Two Chairs and a Box of Tissues

Memoirs of a Counselor/Educator

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I gratefully dedicate this book to all of the clients and students who have made its contents possible. You all will likely never know how profoundly and deeply you touched me during the time our paths crossed. I often tell students that I have learned more from them all than from any course, training, or reading

To the Reader

You are holding in your hands a collection of my experiences, anecdotes, lessons, and observations as a student, a counselor, and an educator during a career of over 30 years. I am honored that you have invested some financial resources in this book, and I hope it exceeds your expectations for readability, enjoyment, educational value, and, most importantly, for insights that will touch you personally as well as professionally. This tome is intended to be my way of sharing with you what I have learned during my journey as a student counselor, a professional substance abuse counselor, and a trainer of the next generation of alcohol and drug abuse counselors. My sincere hope is that the contents prove to be of value to you in whatever context you need it to be.

I have been told many times by various people that "everyone has a book within him/her." Along those lines, then, this is mine. It is not my intention to present myself as some kind of "expert" in any of the endeavors upon which I have embarked during my career. This is not my "opus" on counseling or education. It is not my expectation that you, dear reader, are "dazzled" by this work. I just want to share with you what I have learned from countless clients and students and to make sure that this learning is not lost once I pass from this earth.

As you proceed through the book, you will note that there is a decided lack of personal disclosure and detail about times, places, people, and other identifying information. What matters most is sharing with you what I have learned; the locations, specific individuals, and person-identifying information are all unnecessary. Moreover, in today's climate of lawsuits and legal actions, it seems prudent to me to present the material in this way. Finally, client and student confidentiality need to be kept and maintained. Federal confidentiality and privacy laws relevant to substance abuse treatment require me to protect client confidentiality even beyond the client's death. If you know me, some of the references may be, to some degree, familiar, but I prefer to keep details out of this work.

Rather than present to you page after page and chapter after chapter of my writing, I chose to present the contents in a, hopefully, more creative and engaging way. What you will encounter are three distinct "sections" of the book that consist of transcripts from fictitious interviews with a master's degree candidate named Kathleen. This very bright and intense young woman contacted me to see if I would be willing to be interviewed as part of her thesis. She told me that a presenter in one of her classes mentioned getting her initial counselor training at the school that currently employs me and that I might be interested in helping Kathleen with her research. I want to assure the reader that while Kathleen and these interviews are fictional, all of the experiences, personalities, and learning I share are real and did occur. I have dispensed with details such as: when and where each interview occurred, which material came from what interview, and how many occurred. These are not relevant to the purpose of the book.

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Section One: The Student

Kathleen: Thank you so much for agreeing to help me with the research for my master's thesis. I hope that these interviews don't take you away from other things you need to do.

Greg: It's really no problem. I've done a lot of thinking about this and believe the process will help me as much as it helps you.

K: How so?

G: I think I will have a chance to, so to speak, look back over the years and recall many different things about my career. Who knows? Maybe this will become the "memoirs" book I have always thought about writing.

K: Really? That would be great! Will I get a copy?

G: If that ever happens, I'll let you know.

K: Fair enough. Will it be okay with you if I record our interviews? I don't want to lose anything that may be important. I'm not a great note taker, either, but I'll try.

G: That's fine, Kathleen. I'll make sure that I don't share anything that might compromise client confidentiality, if you happen to ask me questions about things that have happened or that I've witnessed.

K: Good thinking. I will, of course, delete the recordings after I've completed the thesis. Okay. The first question I'd like to ask is, why did you decide to help me with this project?

G: What piqued my curiosity and sparked my interest in working with you was the nature of your thesis itself. When you told me that you wanted to research the idea that the training and development of helping professionals are closely aligned with the personal growth and healing of those professionals, I was hooked.

K: Really? Why is that?

G: Because the relationship between personal and professional growth and development has become a fundamental belief of mine concerning training counseling professionals. If you asked me what I believe makes the program we offer unique, that would be my answer: We emphasize that throughout the process. Students need to understand that we can't separate our personal selves from our professional role. After all, we don't have "tools" in our profession.

K: But we have all kinds of skills and techniques and theoretical ideas, right?

G: You are right. But at the same time, the counselor who has all of this knowledge and these skills is a human being, with all the flaws and problems common to humanity. If, for example, a counselor suffers from depression, let's say, she may not be in an emotional place to be "there" for the client, even though she "knows" how to help the client.

K: Okay. So, you are saying that the effectiveness of a counselor depends, at least in part, on that person's emotional stability. That's part of my thesis.

G: Exactly! But the ability to provide quality behavioral health care depends on even more than just emotional stability. Factors like past trauma, unresolved emotional pain, personal maturity, psychological development, and who knows how many more can also be involved. I like to tell our students that we, as counselors, ARE the tool. In fact, that's one of my "Gregisms."

K: Oh, you mentioned those when we were talking about doing these interviews. What exactly are those?

G: Nothing more than little maxims, "slogans," and truisms I've gathered or come up with during my work. I have a collection of them, and I'll share them with you sometime.

K: Okay. I'm sure they will be interesting. Anyway, how about I ask you the most obvious starting question about your career: Why did you choose to become a substance abuse counselor?

G: The simple, glib answer is that I was nearing the end of my bachelor's degree studies and realized I had few, if any, marketable skills. My major in French and minor in Criminal Justice Studies was not likely to impress most employers.

K: That's an odd combination. Why did you choose those?

G: Because I was under 25 years old, my brain was not yet fully mature, and I had no guidance. Seriously, I initially wanted to teach French at a high school level. At that time, the economy in this country was terrible, and I realized that it wasn't a good idea. Education cuts were everywhere. So, I thought about going to law school and started to learn about criminal law. My grades were good but not good enough to get into law school, so I was adrift, in a very real sense.

K: Actually, I kind of understand that. My undergraduate major was psychology. But no one told me that you couldn't get a job with just that degree. So I worked low-paying jobs because my student loans came due, and I needed to start repaying them.

G: At some point, you must have realized that you would need a higher degree if you wanted to work with people, and you got into this master's program.

K: Yep. I found out that a person needs a license at a master's level to do therapy.

G: But at least you had a bachelor's, so you could apply to graduate school.

K:And so I did. Getting back to your situation … why substance abuse counseling?

G: I had three parent figures growing up, all of whom had serious problems with alcohol. There was also prescription drug abuse, so I thought that I would understand drug and alcohol problems from those experiences. The young lady I was dating at the time was attending the school where there was a training program for substance abuse counselors and told me about it. It was only a year long, and I did pretty well in college, so I figured it was a good choice.

K: So your personal experiences growing up "led" you to the profession of drug and alcohol counseling. What kind of training was being done at that time? Do you mind sharing a little about it?

G:To be honest I really had no idea what I was in for. I wasn't very familiar with the profession and all of the duties, so just about everything was new and unfamiliar. For instance, just to get into this school I had to write a long essay about why I wanted to be in the program and then had to do an interview with the program director. Acceptance wasn't at all guaranteed.

K: It must have been a private school then…

G:Yes, it was. (chuckles). They were able to "discriminate" by screening applicants to make sure those accepted were appropriate. That's something we cannot do now in our training program. I could go on about that, but I'll hold off on those remarks. Let's just say that the training process is made more challenging when you must accept everyone who applies.

K: I can imagine. I had to go through several hoops to get

into graduate school. I needed a certain GPA, and then there were letters of recommendation, an interview, and an essay, just as you mentioned. There's a lot of competition to get into graduate schools.

G: The result of that competition is finding the best candidates and screening out those that seem less promising.

K: And you got into the program . . .

G: I was told later that it was my family's history of substance abuse that got me in, not any academic brilliance or a stellar performance in the interview.

K: How was this program set up?

G: The aspect of it that intrigued me was the emphasis on family systems theory and on seeing addiction not as an individual phenomenon, but a systemic one. They believed that treatment should be family-focused and not concentrated only on the "identified patient."

K: Those are family systems terms. I remember them from our theory class. The philosophy, then, was to look at a substance abuse problem as an issue for everyone in that system.

G: Exactly. I've carried that idea and this theory with me for over 30 years. In our program, we have a separate course focused just on family systems theory.

K: (Pauses) Well, that sounds like a class I might want to take . . .

G: We have "guests" in the course from time to time. I call it a "professional courtesy" (pauses). Anyway, I think it was the emphasis on family systems theory that led me to look at both the personal and professional development of counselors. One of our courses was an all-day seminar once a month on a Saturday. It ran for nine months, if I recall correctly. The class was all about our own families and us.

K: Whoa! That sounds interesting *and* intimidating at the same time.

G: It was. The teacher was a fairly prominent expert in family therapy with alcoholics and drug addicts. All of us had to create a family diagram, better known as a "genogram," and present our family's history to the class.

K: So, not only were you learning about the theory, but you were applying it to yourselves along the way.

G: Yes. And some students were not so happy with having to do this. There were 20 students admitted that year, with 10 being people in recovery from addiction and 10 who didn't have a substance abuse diagnosis. I think at least four or five of us felt very threatened.

K: What was the problem? Did they think it was too personal?

G: Probably. In my early years working in the profession, I encountered several counselors who saw no value in "digging up the past" with their clients and unearthing all the pain from it. I believed then and still do that this is a very harmful attitude. It doesn't take a genius to see how past pain and trauma can very often be the beginning of a substance use disorder. People cope with their pain by drinking and using and then lose control once the brain disease we call addiction is activated.

