).
____ Effectively uses clinical supervision.
____ Demonstrates empathic listening skills and reflection.
____ Demonstrates competency in at least two of the common approaches to managing depressive symptoms (motivational interviewing, cognitive–behavioral, supportive-expressive approaches).
____ Displays confidence in ability to provide services for depressive symptoms.
____ Acts as a role model for a balanced, healthy lifestyle.
____ Exhibits advanced skills in dealing with resistance to change through nonconfrontational approaches.
____ Identifies and responds to variations in learning styles among clients.
____ Demonstrates the ability to quickly establish a therapeutic alliance with the client: treating the client with respect, communicating a nonjudgmental attitude, listening reflectively, setting appropriate limits, being sensitive to culture and value contexts, and acting as a role model.
____ Is comfortable with and able to resolve conflict.
____ Is able to prepare clients for termination from the program.

Checklist 4: Characteristics and Competencies of Clinical Supervisors
Attitudes ____ Substance abuse counselors have the basic characteristics needed to provide services to manage depressive symptoms. ____ Clinical supervision extends beyond talking about treatment to observing and coaching counselors directly.
Knowledge ____ Possesses all of the knowledge areas listed on Checklist 3. ____ Is knowledgeable of the role of clinical supervision. ____ Recognizes the limits and opportunities related to the role of substance abuse counselors with specialized training in the management of depressive symptoms and supports training about depression for counselors as needed. ____ Can determine when a client with depressive symptoms needs additional skills and services beyond the qualifications of substance abuse counselors. ____ Is trained to use screening instruments for depressive symptoms. ____ Is aware of the role of transference and countertransference in the counseling and supervisory relationship. ____ Recognizes resistance to change among clinical staff and is knowledgeable of strategies to address resistance. ____ Is aware of change processes, process steps and strategies for supporting them.
Counseling Skills ____ Possesses all of the skills listed on Checklist 3.
Supervisory Skills ____ Articulates his or her approach and philosophy to clinical supervision as it relates to clinical supervision approaches described in the literature. ____ Identifies and responds to variations in learning styles among counselors. ____ Is comfortable with and able to resolve conflict among team members. ____ Models advanced counseling skills including development of therapeutic alliance, termination, and dealing with client resistance. ____ Uses direct observation or taping to conduct supervisory sessions. ____ Is able to teach and model skills in motivational interviewing, cognitive–behavioral, and supportive–expressive approaches for managing depressive symptoms. ____ Is able to determine when referral to a QMHP for a mental health assessment is required. ____ Facilitates referrals to QMHP both within and outside the treating agency. ____ Provides incentives through encouragement and support for counselors to enhance skills in treating clients with depressive symptoms. ____ Conducts competency assessment of counselors' skills in treating depressive symptoms.

Addressing Gaps in Staff Capacity To Deliver Services

Not all clinical staff are ready, willing, or able to address co-occurring symptoms. The clinical supervisor is charged with helping staff and administration differentiate the level of new knowledge, attitudes, and skills needed to help counselors and support staff address co-occurring substance use disorders and depressive symptoms. The characteristics and competencies checklists presented above outline the qualifications needed at various levels or in agencies wishing to provide services for managing depressive symptoms in clients with substance use disorders. However, gaps may exist; staff may be lacking in various areas and require additional training and support. In this instance, the implementation work group described in earlier sections may be commissioned to identify these gaps and to develop plans to provide specific training and support to individual staff members on an as-needed basis.

In addition to developing individualized plans to develop attitudes, skills, and knowledge, a number of organizational approaches can be used both to reinforce the change and to overcome resistance to change. *The Change Book* (ATTC, 2004) offers valuable suggestions on addressing resistance to change. These include such strategies as openly discussing staff feelings related to the change, celebrating victories, promoting feedback about the change as a vehicle to improve the process, being realistic about goals, identifying and using the change leaders in promoting the change, and providing training related to the change.

Approaches to Staff Training

It is recommended that training aimed at developing the basic attitudes, knowledge, and skills for managing depressive symptoms be provided to all agency staff as part of implementation. It is important for clinical staff to see the link between the change and organizational leadership. Thus, administrators need to attend these sessions to personally provide the vision of the organization. In addition to training current staff, it is important to consider the ways in which the organization can communicate the vision to new staff. This may be most efficiently accomplished by using existing vehicles, such as new staff orientation and training sessions and worksite orientation procedures.

Training of all clinical staff members on attitudes, knowledge, and skills specific to their positions can be conducted by administrative or clinical supervisors. Again, it is important to communicate the commitment of leadership to integrating services for depressive symptoms. In addition, it is recommended that training sessions provide practice in the skill areas outlined in Checklist 3. To reinforce the importance of the need to provide services to individuals with depressive symptoms, clinical and administrative supervisors are advised to incorporate didactic education, identification of incompatible attitudes, and coaching on the skills needed to implement the policies within existing supervision sessions and team meetings. In short, the agency's vision and commitment to addressing depressive symptoms must infiltrate all clinical interactions between supervisors and counselors.

Formal training of the clinical supervisors and counselors providing services for managing depressive symptoms is also required. It is recommended that the trainer (either internal or external to the organization, and, ideally, a combination of both) identified to conduct the training have advanced education in counseling, social work, or psychology; significant work experience in the substance abuse field; and an understanding of the importance of and commitment to the process of preparing substance abuse counselors to deliver services to clients with depressive symptoms. In addition, the individual must be versed in conducting and teaching others to conduct clinical sessions using motivational interviewing, cognitive–behavioral, and supportive-expressive approaches to symptom management and to meet all of the qualifications and competencies for clinical supervisors. See Figure 2.2 for a list of recommended credentials for trainers. See also How-To 2.7 for how to select a trainer and How-To 2.8 for how to continue the learning after the initial training is completed.

Figure 2.2
Recommended Credentials for Individuals Providing Training in Management of Depressive Symptoms

- Advanced education in counseling, social work, or psychology
- Minimum of 5 years' experience delivering substance abuse treatment
- Understanding of commitment to preparing substance abuse counselors to manage depressive symptoms
- Being a skilled teacher and clinical supervisor
- Possessing skills and experience in using motivational interviewing, cognitive–behavioral, and supportive-expressive approaches to managing depressive symptoms
- Meeting all certification or licensure qualifications and competencies for clinical supervisors

How-To 2.7: How To Select a Trainer

Qualifications to look for in a trainer include:

1. Experience working with the clientele being served.
2. Ability to demonstrate the techniques as needed in role play with staff or in vivo (if possible).
3. Ability to address the types of challenging cases frontline staff encounter and how to work with challenging clients.
4. Understanding of the obstacles and challenges with which the frontline staff and the clinical supervisors are dealing.
5. Respectful attitude toward the clinical staff.
6. Models the principles and strategies of the intervention with the participants.
7. Ability to maintain and modify the technique for the treatment setting, willingness to review transcripts or tapes of actual sessions, and willingness to consult on the phone.
8. Willingness to accept specific training objectives to target specific staff skill sets in a case review format.

How-To 2.8: How To Continue the Learning After the Initial Training Is Completed

1. Assess the staff's knowledge, abilities, and skills with the core components of the techniques (see Fidelity Checklists 1–5 in Appendix C).
2. Emphasize mastery of the underlying principles of the interventions. Always give feedback on how well staff members are doing with interventions and provide advice on simple ways to improve practice.
3. Emphasize mastery of the common techniques across approaches (e.g., reflective listening, affirmations, increasing self-efficacy).
4. When staff members have the basics, let them choose the approach they want to focus on next (e.g., behavioral, cognitive, beliefs, affective).

Addressing Community Relationships

How Do You Develop Referral Relationships?

Access to a range of mental health and other health and social resources is essential to quality care, particularly for clients with depressive symptoms. Agencies to which staff might refer can be screened using the following variables:

- Sensitivity to substance abuse treatment issues.
- Ability and willingness to work with agencies such as ours.
- No or low funding impediments to working collaboratively.
- Good professional reputation in the community.
- Sufficient funding to address the needs of clients we are referring.
- Willing to cross-train with our staff.
- Willing to accept referral of clients at increased risk of suicide.

How Do You Develop Relationships With the 12-Step Community?

It is useful to have the program's policy and procedures manual reflect an understanding of the essential role that 12-Step programs play in the treatment of clients with substance abuse complicated by depressive symptoms. Mental health personnel need to be sensitive and competent in integrating the principles and practices of self-help programs into the clinical process. This requires knowledge of the underlying philosophy of the 12-Step model, and an understanding of how the programs function and are structured. In like manner, counselors practicing from a 12-Step facilitation model need to appreciate how principles and practices are linked to sound counseling. For example, the use of slogans as a form of cognitive restructuring and disputation is helpful to most clients. The use of structured practices like daily meetings, sponsor contact, and reading self-help group literature can help create alternate forms of reward, relief, and life-management. The policy should recognize barriers to individuals with depressive symptoms accessing and using 12-Step programs.

How Do You Find and Use Mental Health Resources in the Community?

Most substance abuse programs can benefit from positive ad hoc consulting relationships with physicians, psychologists, social workers, and other community medical, rehabilitation, social service, and mental health providers who have specialized knowledge and resources in addressing the needs of clients with depressive symptoms. These resources can provide an adjunct resource for such issues as difficult assessments and differential diagnosis, placement in appropriate treatment programs, medical management of co-occurring chronic medical conditions (such as HIV or tuberculosis), clients with special physical rehabilitation needs, specialized psychopharmacological services for clients with specific medication needs, discharge planning, and family services. Finding and using these resources may be different from finding and using referral resources. Understanding the services that can be provided, fees for service, whether the service can be provided in the treatment program or whether the client must travel to a remote site, and the processes for reporting results of evaluations are some of the issues that need to be considered in using community resources. Generally, unlike referral resources, community resources will not have a formalized contract or agreement with the treatment program. Therefore, issues of confidentiality and information reporting will need to be explored.

Addressing Financial Considerations

Billing

Integration of services for depressive symptoms is intended to enhance substance abuse treatment outcomes and because these services are delivered by substance abuse counselors, such services are likely to be reimbursable under the client's substance abuse diagnosis. In this case, individual sessions aimed at managing depressive symptoms may be billed as individual counseling or psychotherapy associated with the substance abuse or dependence diagnosis. Organizations are advised to clarify this with State and private funding agencies and to identify the specific procedures required to facilitate billing. Financial considerations also reinforce the need for support staff responsible for billing to understand how these services are delivered and their relationship to the primary diagnosis of substance abuse or dependence.

For organizations reimbursed based on case or capitated rates, reimbursement is not likely to change. Services for depressive symptoms are likely to be viewed by managed care organizations or funding agencies as value-added or optional services and thus included in established rates of reimbursement. Although incorporating services for depressive symptoms is not likely to increase reimbursement rates, it may improve performance on contractually mandated outcomes such as treatment engagement, retention, and effectiveness.

