

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 exam-

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

ple, 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.

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.samh-sa.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 joint 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.

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

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.				

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.

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

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.

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 countertransference 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.

Countertransference 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 depression 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 psy-

chiatrist, 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.

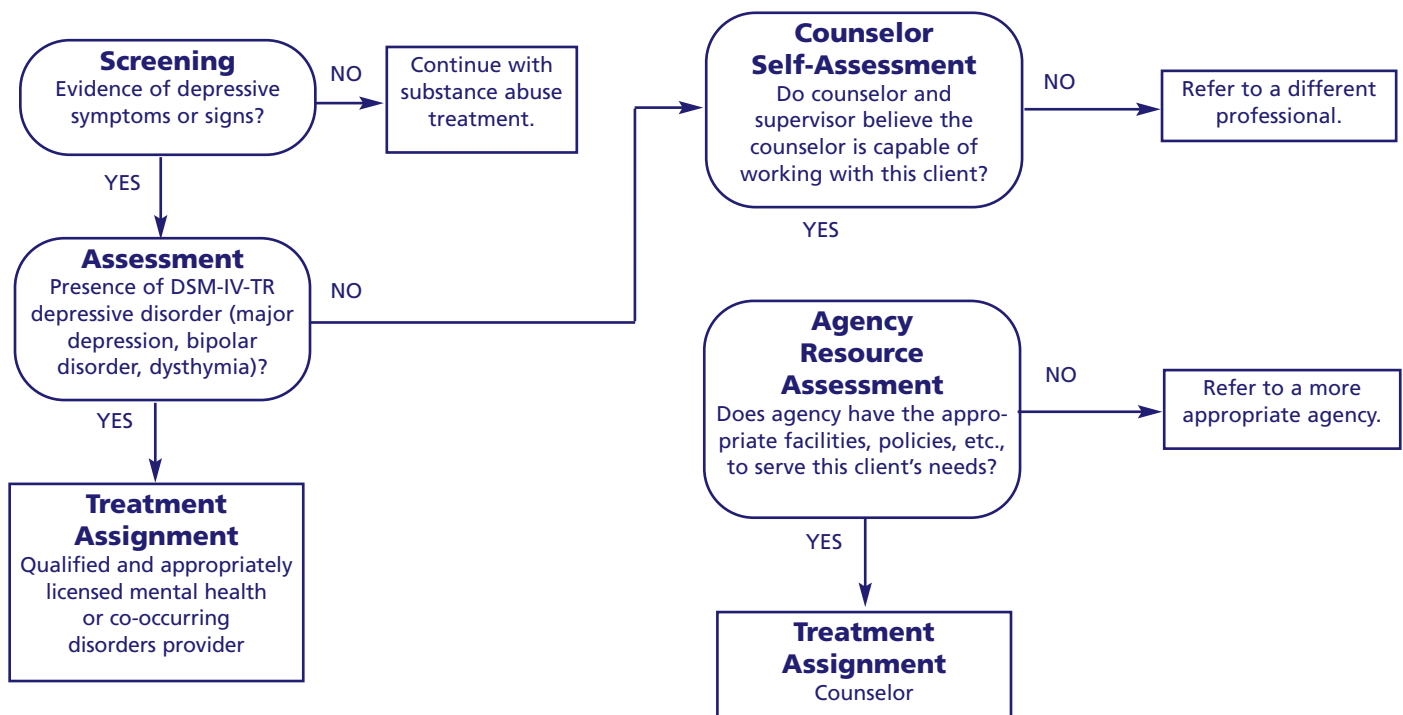
Note: The clients in the vignettes of chapter 2 have all been identified as experiencing depressive symptoms, not a DSM-IV-TR mood disorder, in their intake assessment or through a process of screening by their counselors and subsequent assessment by a qualified mental health professional.

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, non-judgmental, 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 non-judgmental 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 mak-

ing 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.

Medications used for abused substance

Alcohol

Medications for alcohol addiction help reduce cravings, manage withdrawal, or create aversion to alcohol. FDA-approved options include Naltrexone, Acamprosate, and Disulfiram, with others like Gabapentin and Topiramate used off-label. These are most effective when paired with counseling or therapy.