K: Why would these counselors refuse to explore those issues with clients? That doesn't make sense.

G: It does if we look at it as possible evidence of their own unresolved pain. I have no proof of this, but over the years, I have seen it and suspected it time and time again. If I, as a counselor, have substantial pain, shame, and trauma, I may steer clients around theirs so that I don't have a countertransference reaction. And then I am not helping them with their pain.

K: (Excitedly) This is precisely what I am looking for!

Counselors who have not healed their own pain might be less effective in practice!

G: Absolutely.

K: And the idea behind this seminar was to help all the students identify things about themselves that needed to be taken care of . . . makes perfect sense to me.

G: I didn't realize this was the intent way back then. I thought it was just about learning more about the theory. So, I contacted relatives and asked a lot of questions so I could put together my own genogram.

K: If you don't mind me asking, what did you find out?

G: Oh, the usual stuff . . . some probable mental disorders, family secrets, out of wedlock pregnancies, some physical abuse, and, of course, some relatives who "liked their beer" (both laughing). Nice euphemism . . .

K: And you had to share all this with the class?

G: Yes, but I have to say that two things made this easier. One was that those who went before me had much worse family troubles, and the second one was that I was so well-defended with my intellect that I felt nothing about all that I was sharing. I was, as one of my supervisors once put it, "reporting," and not sharing.

K: There were no feelings about what you were telling the class?

G: It's probably more accurate to describe them as "deeply buried." Of course, at the time, I had no idea what kind of defense mechanisms I had and how strong they were. I'd emotionally survived my childhood by staying, as they say, "in my head." As is the case with so many of our clients, my awareness of my defenses and personality traits was next to zero. I guess I could say that this was my "normal."

K: If that's the case, what did you get out of this seminar class?

G: A good, challenging question, Kathleen. I completed the class with some useful knowledge about family systems and an intellectual understanding of countertransference. Looking back, I think I rationalized the absence of pain by minimizing how troubled I might be. I lifted up my academic success as "evidence" that I couldn't be as affected as other people seemed to be.

K: Okay. Time to move on, I guess.

G: Did I just frustrate you?

K: No, what I think you did was share a common way that some people protect themselves from looking deeper into themselves. I've done the same kind of thing for most of my life.

G: Your intellect and success in school have done the same thing for you.

K: Yes. Nice use of motivational counseling there, by the way.

G: Thanks (pause). You know, you just brought something to my mind that might be useful to your research.

K: What's that?

G: You know how people in our lives sometimes accuse us of "using our counseling stuff on them"?

K: Yeah, my friends say that once in a while.

G: Do they seem to think that you are using that "stuff" on them, as in some kind of malicious way?

K: It seems that way sometimes, like they think I'm trying to get an advantage in a discussion or argument.

G: I've had a couple of people in my life say something like, "Oh, don't pull that counseling crap on me." In some cases, they said it to try to discount what I was saying.

K: Like it really wasn't you, the person, talking?

G: Right. I think what they don't realize and maybe don't believe is that the "counseling stuff" is not a separate part of us. For example, all the knowledge and skills and experiences don't reside in one part of me, and I don't "click" into "counselor mode" or something like that. I think after a while, all of that just melds into our personalities. I didn't think to do some kind of reflecting on what you just said; it just came out naturally, like part of the conversation.

K: That makes sense. I remember back to my first counseling skills class and how awkward I felt trying to make sure I was doing the "right" skill at the right time and thinking a lot about where I was going with my client. It was very artificial. I still feel that way sometimes, but it's better now.

G: More like just having a conversation with the client…

K: Yes, that's it.

G: I think that integration process, for lack of a better term, allows us to be more genuine and "real" to people. We're not playing a role; all of our skills and knowledge are just part of who we are. We try to get the students in our program to begin defining their counseling beliefs and "style" early on.

K: I think that's what my professors do in our classes. We study all kinds of theories and they encourage us to keep track of what things we like and don't like about those theories.

G: Yep. We do that, too. So, family systems became my first theoretical foundation, even though I didn't grasp the emotional part of it.

K: What other kinds of courses did you have in this training program?

G: We had individual and group counseling skills - I checked my transcript and the group class was a B, my only B. But no resentment here… (both laugh). Let's see, we had one about psychopharmacology, a class in assessment, the history of substance abuse, establishing the therapeutic relationship, and a lot about the disease concept. I think there was one related to ethics and confidentiality too. That's what I can recall.

K: A "B" in group therapy?

G: Yes. For several reasons, I had trouble with running groups. The number of people and the complexity of group interaction intimidated me. I also was passive back then, and I was afraid I would make some kind of horrific mistake. I think it is far more challenging to learn group skills and those we use in individual counseling.

K: I agree. We have so much more experience talking to just one person than we do working with groups. One of my professors says that it takes several years to get reasonably good at doing group counseling.

G: No argument from me . . . One thing about that course that you might find interesting is that I first got the idea that someday I wanted to teach counselors in that class. I wasn't preoccupied about it during my career, but I recall thinking, "I could do this!"

K: That is interesting. And here you are doing it.

G: Yes, with many years in between! (laughs)

K: Anyway, am I safe in assuming that the passivity and fear of doing something wrong in groups were examples of personal traits that made groups more difficult for you?

G: You are. And both relate to family issues I had. I hated making mistakes in front of people. I felt like I needed to be perfect.

K: How did you get over that?

G: I'll let you know if it ever happens (mutual laughter).

K: I asked because, to me, it's easy to see how those issues could hinder you as a counselor.

G: You got it. Our psychopharmacology teacher was a former pharmacist who lost his license due to his addiction. He was very smart, but that wasn't enough to overcome an addiction.

K: Right.

G: I remember him telling us that if alcohol never existed and we discovered it now, it would be a Schedule I drug, too dangerous for human use and with no medical value. He got me to think about how it is that a drug that causes so much pain and damage is and has been so widely accepted by human beings.

K: Because it is something people can drink and not just a drug like cocaine and heroin?

G: I think that's part of it. But maybe the more significant factor is social acceptance. Alcoholic beverages are widely accepted worldwide, at least in many cultures, so the dangers are downplayed, I think.

K: Okay. I understand that. Do you think that marijuana will eventually become legal as a recreational drug? There is more acceptance of it, or at least, tolerance of it, than in the past.

G: That's a good point. It won't surprise me if it does, although recent research is showing it's not such a harmless drug. Besides, is it a good idea to legalize another recreational drug when we can't handle the problems created by alcohol and tobacco?

K: Interesting. Some of my friends think pot should be, but I'm not so sure. I never tried it. It wasn't acceptable in my family, while alcohol was.

End of Session

K: So, here we are, back at it.

G: It was helpful for me to take a little break and recall some things I think will be useful.

K: That's great! I listened to the recording. There are some excellent information and thoughts in there.

G: Now, you do remember me telling you that sometimes I can get a little long-winded, right?

K:Yes, but I don't think I've seen that yet.

G:You probably soon will. Students learn fairly quickly that I can get into what I call "excruciating detail" sometimes, so call me on it if I do.

K: Deal. I'd like to hear more about this training program you were in. I'm curious about the similarities and differences to what I've gone through in my master's program.

G: Okay. I don't recall the level of academic rigor or anything like that, though. I can honestly say that much of what I got in graduate school, a decade later, was more of a review and repetition of what I already knew, rather than "new" learning. I did well in the classes, academically, which wasn't surprising since I more or less lived my life in my intellectual self at that time.

K: So, classroom work played right into your strongest skill set . . .

G: Yes, but more importantly for me, it was an emotionally safe process. Aside from the Saturday seminar class, we didn't have to focus on other aspects of ourselves, like feelings and intuition.

K: Those are important parts of who we are as counselors, though . . .

G: True, but at that time, I had no idea how vital they are, and I had buried both under my system of defenses. Getting back to your theme of unresolved issues, however, this was one of my main liabilities as a counselor in training.

K: You didn't feel feelings and have intuition? From childhood?

G: Correct. People living in troubled family systems have to develop strong defense systems to get through the problems and emotional pain. So, we often just bury our feelings and other vulnerabilities deep within and develop strong walls to protect ourselves. The problem is, once the "war" is over and the barriers are created, they just don't go away by themselves.

K: I understand. You repressed a lot of yourself to get through life, and you couldn't, um, bring it back. So, the classroom setting and the academic work, because they are intellectually-oriented, were not threatening.

G: You've got it. Safe, but no challenge to look beyond just the thinking part of learning. Ironically, or maybe predictably, when we were in a counseling theory class, I really resonated with Rational-Emotive Behavior Therapy (REBT). It made perfect sense to me and didn't push very much into the feeling world of people. "Changing your thinking will change your feelings, and you'll behave more rationally" seemed logical and sensible to me.

K: Of course! You could understand the logic behind it, and, if I recall correctly, those cognitive therapies put the counselor more in the role of teacher than "therapist."

G: Right. Feelings to me at that time were messy, unpredictable, and dangerous. Maybe at some level I knew I had things that needed to come out, I don't know for sure. But I knew that if I could use something like REBT, which was and still is considered to be effective, I could be a decent counselor.

K: There were other theories in the class, though, right?