Sources of Funding

Most of the costs of implementing services for managing depressive symptoms occur early in the process of implementation, so local foundations are potential sources of funding. A one-time cost of training and knowledge dissemination to staff offers a discrete, relatively low-cost, and attractive opportunity for local foundations to contribute to improving substance abuse treatment outcomes. Other potential sources of funding include traditional State and Federal grants and contracts, direct charges for services from third-party payors, and client fees for service. Additionally, if the services provided are innovative, agencies should consider partnering with social and psychological researchers at a local university to obtain research funds to support clinical efforts. Such research efforts can have many beneficial secondary effects for agency status in the community, such as developing alternative sources of funding, partnering with new groups interested in substance abuse in the community, as well as providing funds for the identified project.

Addressing Continuity and Fidelity

For services for management of depressive symptoms to be fully adopted, the importance of these services will need to be consistently communicated. Policies, mission statements, program descriptions, clinical and administrative training, team meetings, and clinical supervision sessions are all useful avenues for communicating the organization's commitment to delivering service for depressive symptoms (see Figure 2.3).

Implementing the Intervention With Fidelity

When implementing any intervention, it is important to identify the active elements that distinguish the new intervention from other activities. Distinguishing the new intervention from standard practice allows administrators to more easily determine whether the new intervention can be attributed to the changes in expected outcomes. One strategy used by researchers and program implementers is the fidelity checklist. Fidelity checklists clearly describe the active elements of an intervention and define them in behavioral terms so that the degree of implementation can be assessed. Examples of fidelity checklists for measuring interventions for clients with depressive symptoms are presented in Appendix C.

Figure 2.3
Avenues for Communicating Organizational Commitment to Delivering Services To Manage Depressive Symptoms

- Mission and vision statements
- Strategic plans
- Annual goals
- Program descriptions
- Treatment philosophy statements
- Policies and procedures
- Training sessions
- Team meetings
- Clinical supervision
- Management meetings
- Quality assurance plans
- Employee newsletters
- Electronic communication vehicles including e-mail and Intranet

Some of the dimensions of these fidelity checklists include:

- General behaviors that underlie all the interventions.
- Behavioral interventions.
- Cognitive interventions.
- Beliefs interventions.
- Affective interventions.

Some of the issues of implementing fidelity checklists that have to be addressed include:

- Who measures which parts of the checklist?
- How are the results conveyed to the staff?
- How does a program define an acceptable score?
- How does one reward positive results of the efforts measured by the checklist?
- What actions need to be taken if there is poor fidelity to program elements and goals?
- How do elements of the checklist get updated over time and with program changes?

Summary

This TIP is intended to provide guidance in implementing services for managing depressive symptoms in clients with substance use disorders and to identify issues that should be considered in implementing these services. Implementing any major change in organizational practices is a deliberate strategic process, requiring a committed leader and a talented and hardworking team. The outcome of this hard work and commitment has the potential to positively affect the lives of clients with substance use disorders, their families, agency staff, and other stakeholders.

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Appendix B—Center for Epidemiologic Studies Depression Scale (CES-D)

Instructions: Below is a list of some of the ways you may have felt or behaved. Please indicate how often you have felt this way during the past week by checking the appropriate space.

During the past week	Rarely or none of the time (less than 1 day)	Some or a little of the time (1–2 days)	Occasionally or a moderate amount of the time (3–4 days)	Most or all of the time (5–7 days)
1. I was bothered by things that usually don't bother me.				
2. I did not feel like eating; my appetite was poor.				
3. I felt that I could not shake off the blues even with help from my family or friends.				
4. I felt that I was just as good as other people.				
5. I had trouble keeping my mind on what I was doing.				
6. I felt depressed.				
7. I felt that everything I did was an effort.				
8. I felt hopeful about the future.				
9. I thought my life had been a failure.				
10. I felt fearful.				
11. My sleep was restless.				
12. I was happy.				
13. I talked less than usual.				
14. I felt lonely.				
15. People were unfriendly.				
16. I enjoyed life.				
17. I had crying spells.				
18. I felt sad.				
19. I felt that people disliked me.				
20. I could not get "going."				
Total Score:				

Center for Epidemiologic Studies Depression Scale (CES-D)

Scoresheet

During the past week	Rarely or none of the time (less than 1 day)	Some or a little of the time (1–2 days)	Occasionally or a moderate amount of the time (3–4 days)	Most or all of the time (5–7 days)
1. I was bothered by things that usually don't bother me.	0	1	2	
2. I did not feel like eating; my appetite was poor.	0	1	2	
3. I felt that I could not shake off the blues even with help from my family or friends.	0	1	2	
4. I felt that I was just as good as other people.	3	2	1	
5. I had trouble keeping my mind on what I was doing.	0	1	2	
6. I felt depressed.	0	1	2	
7. I felt that everything I did was an effort.	0	1	2	
8. I felt hopeful about the future.	3	2	1	
9. I thought my life had been a failure.	0	1	2	
10. I felt fearful.	0	1	2	
11. My sleep was restless.	0	1	2	
12. I was happy.	3	2	1	
13. I talked less than usual.	0	1	2	
14. I felt lonely.	0	1	2	
15. People were unfriendly.	0	1	2	
16. I enjoyed life.	3	2	1	
17. I had crying spells.	0	1	2	
18. I felt sad.	0	1	2	
19. I felt that people disliked me.	0	1	2	
20. I could not get "going."	0	1	2	
Total Score:				

Appendix C—Fidelity Checklists

Fidelity Checklist 1: General Underlying Principles

Adherent Behaviors

____Respect is apparent when the counselor (1) shows respect for a variety of plans about how change can occur and (2) can accept differences between the ideal plan and the plan the client is willing to endorse. Counselors high in respect can negotiate with the client and avoid an authoritarian stance.

____Understanding is apparent when counselors have a stance that is curious and patient and emphasizes drawing out clients' ideas rather than educating clients or giving opinions without being asked.

____ Accepting counselors accept that a client may choose not to change. They are invested in specific behavior changes, but they convey an understanding that the critical variables for change are within the client and cannot be imposed by others.

____Strengths-based counselors focus on identifying, enhancing, and using the client's strengths as the foundation for the client's plan to create positive change. The counselor understands that the client must believe he or she is able to make a change to maintain motivation to make the change.

____Commitment to follow up on the planned activities between sessions is elicited by the counselor by summarizing the client's stance on the issue, framing the next steps, asking the client whether the plan is acceptable, and making any necessary changes to the plan.

Nonadherent Behaviors

____Low respect is evident when the counselor's stance is rigid and authoritarian and little effort is made to include the client's ideas about how change might be accomplished. It includes attempts to persuade clients about the need for change and occasions when clinicians confront clients with their point of view.

____Low understanding is evident when the counselor neglects the task of eliciting the client's verbalizations about need for change. The counselor might convey cynicism about the client's desire for change or focus on giving information or educating the client.

____Low accepting counselors convey a sense of urgency about the need for change. They have difficulty accepting that clients might choose to avoid or delay change or decide to proceed with change in an unconventional manner.

____Low strengths-based counselors neglect to elicit and incorporate client strengths in the plan for change. Counselors base the plan for change on client weaknesses instead of strengths.

____Low commitment to follow up on the planned activities is evident when the counselor assigns homework without eliciting and summarizing the client's stance on the issue and making any necessary changes to the plan.

Fidelity Checklist 2: Behavioral Techniques

Adherent Behaviors

____Identifies specific behaviors that the client identifies as wanting to change. Helps the client identify what to do instead of what not to do. Understands the value of collaborating with the client to find alternative behaviors that are reinforcing to the client.

____Helps the client set achievable goals for behavioral change. Helps the client to take big changes and break them down into smaller changes that can be more easily accomplished and maintained. Understands that the client will continue a behavior until there is good reason to believe that another behavior will be equally satisfying or reduce anxiety.

____Helps the client find the support needed to plan for, initiate, and maintain behavioral changes. Helps the client find internal and environmental resources that will help him or her develop and maintain the motivation necessary to sustain behavioral changes.

____Collaborates with the client on specific behavioral interventions (e.g., mild or moderate physical exercise, getting adequate rest, managing stress).

Nonadherent Behaviors

____Neglects to identify specific behaviors for change. Focuses on what the client is feeling or thinking instead of identifying specific behaviors. Or, chooses to focus on changing a behavior the client does not identify as important to change. Does not understand the role of reinforcement in the role of behavior change.

____Neglects to break big changes down into manageable goals. The counselor expects the client to take on more than the client feels able to take on. Or, the counselor expects the client to replace a reinforcing behavior with a behavior that is less reinforcing or is aversive.

____ Neglects to help the client find the support he or she needs to initiate and maintain behavioral changes. Does not understand the role of aversive experiences in causing clients to avoid making change.

____ Neglects to identify specific behavioral interventions. Instead offers other types of interventions (e.g., cognitive, affective).

Fidelity Checklist 3: Cognitive Interventions

Adherent Behaviors

____Identifies automatic thoughts that are evoked by unpleasant events. Specifically, negative thoughts about self (e.g., worthlessness), the world (e.g., negative interpretation of experiences), and the future (e.g., expectation of failure).

____Collaborates with the client to determine whether the client's negative thinking is inaccurate.

____Elicits from the client the link between negative thoughts and increased feelings of depression and less functional behaviors. Increases client's objectivity about his or her thoughts and helps the client differentiate between unrealistic and realistic meanings of events.

____Uses cognitive techniques such as searching for alternative explanations or assessing for negative self-talk, and offers reasonable responses to decrease the client's distress.

____Discusses homework, including understanding obstacles to completing homework.

Nonadherent Behaviors

____Focuses on feelings or behaviors instead of identifying automatic thoughts, or identifies automatic thoughts that are not connected to the unpleasant event or feeling.

____Tells the client that his or her negative thinking is inaccurate instead of collaborating with the client to come to this conclusion.

____Tells the client about the link between negative thoughts and increased feelings of depression/less functional behaviors, instead of eliciting an understanding of the link from the client. Does not increase the client's objectivity about his or her thoughts, and does not help the client differentiate between unrealistic and realistic meanings of events.

____Uses techniques other than cognitive techniques (e.g., affective techniques).

____Assigns homework but does not review it.

Fidelity Checklist 4: Beliefs Interventions

Adherent Behaviors

____ Listens carefully to identify the underlying meaning of what the client is saying.

____ Elicits the meaning the client attaches to negative events.

____ Identifies core beliefs (e.g., extreme, negative, categorical, absolute, and judgmental meanings are attached to negative events) that lead to the conclusion that the client can't take care of the problem.

____Facilitates the client's objective assessment of his or her core beliefs.

____Elicits from the client alternative beliefs or solutions.

____Elicits from the client the link between the client's behavior and feelings and the client's underlying beliefs about self.