FDA-Approved Medications

- **[Naltrexone](#) (ReVia, Vivitrol):** Blocks the pleasurable, euphoric effects of alcohol, reducing the urge to drink. It can be taken as a daily pill or a monthly injection (Vivitrol).
- **Acamprosate (Campral):** Helps reduce long-term withdrawal symptoms like anxiety and insomnia by restoring brain balance. It is typically used after the patient has already stopped drinking.
- **Disulfiram (Antabuse):** A deterrent that causes severe, unpleasant physical reactions—such as nausea, vomiting, and flushing—if alcohol is consumed.

Off-Label and Other Medications

- **Gabapentin (Neurontin):** Often used to reduce cravings and improve sleep during alcohol withdrawal.
- **Topiramate (Topamax):** Used to reduce the desire for alcohol and reduce heavy drinking.

Important Considerations

- **Disulfiram** should never be taken while consuming alcohol.
- **Naltrexone** should not be used if the patient is currently taking opioid medications.

Nicotine

Medications for nicotine addiction include FDA-approved nicotine replacement therapies (NRT)—patches, gum, lozenges, nasal spray, and inhalers—which deliver controlled nicotine to reduce withdrawal. Prescription, non-nicotine options include Varenicline (Chantix) and Bupropion (Zyban), which ease cravings and block nicotine effects, often most effective when combined with behavioral counseling.

FDA-Approved Smoking Cessation Medications

- **Nicotine Replacement Therapy (NRT) (OTC & Prescription):**
 - **Patch (Transdermal):** Provides a slow, steady release of nicotine.
 - **Gum & Lozenge:** Fast-acting, used for immediate cravings.
 - **Nasal Spray & Inhaler:** Prescription-only options for higher dependency.
- **Non-Nicotine Prescription Pills:**
 - **Varenicline (Chantix):** Reduces cravings and withdrawal symptoms by acting on the brain's nicotine receptors, reducing the pleasure derived from nicotine.
 - **Bupropion (Zyban/Wellbutrin SR):** An antidepressant that helps reduce nicotine withdrawal cravings and has no nicotine.

Key Considerations

- **Combination Therapy:** Using a long-acting NRT (patch) with short-acting NRT (gum/lozenge) or pairing medication with counseling is generally more effective.
- **Timing:** Varenicline is typically started 1–2 weeks before the quit date, and Bupropion is also started 1–2 weeks before, with treatment often continuing for 12 weeks or more.
- **Side Effects:** NRT side effects include skin irritation (patch) or mouth irritation (gum/inhaler). Varenicline may cause nausea, vivid dreams, or insomnia, while bupropion can cause dry mouth and insomnia.
- **Other Options:** Although not FDA-approved specifically for smoking cessation, medications like Clonidine (high blood pressure) and Nortriptyline (antidepressant) are sometimes used off-label to treat nicotine addiction.

Cannabis

There are no FDA-approved medications specifically for cannabis addiction (Cannabis Use Disorder), but several off-label, pharmacological options are used to manage withdrawal symptoms, cravings, and associated mental health issues. Common approaches include [N-acetylcysteine \(NAC\)](#), [gabapentin](#), and [dronabinol](#) to aid in cessation.

Key Medications Used Off-Label

- **[N-acetylcysteine \(NAC\)](#):** An antioxidant shown to reduce cravings, particularly in adolescents and young adults by regulating brain chemistry.
- **[Gabapentin \(Neurontin\)](#):** An anticonvulsant that can help manage withdrawal symptoms like anxiety, irritability, and insomnia.
- **[Dronabinol \(THC\)](#):** A synthetic cannabinoid used to relieve withdrawal symptoms by providing a tapered dose of THC.
- **[Buspirone](#):** An anti-anxiety medication that may reduce cravings.
- **[Baclofen](#):** A muscle relaxant sometimes used to reduce the reward effect of cannabis.

Medication Strategies

- **Withdrawal Management:** Medications like Vistaril (hydroxyzine) are used for anxiety, while Gabapentin addresses insomnia and irritability.
- **Relapse Prevention:** Research focuses on reducing the rewarding effects of cannabis.

Opiates

Medications for opioid use disorder (MOUD), or medication-assisted treatment (MAT), include methadone, buprenorphine, and naltrexone. These medications help reduce cravings, withdrawal symptoms, and the risk of overdose. They are most effective when combined with counseling. Methadone and buprenorphine are maintenance treatments, while naltrexone prevents relapse.