G: Of course, but this one made sense. I couldn't get into Gestalt at all, maybe because we were shown a movie of someone doing Gestalt and it seemed to me like he was always attacking people. That's about as far away from where I wanted to go as we can get. I couldn't get into psychoanalytic theory and some of the others seemed pretty "out there" to me. I knew I liked family systems and REBT, so those formed my "repertoire" for a long time.

K: One thing I want to ask you from the last interview was your mention of the class being half people in recovery and half people who didn't have a substance abuse diagnosis. What was that like?

G: Oh, this will be fun! By the way, I know that some people will say, "in recovery" and "not in recovery" but I choose to describe it differently. "Not in recovery" could imply that a person has a severe alcohol or drug problem and hasn't gotten help yet. That's not really what it is. Thus, I use "people who do not have a substance use diagnosis" to make it clear.

K: Good point. I am writing that down.

G: First, here's some historical context. The profession of Alcohol and Other Drug Abuse (AODA) counseling is relatively new, with its origin probably going back to the very late 1960s and early 1970s. Doctors treated alcoholism and drug dependency before that, at least medically. The first AODA counselors in the United States were people who had gotten into recovery from addiction and who worked pretty informally

with others in a treatment program. I think it's safe to say that they were paraprofessionals at best, with limited formal training and a lot of on-the-job experience. I don't know that there were any formal training programs at this time, but there may have been. Anyway, the assumption was made that recovering addicts could best work with others with the same problems. I don't know for sure, but I wonder about the influence of self-help groups on this belief.

K: You mean, "Who else but another alcoholic can understand a person with alcohol problems?"

G: Exactly. Regardless of how one feels about it, those groups have been very effective for many people for many decades. I think it followed logically that alcohol and drug counselors "needed" to be recovering from addiction themselves to be helpful.

K: Then, back at this time, most AODA counselors were recovering addicts and alcoholics.

G: As well as I can recall, yes, and the history of the profession seems to bear this out.

K: Well, then, having a training program with that many people not having a diagnosis was not the norm . . .

G: It seemed that way to me. To be fair, the director was a person in recovery, and he appeared not to have the bias of some of the students.

K: This must have made for some interesting classroom discussions.

G: Not to mention what was talked about during breaks and outside of class! Actually, I think there was more talk about it when we were on our own. I recall a couple of recovering students who were adamant that someone without a diagnosis and abstinence simply would not be effective. They maintained that they would never have trusted a counselor without a history of addiction when they were in treatment.

K: Well . . . Having gone through an addiction problem and then changed one's life so dramatically must give someone in recovery some advantages working with clients with substance abuse issues, right?

G: No doubt about it. The AODA counselor in recovery will likely have some "instant credibility" with some clients, and there will be an understanding of the power of addiction that someone like myself is not likely to have. A big part of substance abuse counseling in its early stages seems to me to have been a lot of self-disclosure by the counselors to illustrate points they wanted to make or to help clients think along different pathways. Such counselors can also speak from experience when it comes to struggling with treatment or their recovery programs early on, and they have many ideas about what might be helpful to clients.

K: Since we know that it is the quality of the therapeutic relationship that suggests the potential for client change, all of those things are valuable assets.

G: I agree. And for a good long while during the training process and early into my career, I felt inadequate about that. I simply could not speak from experience and full understanding when it came to relating to clients. I had waited until the legal drinking age of 21 to have my first drink, and I never used drugs or tobacco. But on the other hand, there are potential liabilities that may come along with a counselor in recovery.

K: (Pauses) I guess the possibility for relapse would be one, right?

G: Yes, it is. Even in the training program we do now, occasionally, a student relapses and needs to go back into counseling or treatment. I feel bad when this happens. We tell all our students that their mental and physical health, along with their families', need to be priorities. Fortunately, relapses don't happen very often.

K: What else?

G: Well, if a counselor believes that the way s/he got clean and sober is the "best" or "only" way to do it, then there's a risk of lack of flexibility and individualized treatment planning with clients. There also may be a certain "close-mindedness" toward new ideas, counseling approaches, and methods for helping. For example, if a counselor believes that total abstinence with no drugs is the only "true" recovery, s/he may have a hard time accepting clients who need to take, for example, antidepressant medications for a co-occurring mental disorder. And you can imagine how someone like that might oppose medication-assisted treatment for opiate-use disorders.

K: Not very favorably . . . Yes, I can see that (pauses). Okay, getting back to you as a person without a diagnosis and recovery becoming an AODA counselor . . . What, then, did you come up with to relate to your clients?

G: Well, first and foremost, having grown up in a family with substance abuse problems did, interestingly, give me credibility with some clients. I remember one saying, "Oh, then you understand" after I mentioned a little bit about my family. I learned from one of the best clinical supervisors I have ever had to bring the focus to feelings and how client and counselor can relate on that plane. "Addiction is a disease of feelings, and we all have those." Ironically, I hadn't discovered my own feeling self yet, but I used it all the same.

K: Was that effective, the "feelings" approach?

G: For some, but the problem is that when a person enters treatment, especially for the first time, s/he is usually well out of touch with feelings, and it takes a while to help the client see how feelings and substance use are connected. What ultimately became my "approach" to relate to clients was the counseling skills we learned in one of our classes. As I look back now, I identify them as belonging to the person-oriented counseling theory, but there was no theoretical name given to it.

K: That's one of the current best-practice approaches now for working with many different kinds of clients. Did they teach motivational enhancement techniques too?

G: No, I think that philosophy and skill set emerged later on. But all of the essential skills for building a therapeutic relationship were given to us. I remember the emphasis on active listening and reflection of feelings, and what was called "primary accurate empathy," and being genuine, and all of that. I think that I blended that together with a cognitive behavior therapy as my "style" (if you can call it that) at that time. I remember such an emphasis on listening rather than talking, and on a skill we called "checking out," which was basically sharing what we heard the person say to make sure we got the message accurately. I think I learned from this that self-disclosure wasn't as vital to the counseling process as some of my peers believed. I tell our students now, "We have one mouth and two ears, so we should be listening to the client twice as much as we speak." I believe this!

K: But you mentioned that a counselor in recovery could use personal background and experiences to help clients through self-disclosure.

G: Yes, but I didn't have all those stories and experiences to share, so I used the person-centered skills a lot and focused on cognitive understanding and a lot of what we call "client education" early on. I also shared a lot of humor to illustrate ideas. I don't want you to think, however, that I had all this figured out and counseled from a clearly developed theoretical framework. I didn't. I mainly "felt my way" along at the beginning, trying new things and discarding ideas that didn't work. Eventually, I developed more effective approaches to work with clients, a natural process in professional development, I believe.

K: (Writing) I want to make sure at some point we get back to that, the professional development part, to see if it connects with your personal growth somewhere.

G: Okay.

K: It seems like it would be a challenge for someone not in recovery to relate to this group of people.

G: I thought it was, in part, because of what my peers were telling me, but I found out it wasn't that difficult. Having a personal background with addiction is one aspect of a counselor that can be brought to the treatment process, but there are many more.

K: So, you and the other students who were not in recovery, how did you handle the doubt and criticism that other students had about your potential?

G: There was a little subsystem of three of us, myself and two women, of about the same age. We did a lot of mutual reassuring and encouraging. I think we also developed an attitude of what I like to call "constructive defiance."

K: Constructive defiance?

G: Yes, a mind-set that makes someone want to prove someone else wrong, like a "I'll show you" mentality. It provides us with energy to apply in a positive direction, even though it comes from what some might call "defiance." To look at it another way, it's the other person's response to "reverse psychology."

K: I see.

G: Our little subsystem, more or less, used the skepticism and critical comments of others to fuel our desire to be successful. Actually, this idea is helpful to encourage clients whose family and/or friends are telling them they won't make it and cannot be successful. We have them use the hurt, shame, and anger to provide energy for the changes they want to make.

K: Instead of the client getting discouraged or depressed by

the negative, the counselor helps him/her positively redirect those feelings.

G: Precisely. I recall one of the other students saying to me, "You're not an addict, you don't smoke, and you don't drink coffee. How in the hell do you think you can be a drug counselor?" One of the women heard this and said something like, "So you think we should all go out and get addicted to cocaine so we can be AODA counselors?" There was no reply.

K: That's a very powerful challenge!

G: It sure was. I wish I'd thought of it (laughing)! I confess I used that line a few times during my career when I got annoyed by someone insinuating my lack of recovery status was a liability.

K: Was there some kind of internship in this training program?

G: There were two different ones, for 11 weeks each, 40 hours per week. A total of 880 hours. When our students get a little testy about our internship requirement, I just share with them what was required of me (laughs). One of the internships was at a local treatment facility and set up by the school. Everyone had a rotation there. Each of us was also required to find a site for the second internship. As I recall, we were on our own with that. I found a day treatment program for adolescents that was affiliated with a local hospital.

K: Day treatment for adolescents?

G: Yeah. The hospital bought a four-unit apartment building and created a treatment center out of it. There was a schoolroom, group rooms, counselor offices, recreational therapy office, and a family treatment center. They even kept a working kitchen in one of the apartments for the clients to eat lunch and make meals occasionally. It was actually a very nice little complex. The kids came to the program every day. They had groups, school, education sessions, individual counseling,

and recreational therapy. Family nights were Tuesdays and Thursdays, making for a couple of long days.

K: That sounds like a nice setup to me.

G: I thought it was, but I'd never been in a treatment center before, so I didn't know how to judge it at the time. Looking back now, it was very nice in the physical sense.