____Elicits from the client possible experiments with new solutions to the problem and ways to test out beliefs.

____Discusses homework, including understanding obstacles to completing homework.

Nonadherent Behaviors

____ Does not identify the underlying meaning of what the client is saying.

____ Tells the client how to interpret negative events.

____ Does not identify the core beliefs leading to the client's conclusion that the client won't be able to take care of the problem.

____Tells the client that his or her core beliefs are irrational.

____Tells the client what the client should believe.

____Tells the client that the client's behavior and feelings are linked to underlying beliefs about self instead of eliciting this from the client.

____Tells the client what experiments or new solutions to the problem to test out.

____Assigns homework but does not review it.

Fidelity Checklist 5: Affective Interventions

Adherent Behaviors

____Identifies the feelings that the client finds too painful, overwhelming, or unmanageable to express.

____Conceptualizes the client's behaviors (e.g., avoidance, controlling, substance use, difficulty asking for help) as arising from the need to avoid these feelings.

____Assists the client in creating a safe enough environment in the counseling session to explore these feelings without having to resort to the use of defenses (e.g., isolating, projecting, drinking).

____Addresses defenses when the client feels comfortable enough to examine them without needing to become more defensive.

____Works at the client's pace toward the goal of helping the client become comfortable with expressing the feelings that are being avoided.

____Demonstrates the ability to help the client pull back from intense feelings and helps the client experience and resolve grief.

Nonadherent Behaviors

____Does not identify the feelings that the client finds too painful, overwhelming, or unmanageable to express.

____Conceptualizes the client's behaviors (e.g., avoidance, controlling, substance use, difficulty asking for help) as arising from reasons other than the need to avoid these feelings.

____Rather than facilitate the client's creation of a safe place to explore these feelings, takes responsibility for creating this environment without regard for the client's concerns.

____Addresses defenses at times when the client is not comfortable enough to examine them.

____Works toward a different goal than the goal of helping the client become comfortable with experiencing the feelings that are being avoided.

____Does not appear to know how to help the client pull back from intense feelings or experience and resolve grief.

Appendix D—DSM-IV-TR Mood Disorders

In substance abuse treatment settings, you are likely to encounter clients with a variety of diagnoses of depressive illnesses. Most of these diagnoses fall in the category of Mood Disorders, as specified in the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, Text Revision (DSM-IV-TR; APA, 2000). You can, however, also work with people who have a diagnosis of Adjustment Disorder with Depressed Mood. Additionally, people with a variety of other psychiatric illnesses are susceptible to depression, and some of those illnesses are described in this appendix.

The descriptions of depressive disorders and their primary symptoms are taken from DSM-IV-TR. Please refer to the source document for a more complete description of these disorders.

1. Major Depressive Episode and Major Depressive Disorder

Major Depressive Disorder requires two or more major depressive episodes.

Diagnostic criteria:

Depressed mood and/or loss of interest or pleasure in life activities for at least 2 weeks and at least five of the following symptoms that cause clinically significant impairment in social, work, or other important areas of functioning almost every day

1. Depressed mood most of the day.
2. Diminished interest or pleasure in all or most activities.
3. Significant unintentional weight loss or gain.
4. Insomnia or sleeping too much.
5. Agitation or psychomotor retardation noticed by others.
6. Fatigue or loss of energy.
7. Feelings of worthlessness or excessive guilt.
8. Diminished ability to think or concentrate, or indecisiveness.
9. Recurrent thoughts of death (APA, 2000, p. 356).

2. Dsythymic Disorder

Diagnostic criteria:

Depressed mood most of the day for more days than not, for at least 2 years, and the presence of two or more of the following symptoms that cause clinically significant impairment in social, work, or other important areas of functioning:

1. Poor appetite or overeating.
2. Insomnia or sleeping too much.
3. Low energy or fatigue.

4. Low self-esteem.
5. Poor concentration or difficulty making decisions.
6. Feelings of hopelessness (APA, 2000, p. 380).

3. Bipolar Episode and Bipolar Disorder

Bipolar disorder is characterized by more than one bipolar episode.

There are three types of bipolar disorder:

1. Bipolar 1 Disorder, in which the primary symptom presentation is manic, or rapid (daily) cycling episodes of mania and depression.
2. Bipolar 2 Disorder, in which the primary symptom presentation is recurrent depression accompanied by hypomanic episodes (a milder state of mania in which the symptoms are not severe enough to cause marked impairment in social or occupational functioning or need for hospitalization, but are sufficient to be observable by others).
3. Cyclothymic Disorder, a chronic state of cycling between hypomanic and depressive episodes that do not reach the diagnostic standard for bipolar disorder (APA, 2000, pp. 388–392).

Manic episodes are characterized by:

"A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary)

B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (4 if the mood is only irritable) and have been present to a significant degree:

   (1) increased self-esteem or grandiosity

   (2) decreased need for sleep (e.g., feels rested after only 3 hours of sleep)

   (3) more talkative than usual or pressure to keep talking

   (4) flight of ideas or subjective experience that thoughts are racing

   (5) distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)

   (6) increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation

   (7) excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)" (APA, 2000, p. 362).

Depressive episodes are characterized by symptoms described above for Major Depressive Episode.

4. Substance-Induced Mood Disorder

Substance-Induced Mood Disorder is a common depressive illness of clients in substance abuse treatment. It is defined in DSM-IV-TR as "a prominent and persistent disturbance of mood . . . that is judged to be due to the direct physiological effects of a substance (i.e., a drug of abuse, a medication, or somatic treatment for depression, or toxin exposure)" (APA, 2000, p. 405). The mood can manifest as manic (expansive, grandiose, irritable), depressed, or a mixture of mania and depression.

Generally, substance-induced mood disorders will only present either during intoxication from the substance or on withdrawal from the substance and therefore do not have as lengthy a course as other depressive illnesses.

5. Mood Disorder Due to a General Medical Condition

It is not as common to find depression due to a general medical condition in substance-abuse treatment settings, but it is important to note that depression can be a result of a medical condition, such as hypothyroidism or Parkinson's disease. The criteria for diagnosis are similar to Major Depressive Episode or a manic episode; however, the full criteria for these diagnoses need not be met. It is important in diagnosis to establish that the depressive symptoms are a direct physiological result of the medical condition, not just a psychological response to a medical problem.

6. Adjustment Disorder With Depressed Mood

Adjustment disorder is a psychological reaction to overwhelming emotional or psychological stress, resulting in depression or other symptoms. Some situations in which an adjustment disorder can occur include divorce, imprisonment of self or a significant other, business or employment failures, or a significant family disturbance. The stressor may be a one-time event or a recurring situation. Because of the turmoil that often occurs around a crisis in substance use patterns, clients in substance abuse treatment may be particularly susceptible to Adjustment Disorders. Some of the common depressive symptoms of an adjustment disorder include tearfulness, depressed mood, and feelings of hopelessness. The symptoms of an adjustment disorder normally do not reach the proportions of a Major Depressive Disorder, nor do they last as long as a Dysthymic Disorder. An acute adjustment disorder normally lasts only a few months, while a chronic adjustment disorder may be ongoing after the termination of the stressor.

7. Other Psychiatric Conditions in Which Depression Can Be a Primary Symptom

Sometimes depression is symptomatic of another mental disorder. This is particularly true when the nature of the mental disorder causes excessive distress to the individual. While, in this context, the depression is a symptom, it is still important to recognize its impact on the person and his or her ability to respond to substance abuse treatment.

Some of the psychiatric disorders in which depression can play a major role include:

A. Posttraumatic Stress Disorder (PTSD)

   Symptoms include episodes of reexperiencing the traumatic event or reexperiencing the emotions attached to the event; nightmares, exaggerated startle responses; and social, interpersonal, and psychological withdrawal. Chronic symptoms may include anxiety and depression. PTSD is categorized as an anxiety disorder.

B. Anxiety Disorders, including Panic Disorder, Agoraphobia (fear of public places), Social Phobias, and Generalized Anxiety Disorder

   Symptoms of anxiety disorders are most often on the anxiety spectrum, but the chronic stress faced by individuals with anxiety disorders can produce depressive symptoms including irritability, hopelessness, despair, emptiness, and chronic fatigue.

C. Schizoaffective Disorder and Schizophrenia

Individuals with schizoaffective disorder have, in addition to many of the symptoms of schizophrenia, a chronic depression with most of the features of Major Depressive Disorder. Because of the difficulty individuals with schizophrenia have in coping with the daily demands of living, depression is often a symptom. With both schizoaffective disorder and schizophrenia, the depression adds an additional dimension to treatment, specifically in helping the person mobilize in the face of their depression to cope with their illness.

D. Personality Disorders

People with personality disorders are particularly susceptible to depression. These individuals are at high risk for substance use disorders. As a result, it is not uncommon to find clients in substance abuse treatment with all three diagnoses. Because personality disorders are categorized in DSM-IV-TR as Axis 2 disorders (see DSM-IV-TR for a description of multiaxial assessment), it is common to find their depression diagnosed separately (from the personality disorder) as an adjustment disorder, dysthymia, or major depressive disorder.

Appendix E—Advisory Meeting Panel

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CSAT TIPs and Publications Based on TIPs

What Is a TIP?

Treatment Improvement Protocols (TIPs) are the products of a systematic and innovative process that brings together clinicians, researchers, program managers, policymakers, and other Federal and non-Federal experts to reach consensus on state-of-the-art treatment practices. TIPs are developed under CSAT's Knowledge Application Program to improve the treatment capabilities of the Nation's alcohol and drug abuse treatment service system.

What Is a Quick Guide?

A Quick Guide clearly and concisely presents the primary information from a TIP in a pocket-sized booklet. Each Quick Guide is divided into sections to help readers quickly locate relevant material. Some contain glossaries of terms or lists of resources. Page numbers from the original TIP are referenced so providers can refer back to the source document for more information.

What Are KAP Keys?

Also based on TIPs, KAP Keys are handy, durable tools. Keys may include assessment or screening instruments, checklists, and summaries of treatment phases. Printed on coated paper, each KAP Keys set is fastened together with a key ring and can be kept within a treatment provider's reach and consulted frequently. The Keys allow you—the busy clinician or program administrator—to locate information easily and to use this information to enhance treatment services.