Key Medications for Opioid Addiction:

- **Methadone (Methadone Maintenance Treatment - MMT):** A long-acting full agonist that acts on opioid receptors to reduce cravings and withdrawal without the high of illicit opioids, usually administered through specialized, highly regulated clinics.
- **Buprenorphine (often combined with Naloxone as Suboxone):** A partial agonist that relieves cravings and withdrawal with a "ceiling effect" for safety. It can be prescribed in office settings (e.g., as of 2023, the X-waiver was removed in the US).
- **Naltrexone (including extended-release Vivitrol):** An opioid antagonist that blocks opioid receptors, preventing any opioid from causing a high, effectively treating both opioid and alcohol use disorders.
- **Naloxone:** Primarily used for reversing opioid overdoses by immediately blocking receptors, but it is often combined with buprenorphine to prevent misuse.

Cocaine

There are currently no FDA- or EMA-approved medications specifically for treating cocaine addiction. Treatment focuses on behavioral therapies, but several drugs have been investigated or used off-label to manage withdrawal, cravings, and associated conditions.

Investigational and Off-Label Medications

- **Withdrawal/Craving Management:** Acetylcysteine, baclofen, and vigabatrin have been studied for treating withdrawal.
- **Antidepressants/Other:** Desipramine, bupropion, and carbamazepine (Tegretol) have been used to manage symptoms.
- **Dopaminergic Agents:** Agents like L-DOPA/carbidopa and amantadine have been investigated to modulate dopamine levels.
- **Vaccines:** Research by Kim Janda on a cocaine vaccine has been explored.

Key Considerations

- **Behavioral Therapy:** Cognitive Behavioral Therapy (CBT) is currently the most effective treatment for cocaine addiction.
- **Emergency Management:** For acute cocaine intoxication or chest pain, vasodilators like nitroglycerin are used.

- **Treatment Focus:** While medications like methadone exist for other addictions, none have proven highly effective for cocaine dependence.

Amphetamine

There are no FDA-approved medications specifically for amphetamine addiction (use disorder), but several drugs show promise in reducing cravings and usage, according to studies. Key medications tested include topiramate, methylphenidate, naltrexone, and modafinil, along with antipsychotics like risperidone for symptom management, though evidence is limited and often shows low adherence.

Commonly Researched Medications:

- **Topiramate:** An anticonvulsant that may reduce methamphetamine cravings and addiction severity.
- **Methylphenidate:** Shown to help manage addiction symptoms, cravings, and depression.
- **Bupropion & Modafinil:** Antidepressant and stimulant medications, respectively, which have shown limited evidence of benefit in reducing use.
- **Naltrexone:** An opioid antagonist, sometimes studied for reducing craving.
- **Antipsychotics:** Risperidone and aripiprazole have been used to manage positive and negative psychotic symptoms, respectively.
- **Riluzole:** Tested for reducing withdrawal symptoms and craving.

Benzodiazepines

Medications used for benzodiazepine addiction (dependence) treatment, particularly for managing withdrawal, focus on gradual tapering using long-acting benzodiazepines to prevent seizures and severe, rapid withdrawal symptoms. Key, evidence-based agents include Diazepam (Valium) and Chlordiazepoxide (Librium), which allow for a safer, gradual dose reduction.

- Long-acting Benzodiazepines (Preferred for Tapering):
 - **Diazepam** (Valium): Most common choice due to its long half-life, allowing for stable tapering.

- [Chlordiazepoxide](#) (Librium): Used as an alternative to diazepam in addicts due to lower abuse potential.
- Alternative Medications/Agents:
 - [Phenobarbital](#): Sometimes used in inpatient settings to manage rapid detox or prevent seizures during withdrawal.
 - [Pregabalin](#) (Lyrica): May reduce the severity of withdrawal symptoms and help prevent relapse.
 - [Imipramine](#): Found to improve the success rate of discontinuation.
 - [Melatonin](#): Used to aid with insomnia during the discontinuation process.
 - [Flumazenil](#): A benzodiazepine antagonist used in specialized, slow-infusion settings for long-term, high-dose dependence.

Important Considerations:

- **Gradual Tapering:** The consensus is to avoid rapid, "cold-turkey" detox, which is dangerous, and instead use 6-12 month taper regimens.
- **Ineffective/Not Recommended:** [SSRIs](#) (antidepressants), [propranolol](#), and [trazodone](#) have not been proven to significantly help with withdrawal symptoms.
- **Psychological Support:** Cognitive Behavioral Therapy (CBT) is highly effective for long-term management and discontinuation, especially for those with anxiety.