K: You said a hospital operated this. How did that work?

G: Most of the kids started out by being admitted to an in-patient unit for detoxification, if needed, and stabilization. I spent a week observing on that in-patient unit at the very beginning.

K: What was that like?

G: I was shocked.

K: Why was that?

G: Remembering that this was during a time when AODA treatment was a very confrontational, "break them down and build them back up" experience, I saw a lot of that.

K: With kids? I mean, I get that they had drug and alcohol problems and weren't probably the nicest clients to work with, but doing a lot of confronting like that seems over the top.

G: I thought it was too, even though I didn't know what treatment was supposed to be. All the kids had to wear hospital pajamas for a while upon admission, so some had their own clothes, and others were stuck in pajamas. Groups were highly confrontational. This was the first time I heard the term "the hot seat."

K: What did that mean?

G: What I remember is that group really wasn't a dynamic process in which everyone got involved as I had learned it. The counselor or counselors would choose someone to be the focus while everyone else watched, and that kid got challenged, called names, insulted, many times to the point of tears. I watched the other group members during these "therapy" sessions and saw how scared they were that they would be next. After group, I heard them talking about how to handle the "hot seat" the best way they could. Of course, they all came to group defensive, anxious, and expecting to be confronted. I remember one girl in particular. Two counselors were confronting her at the same time, and she was trying not to cry, but I could see she was distraught. She was told she was "in denial" about her feelings. Finally, she started sobbing, and one of the counselors told everyone that she was just doing that for attention.

K: Oh my God! What were they trying to do?

G: I guess the idea was to get her in touch with her feelings and to break down her defenses. But it was like a double-bind situation. If she didn't express feelings, she was in denial, and if she did express emotions, she was merely seeking attention. To be fair, I didn't see every counselor work with clients, and I never got to see a one-on-one session so that other counselors may have been doing things differently.

K: But as an intern, didn't you ask about what was being done, just to learn about it?

G: No way! I was scared to death of these counselors. Remember, at this time, I was very passive and disliked conflict. I wasn't going to risk getting on the "hot seat" myself!

K: What else did you see?

G: Well, I never met this client, but one day, I was reading the chart of a new client who was 13. She had just been admitted and was in the detoxification section of the in-patient unit. She had been drinking

over a quart of hard liquor per day, doing pot and cocaine, and had liver damage. She was also prostituting herself to get money so she and her cocaine-addicted mother could live. That really struck me—someone that young using so heavily, already physically damaged, and selling herself to make ends meet. It was like a slap in the face for someone as naïve as I was!

K: Liver damage at age 13?

G: Yes. I couldn't believe it either. I guess she began drinking at age 8. It didn't seem like a very long time, but later, I learned that alcohol and drugs take a physical toll on the bodies of adolescents because the organs are not yet fully developed and cannot handle the toxicity of the drugs.

K: I would never have thought about that. Wow . . . (looking off in the distance for a brief while)

G: I tell the students that this is a traumatic profession because of the stories we hear and the realities with which we are confronted. I think that was my introduction to "vicarious trauma."

K: No kidding. Sorry I spaced out for a minute there. I have a niece just about that age, my sister's daughter. That's a sad story.

G: I agree. Every now and again, I wonder what became of her.

K: (Sighs heavily and clears throat) Okay, let's move on. You were talking about what I would call the mistreatment of the kids on that unit. Any other memories?

G: I saw one of the male clients was forced to wear a sign that said: "I am a baby." Apparently, he had done something wrong on the unit or behaved immaturely. It was just like the patients wearing signs in situation comedies or movies.

K: In movies? I've never seen any movies about treatment.

G: A good number of years ago now, there was a movie about a woman in addiction treatment, and some of the patients in the center were told to wear signs relating to issues they needed to work on. But this was just demeaning. I couldn't wait for that week to be over and to get out of there.

K: What could you possibly have learned from that experience, other than how *not* to be a counselor?

G: Kathleen, that was precisely one of the things I did learn. There was no way I could behave like that. My personality and my values about clients, as we had learned about them, would not allow it. Little did I know that there was more to come (pauses). I also learned that attacking clients with "caring confrontation," as they called it, was not a good way to build trust and to help them share. I also initially got the idea that at least some counselors viewed their clients as "adversaries" who were wholly dishonest, could not be trusted, and who wanted to defy their counselors purposely.

K: So, your sense of treatment was that counselors weren't as much supportive, encouraging people as authority figures whose job it was to, as you said before, break the clients down. That just goes against everything I believe about being a counselor. Why was this behavior tolerated?

G: At that time, it's what many AODA counselors believed needed to be done. Now I look back and think a lot of it was countertransference. The counselors always seemed to be angry with the clients for one reason or another. Since I hated conflict at this time, I just kept my mouth shut and didn't ask many questions.

K: Is this, then, another example of how some of your personal issues or whatever kept you from getting more out of that week?

G: Correct. I have some guilt for not having the courage to speak up about it. Being scared, passive, and not knowing what good treatment was kept me silent.

K: Doesn't this kind of thing strengthen the case that only people with higher degrees like a master's should be able to work with people with substance use disorders?

G: (Smiles) I have been waiting for you to mention that. I think your point has some validity. Remember that this was a long ago and at a time when many substance abuse counselors were recovering people who'd had a minimum of formal training. I doubt that they had as much theoretical preparation as we'd gotten in our classes. Most definitely, counselors at this time needed far more than they had. For example, they told clients that addiction was a disease, but then treated them like conniving, evil, reprehensible people for behaving in treatment as addicts do! I think, looking back, that at least some counselors were not able to separate the person from the behavioral manifestation of the disease.

K: But doesn't that mean that those counselors shouldn't have been working with these kids in the first place? They were incompetent!

G: As we look back now, for sure, they were not adequately prepared. But getting back to your point about AODA counselors needing a master's degree, I guess I have to add that it isn't a specific degree that imparts competency; it is the curriculum, the level of rigor, and the quality of supervision that creates that. Well, those things, plus experience. I have known people with master's degrees and above who seemed to have no idea of what they were doing with AODA clients. I have also known counselors with no degree at all who were extremely effective.

K: But how many of these clients were harmed by what they experienced in treatment?

G: A good many, I believe, just like how many patients were harmed or died in the early years of medicine. Like everything else, this profession is evolving and developing, hopefully, for the better. It may well be that someday there will be a universally accepted education level for AODA counselors. However, I still maintain that it is competency that matters most and that degrees do not guarantee that. One of the reasons we are always trying to improve our training program is to produce more competent counselors. One of our former instructors used to tell students, "We want you, the next generation of AODA counselors, to be better than we have been."

K: I like that. But I still think a higher degree would be better.

G: Fair enough, and I have heard this from many professionals over the years. More recently, I have received comments like this about our students, since they graduate with an associate degree. I think an assumption is sometimes made that we don't provide a sufficient level of ethical training, skills, and theoretical background for our students because we are not a university and don't offer a master's degree. How about we return to this in the future?

K: I'll make a note of that. And, just so you know, I didn't mean to insult you or the program you have.

G: I understand. No offense taken. I'm going to suggest a break at this point. We have covered some things today that have a lot of emotion attached to them.

K: You saw that I was a little distressed about the descriptions of how those kids were treated.

G: True, but I have my own discomfort about this too.

End of Session

K: I'm sorry you got that flu bug last week.

G: I am sorry too, for several reasons (laughs). I apologize for postponing this session until now, but I was in no shape to do it, and I didn't want you to get ill.

K: It's not a problem. The extra week gave me some time to review that last meeting and to think about the things we discussed (pauses). I guess I want to start by apologizing for the way I came off about AODA counselors needing to have master's degrees to be competent. That was rude of me.

G: No apology needed. Believe me, this topic has come up so many times over the years that I don't even flinch. There is some validity to the idea, and it may well be that in the near future, an advanced degree will be required. Some of the heavyweights in the profession are bringing this up more and more, especially as more is discovered about the biology of addiction and the complexity of brain chemistry, the use of medications, and so on. There was talk of this back in the 1980s even before we knew what we now know about the brain. I went back to school to get a master's in counseling as some insurance for the future. And yet, here we are with no such mandate.

K: My comments insinuated that your students are not competent because they are not at that level. That's not what I meant.

G: What I heard was a very sincere and strong value about counselor competence. We agree on that point, and it is the one that matters to me (pauses). I noticed that you also have some very strong values about how clients should be treated in counseling. The anecdotes I shared with you last time, especially about the kids in the in-patient unit, hit a nerve, I think.

K: Yes, it did. I want to work with children and adolescents once I get my license. I realize that my reaction was pretty

intense. I guess this might be one of my own possible triggers for countertransference. Since my thesis is about how personal issues and background impact the counselor's ability to practice, it's good that it happened. I did have to talk to my adviser about it, though. She assured me that every counselor has some of these vulnerabilities and that it is our professional responsibility to work through them.

G: I thought about the same thing, and I'm glad you took it positively. I too had some emotion about what we were talking about. I guess that being as removed from my feelings as I was then, I didn't feel much about what I saw and heard, but I did as I was sharing those events.

K: That seems like a perfect transition to the next subject, your internship at this facility.

G: Yes, it is. There were two counselors at this facility. Both were recovering people. The more experienced counselor was a middle-aged male, intimidating, and could stop a discussion with a look. I swear that lightning shot out of his eyes sometimes! The other counselor was a young woman, not experienced, and kind of the gum-chewing, sarcastic, take-no-crap-from-anyone type, if that makes sense.