TIP 1 **State Methadone Treatment Guidelines**—Replaced by TIP 43

TIP 2* **Pregnant, Substance-Using Women**— *BKD107*
Quick Guide for Clinicians *QGCT02*
KAP Keys for Clinicians *KAPT02*

TIP 3 **Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents**—Replaced by TIP 31

TIP 4 **Guidelines for the Treatment of Alcohol- and Other Drug-Abusing Adolescents**—Replaced by TIP 32

TIP 5 **Improving Treatment for Drug-Exposed Infants**—*BKD110*

TIP 6* **Screening for Infectious Diseases Among Substance Abusers**—*BKD131*
Quick Guide for Clinicians *QGCT06*
KAP Keys for Clinicians *KAPT06*

TIP 7 **Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System**—Replaced by TIP 44

TIP 8 **Intensive Outpatient Treatment for Alcohol and Other Drug Abuse**—Replaced by TIPs 46 and 47

TIP 9 **Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse**—Replaced by TIP 42

TIP 10 **Assessment and Treatment of Cocaine-Abusing Methadone-Maintained Patients**—Replaced by TIP 43

TIP 11* **Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases**— *BKD143*
Quick Guide for Clinicians *QGCT11*
KAP Keys for Clinicians *KAPT11*

TIP 12 **Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System**—Replaced by TIP 44

TIP 13 **Role and Current Status of Patient Placement Criteria in the Treatment of Substance Use Disorders**—*BKD161*
Quick Guide for Clinicians *QGCT13*
Quick Guide for Administrators *QGAT13*
KAP Keys for Clinicians *KAPT13*

TIP 14 **Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment**—*BKD162*

TIP 15 **Treatment for HIV-Infected Alcohol and Other Drug Abusers**—Replaced by TIP 37

TIP 16 **Alcohol and Other Drug Screening of Hospitalized Trauma Patients**—*BKD164*
Quick Guide for Clinicians *QGCT16*
KAP Keys for Clinicians *KAPT16*

TIP 17 **Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System**—Replaced by TIP 44

TIP 18 **The Tuberculosis Epidemic: Legal and Ethical Issues for Alcohol and Other Drug Abuse Treatment Providers**—*BKD173*
Quick Guide for Clinicians *QGCT18*
KAP Keys for Clinicians *KAPT18*

TIP 19 **Detoxification From Alcohol and Other Drugs**—Replaced by TIP 45

TIP 20 **Matching Treatment to Patient Needs in Opioid Substitution Therapy**—Replaced by TIP 43

**Under revision*

TIP 21 **Combining Alcohol and Other Drug Abuse Treatment With Diversion for Juveniles in the Justice System—** *(SMA) 08-4073*

Quick Guide for Clinicians and Administrators *QGCA21*

TIP 22 **LAAM in the Treatment of Opiate Addiction—** Replaced by TIP 43

TIP 23 **Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing—** *(SMA) 08-3917*

Quick Guide for Administrators *QGAT23*

TIP 24 **A Guide to Substance Abuse Services for Primary Care Clinicians—***(SMA) 08-4075*

Concise Desk Reference Guide *BKD123*

Quick Guide for Clinicians *QGCT24*

KAP Keys for Clinicians *KAPT24*

TIP 25 **Substance Abuse Treatment and Domestic Violence—** *(SMA) 08-4076*

Linking Substance Abuse Treatment and Domestic Violence Services: A Guide for Treatment Providers *MS668*

Linking Substance Abuse Treatment and Domestic Violence Services: A Guide for Administrators *MS667*

Quick Guide for Clinicians *QGCT25*

KAP Keys for Clinicians *KAPT25*

TIP 26 **Substance Abuse Among Older Adults—***(SMA) 08-3918*

Substance Abuse Among Older Adults: A Guide for Treatment Providers *MS669*

Substance Abuse Among Older Adults: A Guide for Social Service Providers *MS670*

Substance Abuse Among Older Adults: Physician's Guide *MS671*

Quick Guide for Clinicians *QGCT26*

KAP Keys for Clinicians *KAPT26*

TIP 27 **Comprehensive Case Management for Substance Abuse Treatment—***(SMA) 08-4215*

Case Management for Substance Abuse Treatment: A Guide for Treatment Providers *MS673*

Case Management for Substance Abuse Treatment: A Guide for Administrators *MS672*

Quick Guide for Clinicians *QGCT27*

Quick Guide for Administrators *QGAT27*

TIP 28* **Naltrexone and Alcoholism Treatment—** *(SMA) 05-4077*

Naltrexone and Alcoholism Treatment: Physician's Guide *MS674*

Quick Guide for Clinicians *QGCT28*

KAP Keys for Clinicians *KAPT28*

TIP 29 **Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities—***(SMA) 08-4078*

Quick Guide for Clinicians *QGCT29*

Quick Guide for Administrators *(SMA) 08-3592*

KAP Keys for Clinicians *KAPT29*

TIP 30 **Continuity of Offender Treatment for Substance Use Disorders From Institution to Community—** *(SMA) 08-3920*
Quick Guide for Clinicians *QGCT30*
KAP Keys for Clinicians *KAPT30*

TIP 31 **Screening and Assessing Adolescents for Substance Use Disorders—***(SMA) 08-4079*
See companion products for TIP 32.

TIP 32 **Treatment of Adolescents With Substance Use Disorders—***(SMA) 08-4080*

Quick Guide for Clinicians *QGC312*

KAP Keys for Clinicians *KAP312*

TIP 33 **Treatment for Stimulant Use Disorders—** *(SMA) 06-4209*

Quick Guide for Clinicians *QGCT33*

KAP Keys for Clinicians *KAPT33*

TIP 34 **Brief Interventions and Brief Therapies for Substance Abuse—***(SMA) 07-3952*

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TIP 48: Part 3, Managing Depressive Symptoms: A Review of the Literature, Section 1—A Review of the Literature*

Introduction

Overview

This Treatment Improvement Protocol (TIP) is designed to assist substance abuse counselors in working with adult clients who are experiencing depressive symptoms (see discussion in Part 1, Chapter 1) and administrators in supporting the work of substance abuse counselors. Depressive symptoms are common among clients in substance abuse treatment. Research indicates that substance abuse counselors will encounter significant numbers of individuals with co-occurring depressive symptoms.

When they occur, depressive symptoms can make working with clients more difficult. They can also interfere with clients' recovery and ability to participate in treatment. Table 1.1 in Part 1, Chapter 1 of this TIP lists symptoms of depression. These symptoms are found in clients with mood disorders defined in the *Diagnostic and Statistical Manual of Mental Disorders* (4th edition, Text Revision (DSM IV-TR; American Psychiatric Association [APA] 2000) as well in clients who present with depressive symptoms but without psychiatric illness. These clients are often referred to as experiencing "subclinical" or "mild" depression. Subclinical depression is differentiated from mood disorders by the number of symptoms present, the impact (or severity) of symptoms on the individual, and by the length of time the symptoms have been present.

The methods and techniques presented in this TIP are appropriate for clients in all stages of recovery. However, the focus of this TIP is on the first few months of **early recovery,** when depressive symptoms are particularly common.

This TIP is not intended to instruct or encourage substance abuse counselors in treating any mood disorder as defined in the DSM IV-TR (APA 2000a). Clients with diagnosed mood disorders (e.g., major depression, dysthymia, cyclothymia, bipolar disorder, substance-induced mood disorder, etc.) need specialized treatment from a trained and licensed mental health professional.

Content

This TIP is divided into three parts that are bound or produced separately:

- ***Part 1:*** *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery*
- ***Part 2:*** *Managing Depressive Symptoms: An Implementation Guide for Administrators*
- ***Part 3:*** *Managing Depressive Symptoms: A Review of the Literature*

This part, ***Part 3*** , is a literature review on the topic of depressive symptoms, and is available for use by clinical supervisors, interested substance abuse counselors, and administrators. It includes literature that addresses both clinical and administrative concerns. To facilitate ongoing updates (which will be performed every 6 months for up to 5 years from first publication), the literature review will only be available online at http://www.kap.samhsa.gov.

The following topics are addressed in ***Part 3*** :

- Review of the literature pertaining to clinical issues discussed in Part 1 of this TIP.
- Review of the literature pertaining to administrative issues discussed in Part 2 of this TIP.
- Information about the methodology used to perform the literature search (see appendix A).
- An annotated bibliography of 82 core sources and a general bibliography.

Printed copies of Parts 1 and 2 can be obtained from SAMHSA's National Clearinghouse for Alcohol and Drug Information (www.ncadi.samhsa.gov). Electronic copies can be downloaded from www.kap.samhsa.gov.

More information on substance abuse treatment for people with depressive disorder diagnoses can be

found in TIP 42, *Substance Abuse Treatment for Persons with Co-Occurring Disorders* (Center for Substance Abuse Treatment, 2005).

Clinical Issues

There is a small but useful body of literature that focuses specifically on the relationship of depressive symptoms that do not reach the diagnostic criteria for clinical depression to substance use disorders and their treatment. This section of the review addresses:

- What is meant by depressive symptoms.
- Epidemiology and nosology.
- Depressive symptoms, substance abuse/dependence, and substance abuse treatment.
- Treatment modalities for depressive symptoms.

Defining Depressive Symptoms

The introduction of specific inclusion, exclusion, and duration criteria for depressive disorders in the 1970s resulted in a high degree of reliability in diagnosis. However, as Klein, Shankman, and McFarland (2006) note, there is growing recognition that these classification systems, including the DSM-IV-TR (APA, 2000) and the International Statistical Classification of Diseases and Health Related Problems (ICD-10; World Health Organization 2004) do not adequately capture the distinction between normality and pathology. On the one hand, some major depressive symptoms are considered a "normal" response to bereavement, but not to other losses such as divorce or abandonment. On the other hand, depressive symptoms that do not meet a diagnostic threshold may cause considerable suffering and impairment (Angst & Merikangas, 1997), and research has consistently shown that dysfunction and impairment (both occupational and social) are associated with subdiagnostic levels of depressive symptoms (Solomon, 2001). At least one major longitudinal study (Angst, Sellaro, & Merikangas, 2000) suggests that individuals followed for 15 years showed little stability in regard to depression diagnoses.

Among the various recommendations for revisions to the classification of depressive disorders have been several efforts to define depressive disorders that are milder in symptomatology or duration than major depressive disorder (MD), dysthymic disorder, bipolar disorders, substance-induced mood disorders, or other depressive illnesses. Most evidence suggests that subthreshold depressive symptoms exist on a continuum with unipolar clinical depression, but further research is needed to rule out the possibility of a latent qualitative difference between subthreshold and diagnosable depression (Solomon, 2001). These disorders have been variously referred to "subclinical depression," "minor depression," and "mild depression." Objections may be raised that terms such as "mild" and "minor" minimize the suffering associated with these disorders. Accordingly, we will refer to "depressive symptoms" with the understanding that this term implies a level of disorder (i.e., clinically significant impairment or dysfunction) that does *not* qualify for diagnosis as a mood disorder. Where investigators use a specific term in their writing, we simply use the term they have chosen.

As early as 1978, Research Diagnostic Criteria (RDC; Spitzer, Endicott, & Robins, 1978, p. 773) defined a non-major depressive disorder as, "Nonpsychotic episodes of illness in which the most prominent disturbance is a relatively sustained mood of depression without the full depressive syndrome, although some associated features must be present. It may be chronic or episodic."

The RDC classification excludes symptoms due to bereavement and requires depressed mood, two depressive symptoms, and impairment or help-seeking. The duration of symptoms must be 1 week for a probable diagnosis and 2 weeks for a definite diagnosis.