K: Yes, I think I know what you mean. And she also was a recovering addict?

G: Yes, she was, and they both used a lot of self-disclosure with the clients. Since she was younger, I think she did more of that than the other one did.

K: So, what was your experience there like?

G: I think I mentioned that each internship experience was a 40-hour workweek for 11 weeks. Moreover, I was there for a good long while. For the first few weeks, they wanted me to observe and read charts and learn how the program worked. These two counselors were tough

on the kids. I think they scared them—I myself was afraid of them—and yet, I could feel a softer side to both of them.

K: A softer side?

G: Yes. I don't know how I got this idea, but I sensed that some caring came through, as hard as they were on these young clients. It seemed almost like they needed to "hide" their caring so that they weren't taken advantage of by the clients. I might be wrong, but I recall them doubting everything the kids told them and thinking the worst about them. In subsequent years, a couple of counselors I knew called their approach "tough love."

K: But isn't that term used more for holding people accountable for their actions and making them take responsibility for themselves? Ripping on clients and always assuming they are dishonest goes beyond that.

G: As we see it now, yes. But back then, I think counselors believed the harsher approach was what they were supposed to do. And this wasn't only in adolescent treatment, but also with adults.

K: Thankfully, we've moved past that!

G: In most cases, yes. Some veteran counselors still approach clients with a "tough love" attitude.

K: You don't teach that in your program, do you?

G: No, but some of our recovering students talk about it when they got clean and sober in treatment. From what they've said, it sounds to me like they learned to comply with what staff wanted from them. I saw this with the kids who'd been in treatment awhile. They learned by experience what each counselor's approach was. I guess I would say they learned compliance instead of real change, just to get through the treatment program.

K: Okay, so how did this internship go?

G: I don't recall *doing* a lot of things, mainly watching. Sometimes, something to say would come into my head during a one-to-one or group, but I didn't say much—it was hard to get a word in edgewise with these two counselors. We had family groups on Tuesday and Thursday nights, and I liked these much better.

K: Because of your family systems background . . .

G: That, and the fact that the family therapist counseled more like the ways we'd been taught. There wasn't a lot of heavy confrontation, and it seemed that she wanted to make the groups more of a dynamic environment. I liked how she worked with the kids and family members.

K: More respectful?

G: That's what I saw. I learned a lot from those family groups. I saw how often the person in treatment could be more of a "symptom" than the cause of the family problems. There were many other problems in those families: divorces, parental use of alcohol and drugs, extramarital affairs, abuses of all kinds. One of the things I contributed was a lecture on the roles in families with addiction problems. Almost always, people in the group could identify the roles they were playing or those that others had. I think I started to get over my nervousness about doing client education in those groups. I felt more useful on those evenings. I mostly just watched during the day.

K: The two counselors didn't let you do counselor duties?

G: Not so much that I can remember. I did document groups and individual sessions and was told I was way too wordy. That, I think, was true. But I wanted to make sure I put down in the notes all the essential details.

K: What else?

G: I did get my own client later on. My first ever client was a high school senior, a female, from a wealthy and connected family.

K: How did you end up getting a client if the counselors hadn't let you do things a counselor does?

G: I was told that the client had asked to switch to me after a week or so. She wasn't doing well with the female counselor she'd been working with.

K: The client requested an intern instead of regular staff . . .

G: Yes, it was brought up to me in a session that could loosely be called supervision. They asked me if I thought I was ready to take on a client. I wasn't sure, and the counselors told me they weren't sure, but I could give it a try.

K: How exciting!

G: I guess. I was more scared than anything. I think we don't understand the role of a counselor until we get our own clients. Role plays and fictional documentation and case histories can take us only so far.

K: I am curious to know how it went.

G: Part of me wishes I could tell you all about my abysmal failure with her and all that I learned from that, but in all honesty, I can't. I got lucky. We got along well, my counseling "style" (whatever it was then) was helpful, and she successfully completed the program.

K: You were off to a great start! Most people don't have a very successful "first client experience."

G: This is true. Many of our interns run into some tough situations when they start taking clients. They get discouraged, and for some, the problems can be somewhat traumatic. I was fortunate. I've wondered a few times if I'd still be in the profession had the case turned out

differently. As it happened, the client shared many "secrets" and a lot of painful events. She'd been sexually assaulted, for one thing, while intoxicated at a party. There were significant issues in her family related to a stepfather and low self-esteem. I got help with referring her to sexual abuse counseling. Have you done your interning yet, by the way?

K: I start that next term. I know it's grueling, at least that's what my adviser says, so, I wanted to get an early start on my thesis.

G: It can be tough, but there are positive, energizing things that happen too, just as I recounted.

K: I bet the two counselors thought differently about you after the success you had with her.

G: They told me that the client liked me, which meant I wasn't being challenging enough, and that I needed to be careful with boundaries because she might try to manipulate me with her looks and sexuality. I couldn't understand how a client liking the counselor and making good progress (in my view) could be wrong.

K: This sounds like that cynical, negative stuff we were talking about before.

G: Probably, but to be fair, I could see how a client could try to manipulate a counselor, especially an inexperienced one. I just didn't have that sense with this young woman.

K: And she completed treatment?

G: Yes. An interesting thing happened a few years later. My wife and I were in a shopping mall, and this loud female voice shouted my name. It was this former client, and she came up to me, hugged me, and told me all about her recovery and being in college and being engaged to be married. I got that counselor feeling of "Yes!! *This* is why we do it!!"

K: Cool!

G: It was . . . except for my wife's understandable reaction to having a very attractive young woman run up and hug her husband out of the blue. My wife was *not* a happy camper.

K: Oh . . .

G: For whatever reason, the woman didn't tell my wife I'd been her counselor, which put me in an ethical dilemma.

K:You couldn't tell your wife who this young lady was and how you knew her . . .

G: Exactly. Moreover, if I said to my wife something like, "I cannot share with you who she is and how I know her," I would be tacitly violating client confidentiality since my wife knew I couldn't talk about clients.

K: Oh yeah. Not a good situation!

G: Yes. I wasn't sleeping on the couch for the next week, but it was awfully chilly in the apartment, if you get my drift.

K: I think I do. That situation shows a big ethical dilemma for a counselor.

G: A similar greeting happened later on in my career, but that former client identified herself and explained why she hugged me. I learned to tell clients that, if we see one another in public, I cannot behave any differently toward them than any other person and that if I am with someone and they want to greet me, they would need to share the client/counselor connection themselves.

K: I hadn't thought of something like this happening, but I can see the problem for the counselor.

G: Yes, and the former client who developed a therapeutic relationship with the counselor might feel somewhat discounted or blown off by

the counselor's apparent indifference or even coldness. This demeanor wouldn't fit at all what the client experienced with the counselor in treatment.

K: I guess this is a case of laws and regulations making things a little more complicated (long pause). Going back to my thesis, how much would you say your personal background and issues affected your role as an intern?

G: I think my own "stuff" significantly limited me. I was too passive, easily intimidated, scared of making mistakes, and especially afraid that I would become a target for the ire of my mentors if I messed up.

K: That all makes sense to me. How about the positives that came from your personal background? How did it help you?

G: Probably the most important benefit was my understanding of family dynamics and problems related to substance use. I felt most at home in the family groups. I could see some of the concepts we learned in the classroom in real life. Maybe another thing was that I wanted to do this well, so I paid close attention to everything I saw and heard.

K: (Pause) I'm a little hesitant to ask this, and it's not meant to offend you, okay? Would you say that you were competent as a counselor by the end of this internship?

G: (Pauses, thinking) In all honesty, I would say that I was not. There was too much observation and not nearly enough experiential learning in this first internship. I think the match of the mentors and me was not the best one for me and those personality traits I just mentioned. I am not saying they didn't try to be helpful, or that I didn't learn anything from them. My anxiety, fear, and feelings of inadequacy made me a pretty weak student intern at that point. Their aggressiveness was not reassuring to me, and I didn't feel comfortable seeking them out for help or asking to try new things. It's quite possible that they saw me as being not capable, and thus, they didn't get me as involved as they might have.

K: So, this internship wasn't a very good one?

G: I wouldn't say that, necessarily. After all, I did get a very clear sense of what I *didn't* want to do as a substance abuse counselor, and I had my first client success. If we go back to your question of competency, it wasn't an effective placement because I hadn't reached that point, and I think that was as much about me and my flaws as it was the environment.

K: But you had another one, right?

G: Yes, and that turned out much better (pause). Say, could we take a break right now? I'm getting hungry.

K: Sure.

G: So, where are the vending machines on this campus?

End of Session

G: Kathleen, thanks for the tour of the campus and for helping me find the commons. You didn't need to buy me the pastry and soda, but I appreciate it.

K: No problem. Are you ready to go ahead and talk about the second internship?

G: Of course.

K: Tell me a little bit about the surroundings and the kind of program you were at.

G: The second one was at a relatively large and fairly well-known rehabilitation center. It was the place where everyone did one of their internships. Half the class had just finished theirs, and now the other half got to work there.

K: This must have been a pretty big place to have 10 interns at one time!

G: It was big, but I think the class had shrunk a little by that time.

K: Some students decided this wasn't for them?

G: That could be. No one talked about what happened. We did find out that one of the students relapsed in her recovery and needed to go back into treatment.

K: Oh, jeez, how sad!

G: Yes, I liked her and felt terrible about it. Her relapse is one of the reasons I feel so strongly about our students taking care of themselves. I tell the recovering students that recovery must be the priority, and if they are having problems, consult with another instructor or me. I also share with all the students that family matters more than school, and if life at home is very problematic, they may need to let school go for the time being.

K: Both of those "suggestions" you give fit nicely into my thesis, of course. Personal issues are such powerful forces in the counseling profession.

G: That student's relapse and the few students we've had go back to using during training made more concrete the self-care teachings of our own training program.

K: You've had some students relapse while in training too?

G: Yes, and we do all we can to help them. It's just a sad reality that this brain disease is chronic, and that some people do go back to drinking and drugging—even if they are studying to be a counselor.

K: You mentioned that the second internship site was a bigger facility. What else can you tell me about it?

G: The level of what I now call "professionalism" was much higher. Since it was a medical facility, there were doctors and nurses and social workers, and so on there. I think it was more like the multidisciplinary teams of which we speak now. Many more patients were there than in the day treatment setting—I think two of the four floors of the facility were just patient rooms.

K: But it wasn't a hospital?

G: It was called a free-standing, in-patient facility. There was a hospital nearby; I believe detoxification took place there, and then patients were transferred to our facility. There were adults of all ages there for treatment. Most looked reasonably healthy, but some of them were quite ill. My first couple of weeks there were very helpful in seeing what substance use disorders physically do to people.

K: You mean like injuries and things like that?

G: Some patients were healing injuries. Others were yellow from jaundice, very thin from malnutrition, or confused like someone with dementia. Most probably, they got stabilized at the hospital and then came over to us for AODA treatment. The top floor of the facility was, literally, a rehabilitation center with occupational therapists and other health professionals.

K: You said it seemed more "professional." What do you mean?

G: All staff, including us, had name badges and the dress code was more like business casual. It seemed more "business-like" to me, if that makes sense.

K: Sure.

G: This was back in the days of 28-day treatment for everyone, so staff had a month to get to know the patients and work more closely with them. I got a better sense there of how addiction harms all areas of a person's life.

K: It's hard for me to imagine being at a treatment facility for a whole month!

G: I know some patients weren't really pleased about that, especially when they first got there.

K: Denial?

G: Yes, there was plenty of that. Others said they could stay a week and then take care of the problem on their own. Outpatient services were minimal at this time. Oh, and people came to this center from all over the country. Occasionally, we had patients from other countries too. I'll talk about several patients who came from the same monastery overseas a little later.

K: Really? This must have been a very well-known and successful program.

G: It was highly regarded, and I soon learned why the school had every AODA student intern there. I met my mentor and clinical supervisor, who was one of the few AODA counselors there who didn't have a diagnosis. She was calm and pretty cognitive, very articulate, and encouraging. She was just what I needed at that time, and I know now how fortunate I was to have her as my mentor in this second internship.

K: She sounds better than the other two you mentioned before.

G: She was definitely a better "fit" for me than what I had in my first internship. Her counseling style was more laid-back than those I saw in other counselors, and it was very much based on cognition, which, as I brought up before, was my strength. I don't recall seeing her lose her temper or being confrontational with patients. She had piercing blue eyes and a "look," however, when she meant business.

K: My mother has that. We kids called it the "mom look." We knew it was time to stop whatever we were doing (chuckles).

G: Since I was uncomfortable with confrontation and anger, her style was more comfortable for me, and I placed much more trust in her.

K: That makes sense. Now, I can add another facet to my thesis: Since the student or counselor will have mentors and a supervisor, the personal issues of the counselor—and those of the other professionals—can impact that relationship.

G: That's a great point. I wonder how many counselors fail to use supervision as much as they could because there is something about the supervisor to which they react. I know I had one later on with whom I didn't feel comfortable, and I basically avoided supervision.

K: I'm making a note of that point, for sure.

G: You know, the other thing about this counselor at my internship is that her demeanor seemed to fit the family systems idea of differentiation of self. She didn't seem to react emotionally to things that happened and to all kinds of patient presentations. She would get very firm when advocating for one of them, but not emotionally out of control. I think I learned to remain calm and in control from her.

K: It sounds like she made a strong impression on you.

G: Yes, I would place her near to the top of all the counselors I have known as far as ability and professionalism are concerned.

K: Okay, so how did this internship go?

G: I was "nudged" a lot to do things that I'd not done before. I got a lot more feedback, and not just from my primary mentor but from other counselors and staff too.

K: You got to shadow some other counselors as well?

G: Some, but not as much as I think our students are encouraged to do now. I learned the value of the nursing and secretarial staff.

K: How so?

G: Well, they often knew what was going on with individual patients who hid their struggles and feelings from the counselors. They encountered the patients when counseling staff had gone home. I used to listen in on the morning change-of-shift reports every day, even though that meant I had to be there at 7:00 a.m. People usually mean something different than a ward clerk or nursing assistant when they use the term "multidisciplinary."

K: That's a good thing to keep in mind.

G: Yes, I encourage interns to meet with and learn from all employees wherever they are placed. I found out that it helps to be on good terms with the support staff as well as professional staff.

K: They feel well treated and respected, right?

G: Exactly . . .

K: What kinds of new learning did you have at this treatment center?

G: (Pauses) Seeing the idea of a multidisciplinary team approach involving medical personnel was new, of course. Having patients from all over the country, including a few celebrities, was something different for me. I remember when a well-known athlete was admitted to the facility, and there were problems with other patients trying to get autographs from and talking sports with this man. It got to the point where the director of the facility brought everyone into a large community room and brought up the fact that the patient was here for treatment just like everyone else and deserved to focus on himself and his recovery. I don't recall continued problems after that little gathering.

K: That was the right thing to do, as far as I am concerned.

G: Yes, it was. And he presented his directive in a very calm and respectful manner, again, unlike what I'd witnessed previously.

K: What about the day-to-day duties of a counselor?

G: In our program, we teach what we call the "12 core functions of counseling," the main things that counselors need to be able to do competently. Some of them are counseling, case management, consultation, reports and record keeping, and assessment. I was eventually allowed to perform all of those functions, although I didn't ever have a patient of my own there.

K: So, you got more experience by doing than just observing.

G: Indeed. I was highly anxious about every new challenge I was offered, but I guess I did okay. I got an A for that internship.

K: Tell me more about the anxiety, please. I can understand it, and I'm already feeling some of it looking forward to my internship.

G: (Thinking) I have always been a somewhat nervous person, so that aspect of it was predictable. But there was more than that involved. I think from the start, I respected my mentor and badly wanted her approval. I put pressure on myself in that way. I also had a real problem with beating up on myself when I made mistakes, which are inevitable as an intern. I knew that cognitively, of course, but I had the irrational idea that I could do this perfectly the first time.

K: Perfectionism.

G: Yes, to the point where I would back away from trying something if I thought I couldn't do it right immediately. I suspect this is what prevents some people from trying new things. I know it did that for me, and not just as a counselor in training.

K: Do you think that you have missed out on things because of this?

G: Not an open-ended question, Kathleen . . . (smiles)

K: Sorry (laughs). Ummm . . . What kinds of things did that need to do it right the first time prevent you from trying?

G: Everything from asking for a date to not applying for a job. This perfectionism thing stems from my feelings of inadequacy, my shame. If I can do it correctly the first time, I cannot be criticized. If I think I cannot, then I avoid the situation in order not to be shamed.

K: That's still true today?

G: Yes, at times. But one of the things I've learned as a client in counseling is that I am more capable than I think I am and that making mistakes can be okay.

K: I think I'll be running into that during my internship too. I hate making mistakes. Anyway, let's go back to anxiety. You mentioned wanting to get your mentor's approval, your perfectionism, and wanting not to make mistakes. What else?

G: I had almost no confidence that I could do this, even though I got excellent grades in classes. Everyone I saw seemed highly skilled and sure of themselves. Almost everyone there was in a recovery program. I was both intimidated by and in awe of this. How could I measure up to that?

K: That seems like it would be a common problem for interns.

G: It is. And I didn't want others to see how incapable I was.

K: All of this is important to me. Not only does it confirm parts of my thesis, but I can relate to them personally (pauses). But this is about you and not about me.

G: Of course, it is good that you identify these things. Part of what I am trying to do by sharing my experiences with our students is to, in

a sense, "normalize" what they go through. After years of doing this, I realized that our interns have no reference points for what is a usual occurrence or "normal" feelings. They have nothing to which they can compare their experiences. So, I try to give them some (pauses). I understand your hint just then. Moving right along . . .

G: I have some anecdotes I will share with you and the lessons I learned from these experiences. Maybe that will give you a better idea of the ongoing learning process at this internship.

K: Sure. I'd like to hear some of those.

G: There was a novelist in our group who was very, very intellectual. He was uncomfortable with feelings and made this quite clear to everyone. He had been there a long while, I remember, and a new group member was asking about how the treatment works. This writer told him that the treatment is about "floating and dumping." When asked for clarification, he said that he had learned to float along with the program and to dump all the "crap" behind him as he went.

K: That's an interesting way to describe it.

G: I thought so too. It seems simple, but it's not. I believe what he was saying is that patients need to go along with the process of treatment instead of fighting it, like trying to swim against the current, and opening up all of the pain and hurtful things they'd been through.