The descriptive portion of the RDC criteria (i.e., "relatively sustained mood of depression without the full depressive syndrome") captures the essence of almost all phenomenological discussion of "depressive symptoms" (e.g., Angst & Merikangas, 1997; Beck & Koenig, 1996; Kessler, Zhao, Blazer, & Swartz, 1997; Rapaport et al., 2002), in which the sufferer feels depressed and is dysfunctional but does not meet the criteria for clinical depression.

Not surprisingly then, many attempts to operationalize definitions of "depressive symptoms" rely on the DSM or ICD criteria for MD, but choose some lesser number of criteria as the cutoff. This is the strategy adopted by DSM-IV-TR in establishing research criteria for minor depression: two to four of the nine criteria for MD (one of the symptoms must be depressed mood) accompanied by distress of impairment of functioning.

Beck and Koenig's (1996) review suggests that the "not MD" operational definition is also widely used. These definitions differ in the number of MD criteria that must be met (which can be as few as one), the requirement that one of the symptoms is depressed mood (not universally required), whether a previous episode of mood disorder is an exclusion criterion, and whether MD and dysthymia must be specifically ruled out.

Within the research context (e.g., Peck, Reback, Yang, Rotheram-Fuller, & Shoptaw, 2005; Rapaport et al., 2002), some investigators have relied on questionnaires and rating scales (e.g., Beck Depression

Inventory, the National Institute of Mental Health Diagnostic Interview Schedule) to classify subjects as having "depressive symptoms." However, these strategies are conceptually similar to those that rely on DSM or ICD criteria in that a lower cutoff than that associated with MD is chosen as the inclusion criterion.

Despite a rather wide range of possible definitions, there appears to be a general consensus that the phenomenon variously called mild depression, minor depression, or depressive symptoms is a real condition and that it causes significant disruptions in functioning for those it affects (e.g., Martin, Blum, Beach, & Roman, 1996; Solomon, 2001).

Epidemiology and Nosology

Because the major work in this area has been conducted by Kessler and his colleagues, we will use here his term, "mild depression." Studies of mild depression are relatively recent and, as already noted, definitions and inclusion criteria differ. However, some epidemiologic findings are available.

Kessler and colleagues (1997) analyzed data from the National Comorbidity Survey (NCS) to study the lifetime prevalence, correlates, course, and impairments associated with mild depression and to compare these with lifetime prevalence, correlates, course, and impairments associated with two levels of MD: 5–6 symptoms (MD 5–6) and 7–9 symptoms (MD 7–9). The estimated lifetime prevalence for mild depression was 10 percent in the general population as compared to 8.3 percent for MD 5–6, and 7.5 percent for MD 7–9. All three disorders were elevated among women, non-Hispanic whites, and the unemployed. However, unlike the case with MD and dysthymic disorder, rates of mild depression showed significant regional differences, with rates highest in the West and lowest in the South.

Almost 75 percent of persons with mild depression report more than one depressive episode. Symptom severity was correlated with the number of episodes and their duration. Over their lifetimes, people with mild depression showed fewer episodes of shorter duration than those with MD 5–6 or MD 7–9. Impairment associated with a given episode also increased as a function of the number of symptoms. However, the number of people with mild depression who reported impairment (42%) was not much lower than the number of persons with MD 5–6 who reported impairment (49.7%).

A replication study has been conducted for the NCS, but to date no publications are available detailing findings from that study relative to mild depression.

Kessler's data are in substantial agreement with a Zurich study of 600 young adults that found 11 percent had experienced mild depression at some time before the age of 30 (Angst et al., 2000). In a review of multiple studies, Beck and Koenig (1996) report lifetime rates of mild depression ranging from 8 to 74 percent using a wide range of inclusion criteria. A recent review of mild depression studies places the point prevalence of mild depression between 2 and 5 percent (Rapaport et al., 2002).

The temporal relationship between mild depression and MD has received some research attention. Kessler and colleagues (1997) found that most people who made a transition to MD did so after a large number of mild depression episodes. Rapaport and colleagues (2002) conclude that mild depression can occur independently of a lifetime history of MD, or can be a stage of MD in the course of recurrent unipolar depression. However, they note an odds ratio of 4.4 of developing MD within a year for persons with depressive symptoms compared with people with no symptoms. Based on their own work and a review of the literature, Rapaport and colleagues (2002, p. 637) sum up the evidence on the relationship between MD and mild depression, stating that "individuals with a history of major depressive disorder freely traverse between major depressive disorder, minor depression, and subsyndromal depressive symptoms."

It is as yet unclear whether mild depression represents a separate disorder or reflects the lower end of a spectrum of depressive disorders (Angst et al., 2000; Solomon, 2001) that differ in intensity and duration, but not necessarily in kind. However, data raise questions as to the validity of viewing mild depression as a separate category. Kessler and colleagues (1997) note that almost all observed differences between mild depression and MD categories 5–6 and 7–9 are monotonic functions that are well described by the number of symptoms. Moreover, the magnitude of differences between mild depression and MD 5–6 are similar to the magnitude of differences between MD 5–6 and MD 7–9. In other words, the data suggest a single disorder varying in severity rather than any real difference between mild depression and MD. Rapaport and colleagues (2002) also note that data on familial transmission of MD and mild depression and the fluidity of MD and mild depression with relatively short timeframes argue against treating these as separate disorders.

Elsewhere, Kessler and colleagues (2005) note that almost half the respondents in the NCS who received treatment did not meet DSM-IV-TR criteria for a disorder.

Using a different measure (i.e., whether individuals endorsed specific screening questions for low mood and anhedonia), the National Institute on Alcohol Abuse and Alcoholism's National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) determined that 33.8 percent of the population had some form of "mild" or "minor" depression (Compton, Conway, Stinson, & Grant, 2006). However, the NCS measure of mild depression is a more clinically significant measure of depressive symptoms than this measure from the NESARC.

The DSM-IV-TR also recognizes that there are specific features of depressive-spectrum disorders related to gender and cultural background, with certain symptoms being more common depending on age, gender, and culture. It should be expected that there can be differences in the incidence and presentation of subclinical depressive symptoms related to these factors as well.

Depressive Symptoms, Substance Abuse, and Substance Abuse Treatment

The recent emergence of concern with subclinical depressive symptoms and difficulties agreeing on definitions of the phenomenon limit the availability of data on the relationship between depressive symptoms and substance use disorders. However, a few studies that directly address the relationship do exist. In addition, useful information may be inferred from studies of clinical depression and substance abuse to the extent that subclinical and clinical depression represent points on a continuum rather than discrete disorders. Pending further research on this hypothesis, however, the most conservative approach is to stay within the bounds of studies that specifically address mild depression as defined by Kessler and colleagues (1997).

Comorbidity

Kessler and colleagues (1997) report that prior substance use disorder raises the odds of mild depression insignificantly, but that all substance use disorders taken together are a significant predictor of mild depression. There is a small but significant relationship between a client's prior history of a substance use disorder and later mild depression.

Karno and Longabaugh (2003) studied depressive symptoms as measured by the Beck Depression Inventory (BDI) in 141 substance abuse admissions to the Providence Clinical Research Unit of Project MATCH. Of these, nearly 30 percent had BDI scores of 10 to 18 (indicative of elevated depressive symptoms) while an additional 18 percent had scores greater than 19 (indicative of clinical depression). By contrast, a study of a nontreatment population of 75 individuals with alcohol use disorders (84% of whom met DSM-IV criteria for dependence) found only about 20 percent of participants had elevated BDI scores (Blume, Schmaling, & Marlatt, 2001).

Another study administered the BDI to 162 gay and bisexual methamphetamine abusers admitted for treatment (Peck et al., 2005). Results indicated somewhat higher levels of depression than those reported by Karno and Longabaugh: 44.8 percent were in the mild to moderate range on the BDI and an additional 28 percent were in the moderate to severe range.

Based on these very limited data, it would appear that the rates of mild depression are perhaps two to three times higher among individuals with substance use disorders than in the general population.

Treatment Outcomes Among Individuals With Substance Use Disorders and Depressive Symptoms

A number of nonexperimental studies have examined the relationship between depressive symptoms and substance abuse treatment outcomes. In general, these studies find that depressive symptoms are an impediment to recovery.

For example, an analysis of 1,450 subjects from Project MATCH (Conner, Sorensen, & Leonard, 2005) examined the association of BDI score and drinking at treatment entry and in months 2 and 3 of treatment. Elevated BDI scores predicted greater quantity and frequency of drinking during the first month of treatment, but showed little association with drinking in months 2 and 3. The authors suggest that this effect reflects drinking as a coping response, but also the interference of depressive symptoms with engagement in or attendance at treatment. Paradoxically, the effects of treatment-entry levels of drinking did not predict drinking levels during month 1. Thus, the authors conclude that depressive symptoms can provide a unique marker of those clients needing specialized interventions to increase engagement and reduce the risk of dropout.

In a study of individuals with polysubstance use disorders, Dodge, Sindelar, and Sinha (2005) found that higher depressive symptom scores at intake predicted decreased likelihood of abstinence at discharge even when demographic and treatment-related variables (e.g., length of stay) were controlled. Doumas, Blasey, and Thacker (2005) found that higher levels of depressive symptoms at treatment entry were also associated with increased dropout rates from treatment. Another study found that current major depression at admission to a hospital inpatient alcoholism program was predictive of poorer treatment outcomes at 1 year (Greenfield et al., 1998), and Strowig (2000) found that depressed mood was the most commonly cited reason for relapse after alcohol treatment.

A study of 298 male veterans (Curran et al., 2000) measured depressive symptoms during and 3 months after participation in an inpatient alcohol treatment program. Clients with mild to moderate depressive symptoms at the 3-month followup were 2.9 times more likely than nondepressed subjects to experience relapse. Severely depressed clients were 4.9 times more likely to relapse. Depressive symptoms both during treatment and at followup were no more likely to be associated with relapse than were depressive symptoms at followup only. A second study by Curran, Kirchner, Worley, Rookey, and Booth (2002) found that severe depression at intake to an intensive outpatient Department of Veterans Affairs program predicted early attrition.

Another study suggests that associating alcohol-related consequences with depression can increase clients' motivation to change their drinking behavior (Blume et al., 2001). The authors hypothesized that elevated BDI scores would be related to greater motivation to change within the stages of the transtheoretical stages of change model (Prochaska & DiClemente, 1992). Seventy-five clients with alcohol use disorders participated in the study. Of these, about 15 percent had elevated BDI scores. As predicted, BDI scores were positively correlated with precontemplation and contemplation scores as measured by the Readiness to Change questionnaire.