K: Obviously, that's an oversimplification.

G: Sure, it is. But in a big picture sense, "floating and dumping" is great advice. I think any counselor would appreciate clients who go along with the process, apply themselves to it, and open up all the doors to their pain.

K: Yes, I can't argue with that.

G: I might have mentioned earlier the slogan "trust the process," used by a couple of our former faculty.

K: I'm not sure… I think so.

G: I believe this writer introduced me to that concept. Well, not in so many words, but "floating" suggests a calm and relaxed state of being, something that we can achieve more effectively by having trust and faith. Anyway, that phrase has stuck with me all these years, and I shared it with clients when it seemed useful.

K: Addicts don't trust, and many of them have lost faith . . .

G: Yes, indeed. Those two states of being might find their way into a treatment plan now and then, eh? (smiles) How about I tell you one more, and then let's call it a day?

K: Sure. It's getting a little late anyway.

G: Earlier, I mentioned the patients we got from an overseas monastery.

K: Yes . . .

G: There were three of them who had treatment during the time I was there. One of them was in our group, and he was one of the most interesting clients I've ever had. All three of these guys were very large, overweight, and very funny. They loved to laugh. This patient was no exception. Apparently, the members of this order made wine, and this created major problems.

K: They drank too much.

G: At least some of them did, and this led to the referrals to our facility. I was meeting with this patient in a one-to-one, and he shared with me that the order to which he belonged insisted on vows of chastity for each member.

K: Chastity, as in no sex?

G: Correct. His was an all-male order, so the chastity vows wouldn't be a huge challenge, right?

K: (Pauses) Were some of these monks or whatever gay?

G: Nailed it! Yes, there was a relatively high percentage of the "friars," as I called them, who were homosexual. Our patient was one of them.

K: So, some of the members of the order were gay, and they had taken vows of no sex, and they drank a lot of wine . . .

G: Precisely . . .

K: Wow.

G: All the makings of drunken debauchery were there, yes? This was the big problem in the order, and the three friars were the first ones required to get substance abuse treatment.

K: (Exhales slowly) Who would imagine that this kind of problem would exist?

G: I certainly didn't, as naïve as I was. Anyway, he shared with me that he was gay and that he had joined the order because of the vows of chastity.

K: (Puzzled) Why would he do that?

G: Because he believed that homosexual behavior is sinful, according to his reference, the Bible, and he wanted to prevent himself from sinning in that way. He shared that he believed he as a homosexual person, was not "bad," and that the Deity loved him, but that expressing himself sexually was not acceptable. There was a lot of guilt and what I would now identify as shame in what he was saying.

K: (Somewhat angrily) But that's ridiculous! Just based on a book of mythology? Why should he have had to deny part of who he was?

G: Well, those were his beliefs, and he wished to abide by them.

K: Well, you tried to explain to him that being gay was not his choice and that he shouldn't feel guilty or ashamed about his sexuality, right?

G: That is certainly one way to approach the situation . . .

K: (Tersely) How else?

G: I'm assuming that you've learned that counselors should take clients where they are at, right?

K: Of course, what's your point?

G: Well, if this patient sincerely believed that same-sex intimacy was sinful and chose to abstain from that behavior, is it my role to try to change that?

K: But his beliefs are based not on science but on a collection of stories with no validation!

G: From a prevalent twenty-first-century viewpoint, but that was not his.

K: So, what did you do, then?

G: Well, clearly, I had very little insight into the sexual preference issue, as new as I was to the profession. I didn't know enough about his faith system to be helpful there, so I talked with my mentor, and she suggested that I speak to him about a referral to our chaplain to deal with those aspects of things.

K: Okay, that makes sense.

G: We agreed that my focus as a substance abuse counselor should be on the role his drinking played in causing him to violate his vows, as one example of how out of control it was.

K: But he was feeling bad for no good reason . . .

G: The spiritual element we left to the chaplain. From the patient's point of view, his drinking led to behavior he would not have done sober, and that's where addiction comes in. Under the influence, he violated his value system, and that's what mattered to us as AODA counselors.

K: It just doesn't seem right to me.

G: I heard that loud and clear, yes, and it sounds like you might have chosen a different course. Thus, my learning from this experience was the ethical dilemma that occurs when a client believes something that we, as counselors, might reject entirely. To what extent may we try to influence, persuade, or modify a client's values and beliefs? Another example might be cultural. Suppose you have a client whose cultural role for women is to care for children, the household, and her husband. Your own values about women and what they may do with their lives is quite different, let's say. How do you handle that? How far would you go with trying to present an alternative worldview? How far could you go before it became a case of values imposition?

K: Okay (heavy sigh). I see where you're going, but I feel awful for that patient.

G: I totally understand that. He was a very nice guy. In all honesty, I didn't have the ethical insights then that I do now. I was too inexperienced. My focus was on his AODA treatment. As for your reaction, I am sure that if this anecdote makes its way into a book I might write, at least some of the readers will react as you did.

K: I would hope so!

G: Along that line, may I ask about your very strong reaction to the friar's spiritual beliefs and his choice to abstain from sex?

K: (Long, heavy pause) Well, I don't usually tell people this, but

my brother is gay, and he has been so hurt by religious nuts who try to condemn him. It's been painful to watch what he has gone through. He even tried suicide once, it got so bad.

G: I am sorry, Kathleen. I didn't mean to open up something painful. It's just that your reaction was so strong.

K: I know you didn't (pauses). I think I need to be done with this today.

G: Of course. Let me know when you want to continue, okay?

L: I will.

End of Session

K: I apologize for the delay in setting up this next section of the interviewing. I spent some time talking to my adviser about my reaction to your "friar" story last time. She listened to me babble on for quite a while and then asked me what I thought happened. I replied that I had a lot of feelings about people who are gay, religious people, and my brother's history.

G: What did she say?

K: She said that there were three points of countertransference I experienced. One was my feelings about my brother. One was a strong bias against organized religion. Then she added one I hadn't thought of: the possibility that I could lose objectivity when working with gay people and start to take care of them because of what happened to my brother.

G: Now, that's interesting . . .

K: She also agreed with your point about not imposing our

values on our clients, even if we seriously disagree with them. She added that we may provide feedback about something like that, but that it is not our right or responsibility to change their belief systems.

G: This adviser sounds like a good counselor.

K: Well, she is, but not for me. I was referred to a counselor on campus to work on some of that.

G: Bravo! I'll assume that you will follow this recommendation (smiles).

K: How ironic . . . Here I am, gathering information about the influence of a counselor's personal life and issues on her development and growth, and I walk right into a real example in my own life.

G: One of my former students once said that he thought he understood countertransference until he actually experienced it during his internship.

K: Yeah, there's nothing quite like in vivo experiential learning (laughs).

G: So, are you ready for a few more anecdotes?

K: Any guarantee I won't react to them? (smiles)

G: Nope, but they are illustrative.

K: Go ahead.

G: Well, toward the middle of the placement, I was in a large family group. All the patients in our group and whichever family members came for the Family Week were there, as well as a family therapist, my mentor/supervisor, and me. I know I mentioned my struggles with groups and also that I was uncomfortable with confrontational situations, right?

K: Yes, you did.

G: Well, one of the patients was a female whose drug of choice was cocaine. Her father had come from a southern state to do the Family Week. He was a living stereotype, really: tall, loud, intimidating, and likely very wealthy. He came to the group dressed in big cowboy boots, what they called a "ten-gallon hat," a gaudy belt buckle, and a pronounced drawl.

K: I bet I can guess which state.

G: Most likely, your thoughts are correct. Anyway, it was his turn to share his feelings assignment with his daughter, and he went on a rant about how she had disappointed him. He'd paid for college for her, bailed her out of jail however many times, covered all of her fines, and sent her who knows how much money. And now, what he had was a drug-addicted daughter.

K: It sounds like he really laid into her.

G: Yes. In a booming voice that probably stunned half the group. I don't know what came over me, but there was a heavy silence, and I said to him, "Sir, the money you're sending her is not helping her. She is tooting it up her nose. You need to stop that."

K: Oh, my . . .

G: I'll never forget how red his face got. I think he was going to go after me then, but his daughter told him that I was right and that she had been doing precisely that. She added that this is the kind of behavior addicts do, using people in whatever way they can, and that she was a cocaine addict who wanted to stop.

K: She kind of saved you, eh?

G: Probably, because I likely had no idea of where to go with this. I don't recall exactly, but I think the family therapist took over at that

point. I looked over at my mentor. She had been watching me. All she did was smile slightly and nod her head once. "You got it, kid!"

K: That must have felt great.

G: I don't recall anything more about that day. I think I was in a state of euphoria or something. In that one little scene, I spoke up in a big group and challenged a very intimidating and angry man. I thought about this on the way over here. There was actually more growth and learning than that even. First of all, I was exactly correct and shared feedback that was spot-on accurate. Without intending to, I helped the patient share part of her addiction and reveal that she accepted she had a problem with cocaine. I also got a note of approval from the woman I respected so much. I think it was on that day that I realized that I *could* do this.

K: True!

G: Looking back, although at the time I did not realize it, I discovered that the best way to overcome feelings of inadequacy is experientially doing something that shows adequacy and competence. This has evolved into some philosophy about healing guilt and shame. I'll get into that later.

K: I can see why this was such a big event for you as an intern.

G: It was, and I can recall it like it happened yesterday.

K: You have others? Stories, I mean?