A limited number of studies have looked specifically at the effects of treating elevated depressive symptoms on substance abuse outcomes. Karno and Longabaugh (2003) examined whether patient depressive symptoms interacted with therapist focus on painful emotional material in predicting the outcome of alcohol treatment. For clients with clinically diagnosable depression, a low therapist focus on painful emotional material was associated with better drinking outcomes. However, this relationship did not hold for clients with mild depression. These results were confirmed by a more recent reanalysis of the data from Project MATCH (Karno & Longabaugh, 2007).

Investigators at Brown University School of Medicine (Brown, Evans, Miller, Burgess, & Mueller, 1997; Ramsey, Brown, Stuart, Burgess, & Miller, 2002) provided 8 sessions of cognitive-behavioral therapy for depression (CBT-D) or a relaxation control to 35 patients undergoing alcohol abuse treatment at a day treatment program. Subjects had Dynamic Personality Inventory scores greater than 10 and were referred to by the authors as "alcoholics with elevated depressive symptoms" to distinguish them from "depressed alcoholics" meeting diagnostic criteria for a depressive disorder. During the first 3 months of followup, the CBT-D group had more abstinent days than the control subjects, but not lower overall abstinence. However, in the 3- to 6-month followup period, the CBT-D group showed significantly greater total abstinence (47% versus 13%) as well as more days abstinent and fewer drinks per day. The authors report that subjects in the CBT-D group found the depression coping skills useful and relevant to their recovery.

Peck and colleagues (2005) monitored the course of depressive symptoms as treatment for methamphetamine dependence progressed. Participants reported a significant decrease in depressive symptoms regardless of specific treatment modality or other key variables such as HIV/AIDS status. A study by Janiri and colleagues (2005) found similar results among alcohol, opioid, and polysubstance users in three different clinical settings. In this study, depressive symptoms were correlated with craving and protracted withdrawal.

A recent meta-analysis (Nunes & Levin, 2004) examined controlled trials of antidepressant medication for the treatment of combined substance use and depressive disorders. Fourteen trials met the analysis inclusion criteria: five trials of tricyclics, seven of serotonin-specific reuptake inhibitors, and two of other classes of antidepressants. The authors conclude that antidepressant medication exerts a modest beneficial effect for patients with combined depressive and substance use disorders. However, medication should not be considered a stand-alone treatment, and concurrent therapy directly targeting the addiction is also indicated.

Subclinical levels of depressive symptoms have been associated with poorer outcomes for other health problems such as heart disease (Kubzansky, Davidson, & Rozanski, 2005).

In summary, limited available evidence suggests that elevated depressive symptoms are an impediment to recovery and that treatment outcomes improve when these symptoms are specifically addressed.

Treatment Modalities for Depressive Symptoms

The literature on the treatment of depressive disorders is vast (see, for example, Reinecke & Davison, 2002; Stein, Kupfer, & Schatzberg, 2006), but the relationship between specific treatments and improvements remains evasive (Lambert & Davis, 2002). However, in summarizing the literature on treatment of depression, Lambert and Davis (2002) conclude that the sum total of naturalistic studies and randomized controlled trials presents a comprehensive picture that demonstrates the effectiveness of psychotherapy for individuals with depression. These same authors conclude that pharmacotherapies are also effective but no more effective than psychotherapy. Additionally, current treatment guidelines for depression indicate that psychotherapy is effective, particularly with mild and moderate depression (APA, 2000b) and that a combination of psychotherapy and pharmacotherapy is more effective than pharmacotherapy alone (Fochtmann & Gelenberg, 2005).

Overall, the major impediment to successful treatment of depression appears not to be a lack of effective treatments but a lack of effective implementation of these treatments.

By comparison, research is sparse on specific treatments for depressive symptoms that do not rise to the level of diagnosable depression. As is the case for treatment of depressive symptoms in substance abuse settings, the pool of available research can be substantially increased by accepting the hypothesis that depressive symptoms and diagnosable depression constitute a continuum of severity rather than kind. Again, however, pending validation of this hypothesis, a focus specifically on populations with depressive symptoms is the most conservative approach.

Ackermann and Williams (2002) report on an extensive analysis of controlled studies of treatment for

depressive symptoms. Studies were collected using the keywords "depressive disorder," and "depression" crossed with "minor," "subsyndromal," "subthreshold," and "nonmajor." They found only five studies that compared a psychological or pharmacological treatment for depressive symptoms to a placebo or control. Their table summarizing these five controlled trials is reprinted below (see Figure 1) in its entirety.

Ackermann and Williams conclude that, collectively, these studies provide mixed support for a small to moderate benefit of the pharmacological and psychological treatments tested. The authors also report on studies of alternative treatments including aerobic exercise. They conclude that the evidence supports a positive effect of supervised exercise three times per week on mild to moderate MD. Some weak evidence exists for various botanicals and vitamins, but there is too little research upon which to base a conclusion about these treatments. The authors conclude that the currently available clinical trial data provide little guidance in the treatment of depressive symptoms that do not rise to the level of diagnosable depression.

Figure 1 Major Characteristics of Controlled Trials in Patients with Minor Depressive Conditions

Citation	Sample Size*	Setting	Comparison	Duration	Major Qualitative Result(s)
Paykel, Hollyman, Freeling, & Sedgwick 1988	37	Primary care	Amitriptyline 125 mg/day vs placebo	6 wk	No significant improvement in depressive symptoms
Parnetti, Sommacal, Morselli Labate, & Senin 1993	130	Not clearly stated	Minaprine vs placebo	12 wk	Small, statistically significant improvement globally and in depressive symptoms compared to placebo
Williams, Barrett, Oxman, et al. 2000	204	Primary care	Paroxetine 10–40 mg/day vs problem-solving therapy vs placebo	11 wk	Modest, statistically significant improvement in depressive symptoms for paroxetine and problem-solving therapy

Citation	Sample Size*	Setting	Comparison	Duration	Major Qualitative Result(s)
					compared to placebo. Clinically significant improvement in functioning for paroxetine and problem-solving therapy groups, but only when severe functional impairment was present at baseline
Miranda & Munoz 1994	49	Primary care	Cognitive-behavioral therapy vs no intervention	8 two-hr sessions	No significant effect on depressive symptoms after completion of CBT, but moderately positive effect when compared with placebo group at 4- and 12-mo follow-up
Lynch, Tamburrino, & Nagel 1997	29	Primary care	Telephone-administered PST vs no intervention	6 sessions	Trend toward improvement in depressive

Citation	Sample Size*	Setting	Comparison	Duration	Major Qualitative Result(s)
					symptoms scores but statistically insignificant at conclusion of intervention

* Number of patients with minor depression, which for some studies is a subset of the total sample.
CBT, cognitive/behavioral therapy; PST, problem-solving therapy.

Adapted from: Ackermann & Williams 2002, p. 296. [Permission pending]

One widely studied intervention for subclinical depressive symptoms is the Coping with Depression (CWD) course, originally developed as a treatment for MD (Lewinsohn & Clarke, 1984). The course content is based on the social learning theory premise that depression is a learned response that can be unlearned. It uses a cognitive-behavioral intervention that teaches participants techniques to influence their moods and to enhance coping skills. CWD has been implemented on a national scale for the treatment of adults with subclinical depressive symptoms in the Netherlands (Allart-van Dam, Hosman, Hoogduin, & Schaap, 2003). In the Dutch version, the course consists of 12 weekly 2-hour sessions consisting of lectures, skills training, and review of homework assignments. A booster session is offered 6 weeks after course completion. Allart-van Dam and colleagues (2003) conducted a randomly-controlled clinical trial of CWD with 110 adults with subclinical depressive symptoms. Short-term outcome data indicated that the course was successful in reducing depressive symptoms as well as affecting mediating variables such as frequency of depressive thoughts, participation in pleasant activities, and social support. Long-term outcomes are currently under investigation.

An effectiveness trial of CWD in the Netherlands was also conducted using participants in 20 CWD groups organized by 10 different providers of outpatient services (Cuijpers, Smit, Voordouw, & Kramer, 2005). Improvements in the treated groups mirrored those in the clinical trial reported by Allart-Van Dam and colleagues (2003). However, the investigators note that their treated clients were still "considerably more depressed than the general population." They conclude that CDW alone may not be a sufficient intervention for some individuals with subclinical depressive symptoms.

In summary, there are some promising treatments for persons with subclinical depressive symptoms and substance use disorders, but few proven strategies.

Administrative Issues

The successful implementation of strategies to address depressive symptoms in substance abuse treatment depends heavily on the leadership and support provided by treatment organizations and their administrators. This section provides a conceptualization of the implementation of clinical innovations and directs the reader to sources that elaborate the empirical basis for recommendations made in the Administrator's Guide that accompanies this TIP.

What Is Known About the Adoption of Clinical Innovations

Numerous recent reports, including the President's New Freedom Commission on Mental Health (2003), have noted a significant gap between what is known about effective treatments and what is actually delivered in practice. Substantial progress has been made in the treatment of substance abuse and co-occurring disorders including depression (see TIP 42, Substance Abuse Treatment for Persons With Co-Occurring Disorders [CSAT 2005]); however, the challenge remains of ensuring that this progress is reflected in the care that is offered to clients.

Although the literature on implementation of clinical innovations is vast (see Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005), there is no more dramatic illustration of the challenges involved than the case of the United States Preventive Services Task Force's (USPSTF) *Guide to Clinical Preventive Services*. This collection of science-based recommendations for health screening was developed by a prestigious panel of experts, well publicized in the professional and public press, accessible online through the National Library of Medicine, and reprinted by private publishers who have sold more than 64,000 copies. Woolf, DiGuiseppi, Atkins, & Kamerow (1996) reviewed studies of the use of this *Guide* and found that 55 percent of family practitioners had not looked at it, and that 25 percent of family

practitioners and 80 percent of internists had not heard of it. Accordingly, the chances of the average patient benefiting from this carefully constructed and heavily publicized clinical resource were quite low. This case study clearly illustrates the point made by Peterslia (1990) that innovative programs such as this "are not self-executing."

A lack of specific and informed attention to implementation leads to frustration (for both administrators and clinicians), wasted resources (both on research and ineffective implementation), and most important, services to clients that are less effective than they could be. As noted by Haynes (1993, p. 221), "it is troubling to spend billions on health care research while neglecting the fact that most of the evidence generated from such studies is going to waste."

However, there is now considerable practical knowledge on how to foster successful implementation of strategies such as those presented in this TIP. The remainder of this review surveys this knowledge and directs the reader to useful resources.

The Centrality of Organizational Change and Administrative Support in Successful Implementation

Two common assumptions must be challenged at the outset: (1) that innovations will be embraced simply because they are superior to current practice, and (2) that the responsibility for adopting clinical innovations rests with clinicians.

Regarding the first point, Emerson assured us that "if you build a better mousetrap, the world will beat a path to your door," but half a century of research on the adoption of innovation suggests that Emerson was wrong about both mousetraps and new clinical practices (Rogers, 2003). Although superiority to current practice is a factor in adoption, it is by no means the only or even the most important factor (Davis & Taylor-Vaisey, 1997).

The second assumption could be an overgeneralization from our experience as consumers (we can freely switch from brand X to brand Y). By contrast, the individual clinician is highly constrained by context, and the factors that facilitate or impede adoption and implementation are almost all associated with the organization (e.g., the program, clinic, or hospital) and with the larger systems in which the organization operates (e.g., local, State) (Fixsen et al., 2005).

Providers may want to be members of what Kamerow (1997) calls, "the good provider club." However, as Kamerow further notes, good intentions are not enough. Without organizational change and organizational support, most efforts by well-intentioned clinicians to adopt new practices will fail. The responsibility for adoption and implementation of new practices falls squarely on organizations and their administrators.

Implementation and the Factors Affecting It

> A primary source used in the preparation of this subsection of the review was Implementation Research: A Synthesis of the Literature (Fixsen et al., 2005). This landmark document is recommended reading for all administrators who wish to improve the implementation of clinical innovations in their programs and organizations.

Implementation is a purposeful and planned process of organizational change, not an outcome, as such. Administrators should be able to describe their implementation activities. These activities should be measurable, and the implementation activities should be visible to those both inside and outside the organization. Implementation has three goals (Fixsen et al., 2005):

1. Changes in professional behavior (i.e., the knowledge and skills of practitioners and other key staff members within an organization or system.
2. Changes in organizational structures and cultures, both formal and informal (values, philosophies, ethics, policies, procedures, decisionmaking), to routinely bring about and support changes in professional behavior.
3. Changes in relationships to consumers, systems partners, and stakeholders (regarding location and nature of engagement, inclusion, and satisfaction).

It is important to understand the difference between something that looks like implementation and something that actually *is* implementation. As described by Fixsen and colleagues (2005), three types of implementation can be identified:

1. *Paper Implementation* in which new policies and procedures are developed, written down, and placed in filing cabinets. Here, actual changes in clinical practice (which do not occur) are uncoupled from the paper trail. However, when necessary, the paper policies and procedures can be produced to demonstrate that change has taken place.
2. *Process Implementation* in which largely irrelevant training is conducted, new vocabulary (usually devoid of operational meaning) is adopted, a new "culture" is promulgated,

motivational posters are hung, and so on. In other words, the trappings of change are visible, but no substantive changes are actually made—this can also be described as a process of "cargo cult implementation" (see box on next page).

3. *Performance Implementation* means achieving the three implementation objectives described earlier in ways that result in tangible benefits to clients and other stakeholders.

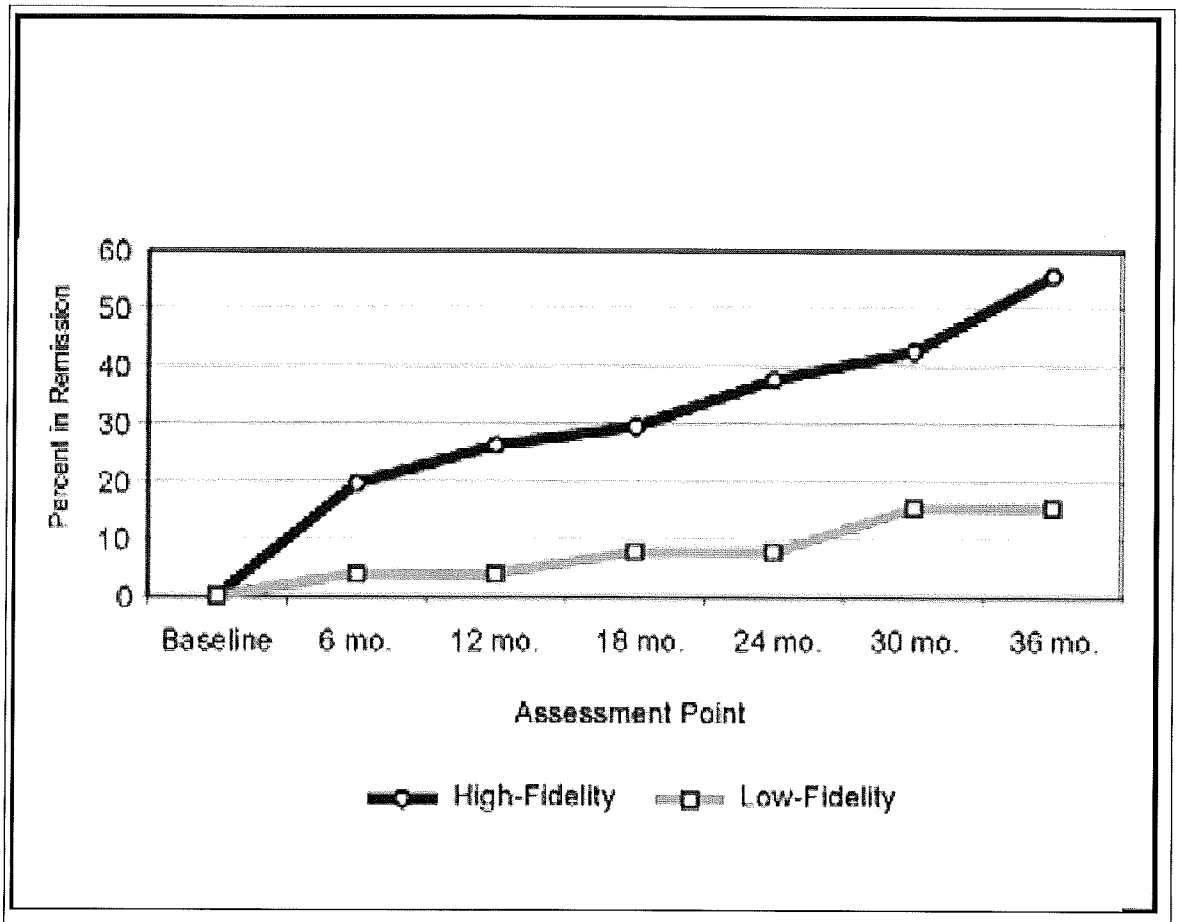

Figure 2 Percentage of Particitants in Stable Remission for High-Fidelity versus Low-Fidelity ACT Programs

The effects of real (performance) versus paper or process implementation on client outcomes can be profound. Figure 2 shows the difference in client outcomes over time for a high-fidelity and low-fidelity implementation of Assertive Community Treatment (ACT). By the third year, remission rates in the low-fidelity implementation were almost four times the rates in the high-fidelity implementation.

Cargo Cult Implementation

In the South Seas, there is a cargo cult of people. During the war they saw airplanes with lots of good materials, and they want the same thing to happen now. So they've arranged to make things like runways, to put fires along the sides of the runways, to make a wooden hut for a man to sit in, with two wooden pieces on his head for headphones and bars of bamboo sticking out like antennas—he's the controller—and they wait for the airplanes to land. They're doing everything right. The form is perfect. It looks exactly the way it looked before. But it doesn't work. No airplanes land.

Dr. Richard Feynman in a 1974 Cal Tech commencement address

Working With Factors That Affect Implementation

Before discussing the factors affecting implementation, it is necessary to distinguish between what we are calling an "innovation" and evidence-based practices (EBPs). By innovation, we mean a new

approach to agency or organization services or some component of these services. So, for example, offering onsite health care at a homeless shelter, providing child care to mothers in an outpatient treatment program, or addressing depressive symptoms in a substance abuse treatment program (the topic of this TIP) fit the definition of an innovation. Innovations often involve considerable experimentation and formative evaluation by administrators and staff (Tharp & Gallimore, 1979).

An EBP is a practice that, based on expert or consensus opinion about available evidence, is expected to produce a specific clinical outcome (measurable change in client status). EBPs are well-specified, and are clearly defined as to what they are and are not, how to implement them, and so on. Examples of EBPs include ACT (Drake et al., 1998) and motivational interviewing (Miller & Rollnick, 2002). EBPs generally must be implemented with fidelity to the original model in order to have the expected impact, and many types of changes to the EBP will be undesirable and threaten outcomes (Adams, 1994; Mowbray, Holter, Teague, & Bybee, 2003; Yeaton & Sechrest, 1981). Such undesirable changes are called "drift."

An innovation may or may not consist of or include one or more EBPs. So, for example, a health screening program in a homeless shelter might draw a number of EBPs for health screening from the USPSTF *Guide to Clinical Preventive Services* that need to be implemented with fidelity. However, the manner in which the screening program is structured, outreach is conducted, and health counseling is provided might better fit the definition of an innovation. Here, approaches used by similar programs might be copied, modified, and/or refined based on actual implementation experience.

Figure 3
Factors Affecting Implementation

Client Population and Community	• Language of preference, reading levels • Expectations • Values and norms • Special health issues • Special social issues
Staff	• Commitment to current practices • Necessary skill sets • Necessary licensure, certification • Appropriate team structures
Facilities and Resources	• Space, equipment • Information technology • Support staff
Agency Policies and Practices	• Training • Supervision • Evaluation
Local/State/Federal Regulation	• Certification and licensure • Reporting/accountability • Zoning
Interagency Networks	• Existence of needed outside resources • Relationships with other agencies

Adapted from Fixsen et al., 2005.

Figure 3 Factors Affecting Implementation

The factors that affect implementation of an innovation are described in detail by Fixsen and colleagues (2005) and summarized in Figure 3. These factors can be conceptualized as a set of matches or mismatches between an innovation and the context into which it is introduced. When such mismatches occur, administrators must find ways to reconcile them. So, for example, changes in training and supervision are needed to respond to a mismatch between staff skills and the requirements of the innovation. One way to respond to a mismatch between current interagency networks and those that the innovation requires might be the establishment of referral agreements. Both of these accomodations operate by changing the context and "matching" it to the innovation.

Accomodations can also be made by altering the innovation. When dealing with an "innovation" as defined above, such accomodations are part of the development process and their effects can be tested with formative evaluations. However, when dealing with an EBP or an EBP that is a component of an innovation, alterations risk drift (noting that local alterations to an EBP can lead to desirable refinements as well as problems with fidelity). In a practical sense, this means that the administrator must make every attempt to alter the context to accommodate the EBP.

Organizational Factors Affecting Implementation

A key organizational factor that affects implementation is receptivity to innovation. Rogers (2003)

discusses how organizations differ in their receptivity and how key factors such as the degree of centralization, how formalized rules are, and the level of staff knowledge/expertise affect the implementation of new innovations. Some of these factors play different roles in the early and later stages of innovation. Low centralization, high complexity, and low formalization appear to facilitate initiation of the innovation process. However, these same organizational characteristics can present challenges to long-term implementation.

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Appendix A: Post Test and Evaluation
Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery, TIP 48

Directions: To receive credits for this course, you are required to take a post test and receive a passing score. We have set a minimum standard of 80% as the passing score to assure the highest standard of knowledge retention and understanding. The test is comprised of multiple choice and/or true/false questions that will investigate your knowledge and understanding of the materials found in this CEU Matrix – The Institute for Addiction and Criminal Justice distance learning course.

After you complete your reading and review of this material, you will need to answer each of the test questions. Then, submit your test to us for processing. This can be done in the following manner:

Submit your test via the Internet. All of our tests are posted electronically, allowing immediate test results and quicker processing. First, you may want to answer your post test questions found at the end of this appendix. Then, return to your browser and go to the Student Center located at:

http://www.ceumatrix.com/studentcenter

Once there, log in as a Returning Customer using your Email Address and Password. Then click on 'View Lesson Quiz' and you will be presented with the electronic exam.

To take the exam, simply select from the choices of "a" through "e" for each multiple choice question. For true/false questions, select either "a" for true, or "b" for false. Once you are done, simply click on the submit button at the bottom of the page. Your exam will be graded and you will receive your results immediately. If your score is 80% or greater, you will receive a link to the course evaluation. You will also receive a link to the Certificate of Completion. This is the final step in the process, and you may save and / or print your Certificate of Completion.

If, however, you do not achieve a passing score of at least 80%, you will need to review the course material and return to the Student Center to resubmit your answers.

NOTE: THE EXAM QUESTIONS AND /OR ANSWERS MAY BE IN A DIFFERENT ORDER IN THE ONLINE EXAM

Answer the following questions by selecting the most appropriate response.

Chapter 1

1. Among people who have had past year contact with health personnel and who also had a past year substance use disorder, _____ percent of those with an alcohol disorder also had a mood disorder.
   a. 20
   b. 30
   c. 40
   d. 10
   e. 50

2. Among people who have had past year contact with health personnel and who also had a past year substance use disorder, _____ percent of those with a drug disorder also had a mood disorder.
   a. 40
   b. 50
   c. 20
   d. 30
   e. 60

3. Early recovery is the _____ of recovery.
   a. first two years
   b. first year
   c. first six months
   d. first three months
   e. first 24 hours

4. Which of the following is **not** a mood disorder?
   a. major depression
   b. bipolar disorder
   c. cyclothymia
   d. dysthymia
   e. neurasthenia

5. Which of the following has not been used successfully to manage depressive symptoms in substance abuse treatment?
   a. 12-step facilitation
   b. motivational interviewing
   c. behavioral
   d. transactional analysis
   e. supportive

6. The term “depressive symptoms” is applied to mood states that _____.
   a. do not meet DSM-IV-TR
   b. meet MSD-III criteria
   c. do not meet SDM-IV-TA criteria
   d. do not meet ISBC criteria
   e. meet DASM-IV-TR criteria

7. Symptoms of depression exist _____ .
   a. on a contingency
   b. as a continuation
   c. as a conundrum
   d. as a paradox
   e. on a continuum

8. _____ is one of the most important risk factors for the development of depressive symptoms.
   a. Repression
   b. ADHD
   c. Stress
   d. Fantasy
   e. Strain

9. The correct word to fix the typo in one of the items in the list of depressive symptoms should be _____.
   a. muck
   b. stick
   c. stuck
   d. shook
   e. locked

10. Chronic exposure to substances may lead to depressive symptoms because of the _____ effects on the nervous system.
    a. rebound
    b. euphoric
    c. reuptake
    d. abreaction
    e. toxic

11. Depressive symptoms can _____ substance abuse symptoms.
    a. precede
    b. follow
    c. co-occur with
    d. all of the above
    e. none of the above

12. A _____ plan is generally more useful than a “no-suicide pact”
    a. commitment to treatment
    b. contingency contract
    c. processing
    d. commitment to sobriety
    e. suicide ideation diary

13. One of the “do’s” for working with clients who have suicidal thoughts or plans is to obtain _____.
    a. self protection
    b. a secrecy pact
    c. suicide ideation diaries
    d. legal records
    e. informed consent

14. The difference between having depressive symptoms and having clinical depression can be the presence of _____ symptom(s).
    a. two
    b. three
    c. one
    d. four
    e. five

15. Picking the best clinical option available for a given client in a given context based on the best current information is termed _____ thinking.
    a. theory
    b. evidence
    c. empirical
    d. analytical
    e. inductive

16. Individuals from different cultures may report symptoms of depression as:
    a. physical symptoms
    b. nervous breakdown
    c. nerves
    d. anxiety
    e. all of the above

17. Substance abuse counselors can _____.
    a. diagnose clinical depression
    b. treat clinical depression
    c. treat mental disorders
    d. treat behavioral disorders
    e. address depressive symptoms

18. Transference and counter transference are _____.
    a. subconscious
    b. unconscious
    c. conscious
    d. trans-conscious
    e. transcendental

19. One of the common beliefs about depression is that it is a lack of _____.
    a. id control
    b. ego strength
    c. centeredness
    d. spirituality
    e. groundedness

20. In motivational interviewing, the concept for wanting to fix the client is referred to as _____.
    a. the hero reflex
    b. the righting reflex
    c. transference
    d. the inkblot reflex
    e. the rescue reflex

21. Beck's cognitive theory of depression includes the "cognitive _____ ".
    a. dyad
    b. square
    c. pyramid
    d. dualism
    e. triad

22. Which of the following is **not** a typical depressive thinking style?
    a. jumping to conclusions
    b. gray-area thinking
    c. emotional reasoning
    d. disbelieving others
    e. discounting the positive

23. Screening and assessment for substance abuse clients with depressive symptoms always needs to include screening for _____.
    a. ADHD
    b. PTSD
    c. suicidality
    d. AIDS
    e. EMDR

24. Which of the following is a commonly used screening tool for depressive symptoms?
    a. SCAT
    b. SEC-A
    c. BDI-II
    d. IDI-IV
    e. BDD

25. The PPC-2R was developed by _____.
    a. CSAT
    b. TASC
    c. SAMHSA
    d. SAAM
    e. ASAM

26. Evidence from a meta-analysis showed many clients with alcohol or drug dependence, taking antidepressant medications, improved with _____.
    a. vitamin therapy
    b. EMDR
    c. hypnosis
    d. a placebo
    e. foot reflexology

27. Good confrontation has _____ faces.
    a. 3
    b. 2
    c. 4
    d. multiple
    e. janus

28. Any given medication for depression has about a _____ percent chance of working well.
    a. 50
    b. 40
    c. 60
    d. 75
    e. 25

29. It often takes at least _____ of treatment before an antidepressant medication begins to work.
    a. four to six days
    b. four to six weeks
    c. two to three weeks
    d. ten days
    e. eight weeks

Part 1, Chapter 2

30. The primary counseling tool that facilitates the expression of accurate empathy is _____ listening.
    a. gut
    b. deflective
    c. zen
    d. reflective
    e. centered

31. Whenever people are considering change, it is normal for them to feel_____.
    a. ambiance
    b. bivalence
    c. competing channels
    d. ambivalence
    e. ambidexterity

32. Effective counseling supports people's efforts to change _____ associated with both depression and substance abuse.
    a. thoughts
    b. beliefs
    c. feelings
    d. behaviors
    e. all of the above

33. Evidence-based treatments include _____.
    a. TPI and MMD
    b. CBT and IPT
    c. TBC and TPI
    d. TA and RR
    e. SOS and RR

34. The counseling circle involves _____ steps.
    a. 5
    b. 4
    c. 3
    d. 2
    e. 6

35. The attitude of humility means being sensitive to the _____ differential between the client and counselor.
    a. transactional
    b. economic
    c. power
    d. political
    e. ethnic

36. Making choices about various courses of action are assisted by _____.
    a. zen paths
    b. decision channels
    c. decision trees
    d. mental decision images
    e. lateral medians

37. There are _____ closely related processes that determine the content of the counseling session.
    a. 6
    b. 5
    c. 4
    d. 3
    e. 2

38. One of the primary differences between professional counseling and simply "talking about" problems is _____.
    a. credentials
    b. treatment planning
    c. groups
    d. screening
    e. assessment

Part 2, Chapter 1

39. Depressive symptoms may be easily mistaken for _____ to treatment.
    a. resistance
    b. ambivalence
    c. abreaction
    d. pre-contemplation
    e. pseudo-readiness

40. The similarities between recovery in an individual and change in an organization are _____ .
    a. incongruent
    b. slightly close
    c. slightly different
    d. strikingly different
    e. strikingly close

41. It is critical to adapt and _____ the change plan to fit specific organizational needs and culture.
    a. project
    b. rationalize
    c. personalize
    d. solidify
    e. clarify

42. For clinical innovation to take, it must maximize the _____ .
    a. TIP guidelines
    b. fit
    c. mandate
    d. team cohesiveness
    e. synergy

Part 2, Chapter 2

43. The three levels where change can occur are program/organization, practitioner/counselor, and _____.
    a. client/parent
    b. client/group
    c. client/patient
    d. family/client
    e. spouse/patient

44. Prior to implementing the intervention, you should measure _____ .
    a. a timeline
    b. a readiness line
    c. values
    d. attitudes
    e. a baseline

45. There are _____ checklists to assess staff and identify gaps in training and supervision.
    a. 2
    b. 3
    c. 4
    d. 5
    e. 6

Part 3

46. Which of the following does not qualify for diagnosis as a mood disorder?
    a. subclinical depression
    b. minor depression
    c. mild depression
    d. sub-threshold depression
    e. all of the above

47. What percent of persons with mild depression report more than one depressive episode?
    a. 50
    b. 40
    c. 60
    d. 75
    e. 25

48. The rates of mild depression are _____ times higher among individuals with substance use disorders than in the general population.
    a. two to three
    b. three to four
    c. one to two
    d. four to five
    e. none of the above

49. One of the alternative treatments studied for treating mild depression was ___.
    a. TM
    b. hypnosis
    c. aerobic exercise
    d. TA
    e. magnets

50. One of the widely studied interventions for subclinical depressive symptoms is _____.
    a. CW-II
    b. WCD
    c. CWD
    d. DCW
    e. ICD-III

51. What percent of family practitioners had not looked at the USPSTF guide?
    a. 25
    b. 35
    c. 45
    d. 55
    e. 65

52. Process implementation, in which largely irrelevant training is conducted, has also been described as _____ implementation.
    a. intrinsic
    b. extra baggage
    c. systemic
    d. cargo-cult
    e. cargo net

53. EBPs must be implemented with _____ to the original model.
    a. federation
    b. fidelity
    c. an approximation
    d. some modifications
    e. flexibility

54. Undesirable changes to the EBP are called _____.
    a. rift
    b. shift
    c. draft
    d. drift
    e. negative modifications

55. Which of the following facilitates initiation of the innovation process?
    a. high centralization, low complexity, high formalization
    b. low centralization, low complexity, high formalization
    c. low centralization, low complexity, low formalization
    d. high centralization, high complexity, low formalization
    e. low centralization, high complexity, low formalization