G: Yes, but are you sure this isn't too much?

K: Not at all. I'm looking forward to something like that happening in my internship.

G: Okay, if you're sure. This next one is about learning humility.

K: Cool.

G: One day, there was a community group first thing in the morning, and one of the patients was being discharged. There was a little ceremony involving her group but also all the patients because staff had been told that her "sharing talk" was going to be special.

K: "Sharing talk"?

G: Yes, at the end of the ceremony, the patient who was graduating would give a little speech about where s/he was at entering treatment, how things went, and what plans s/he had for the future. Most of the time, people said pretty much the same things, but it was nice to witness these anyway.

K: And this patient's "sharing talk" was going to be special?

G: Yes, she was a professional singer who had done background vocals for several well-known artists. She had written a song as her sharing talk and sang it while playing her guitar.

K: Oh, wow.

G: It was amazing. Her voice was beautiful, and the song and lyrics were great. Many people had tears in their eyes when she finished.

K: Forgive me for asking, but what does this have to do with your learning humility?

G: The humility comes in when I tell you that after a 15-minute break, I was scheduled to present an education piece on honesty and how it's needed in recovery.

K: Oooooh. I get it. Who would be interested in your lecture after that?

G: Exactly! I did the best I could—after getting sick in the bathroom during the break—but there wasn't much interest in a didactic presentation after her sharing talk.

K: You got sick?

G: Nervousness. I was speaking to the entire treatment population and many staff.

K: That would do it.

G: So, I learned that as great as my material might be, as well as I prepared, as interesting as I make it, the audience may not appreciate what I'm trying to do. That's humbling. It happens in classes too (laughs).

K: But you didn't have a fair chance at it after that singer said goodbye.

G: I know. I felt disappointed that most people didn't seem interested, but one of the staff came up to me and said something like, "You did a good job. No one could've held their interest after that song." It was true, but I felt like a failure. Later in the day, a counselor asked me if I knew the guy who came up afterward and tried to reassure me. I didn't. He told me that he was the director of the facility, whom I'd never seen before.

K: Whoa!

G: I guess he knew I was an intern and wanted to encourage me. After learning who he was, I was grateful that he did that. His kindness took away some of my shameful feelings. So, I learned some humility that day.

K: Interns need a lot of encouragement and not just critical feedback.

G: Exactly! I was beating myself up about the lecture because of my perfectionism, and I needed that. I need to add, however, that shame is such a powerfully embedded feeling and sense of self that it takes many more successful events to banish it from within ourselves slowly.

K: You bring that feeling up a lot. I assume it's a part of your counseling "style," for lack of a better word.

G: Indeed, it is. But I didn't realize it until later. I promise we'll get to it.

K: I've read a couple of books about it, and I think we can link shame to trauma-based care, so I find the whole idea interesting.

G: How about I share with you another client situation that taught me about how family systems work and how physical abuse brings about shame?

K: Okay. I guess . . .

G: What's wrong?

K: I'm a little hesitant about the abuse thing. It's not about child abuse, is it?

G: Yes, it is. If you want, I'll skip it and talk about the last event I have in mind for today.

K: No, I'll be okay.

G: Alright. My mentor was working on her master's degree during this time, and she needed to produce a kind of research study to finish—she called it a "colloquium," as I recall. We had a patient who was a very "tough guy" on the outside, heavyset, beard, kind of the stereotypical "biker" type of man. I had worked with him some and knew that he was more sensitive and emotional than he let on, but this is how he presented to the world: gruff, profane, intimidating . . . a real "lone wolf."

K: Sure, kind of a scary guy when you first meet him.

G: Definitely. Anyway, he came from a large family, and during Family Week, my mentor arranged to have about six of his siblings and he meet together for a discussion about their family as they recalled it and also how they were parented. My job was to use a video recording

camera to tape the entire session as part of the project. I thought that was kind of a nice honor for me, and I wanted to do a good job.

K: Of course. Had he been in close contact with his brothers and sisters?

G: Five brothers and one sister came; our patient had burned bridges with other family members. There was about a 20-year span of age between the oldest and the patient. I don't recall how long this went on once we began, but I learned a ton from it. There was such a difference in the family dynamics between what the oldest recalled and what our patient remembered. You would have sworn they grew up in different families.

K: Was that due to the difference in the progression of addiction, by any chance?

G: Part of it was that, definitely. But there was so much more at work: birth order, favoritism and scapegoating, subsystems, everything. The video was like a study of all the family systems dynamics I'd learned. What was unnerving, though, to get to the main point, was how our patient's siblings discounted his perceptions and accused him of trying to ruin the memory of their parents. The oldest started it, and everyone more or less "piled on" him with shaming and blame and accusations of making things up. As things heated up, my mentor calmly ended the session and thanked everyone for coming. The brothers and sister left in a rather agitated state.

K: So, you saw how much emotion was pent up in all these people. How did the patient react to the accusations they were making?

G: He tried to stay calm, but I could tell he was getting increasingly upset. Within a few minutes after their departure, he looked very sad and had tears in his eyes.

K: Oh my goodness. His tough exterior was cracking.

G. He was feeling a lot, and my mentor asked if he wanted to share what was going on. The patient recounted an incident with his father when he was a little boy. He claimed that a couple of siblings witnessed it, but the way they were attacking him, he just kept quiet. Anyway, allegedly, his father got down on his knees and held out his arms for the patient as a little boy to run into his arms for a hug. And he did so. Dad promptly threw him over his head into the wall, walked over to him, and reportedly said, "Don't you ever trust anyone in this damned world. Not even me!"

K: (Gasps) Oh my God!

G: I watched my mentor gradually and gently help him stop the sobbing he was experiencing, tears in her own eyes, and she did what I consider a masterful job of just being there, as we say, for him.

K: How could any parent do such a thing?? This wasn't just child abuse; this was a setup that could've seriously injured or even killed that little boy!

G: Absolutely. The brutality of this action blew me away, and I couldn't say anything. My mentor looked at me a few times, more or less saying, "Yes, Greg, this is the kind of thing our patients go through." What surprised me most was that after he "put himself back together," so to speak, he hugged each of us and said he'd never told that story to anyone, and that he'd never trusted anyone until that moment when he shared it with us.

K: (Slightly stunned look on her face) I don't even know what to say right now. As you described it, I tried to picture what happened in my head. I don't know what to say. I think I need a quick break.

G: For sure.

(Pause)

K: I'm sorry about that. I just needed to gather myself a little after that. I hate child abuse in any form, and that story is just cruel (pauses). How can a father do that to his son?

G: I think we both know that this kind of violence was most likely inflicted on the father, perhaps even under similar circumstances. It's hard for me to understand it more than just cognitively, and at the time, I was kind of stunned.

K: Was this patient's dad an addict too?

G: From what I can recall of this incident, he most likely was. There were addiction and violence and sexual abuse throughout the family.

K: (Head shaking) It's just unreal that someone would do that. No wonder this patient nearly drank and drugged himself to death. His own father, the person to trust above anyone else . . .

G: Yes, Kathleen. My mentor and I had a debriefing about it afterward. What amazes me now looking back is how unemotional I was throughout this. I was still so "up in my head," we might say, that any emotional reaction to this or even empathy (since I've been physically abused too) was just blocked. To me, that was normal, but for most people, there would have been a wide range of emotions, hearing and witnessing this. I didn't recognize it at the time, but this "coldness" was how far removed from my own feelings I was.

K: But that allowed you not to get "fused" into the situation, right? On the positive side of things, I mean.

G: It did, but feeling nothing is too far to the other extreme. As I mentioned, even my mentor, as experienced as she was, had tears. It took me many years to learn that I needed both intellect and feelings.

K: Alright. I think I've had enough of that one. What else did you learn in this internship?

G: I don't have more stories, but I know that I learned that men also develop eating disorders, and that small children and their honesty can often break down a client's barriers better that professional counselors can, and that professionals should always treat all workers at a treatment facility with respect. The adage about all work having importance is very accurate in the helping professions too. I already mentioned that I learned to listen to the morning "report" of the third-shift nursing staff to the first shift because they saw the patients in a different light when counselors weren't around. I also discovered that ward clerks and secretaries knew how to get things done, and I often needed their help, so I made it a point to get to know and to value them as well.

K: I've heard about professional egos and arrogance on the part of doctors and other professionals, so that seems like a good idea.

G: Yes, that can be true. But I had good role modeling too from some of the counselors there. They made a point to ask the floor staff what they encountered with patients after the counseling staff left for the day. Say, you just brought to mind my very last day at this internship . . .

K: What happened?

G: My mentor had the idea that she would take the day off on my last day there, and I would be in charge of that Friday. As that time drew closer, we planned the whole day and let other staff know I was on my own, so to speak. We didn't tell the patients, to make it as real as possible, and in the morning group, I told them that the other counselor wasn't able to make it in.

K: I guess I can understand why you didn't tell them ahead of time.

G: They knew it was my last day but not that I would be handling the job "solo." I have to say that it went better than my catastrophic mind thought it would. I think I did two groups, one individual session, a family collateral contact, and took care of all the paperwork I needed to. I wanted my mentor to come in on Monday and see that everything was in order. I did my best.

K: And was she pleased?

G: We had lunch a couple of weeks later, and she said I did okay. She asked me if anything "interesting" happened that last day.

K: She wanted to see if you handled anything out of the ordinary?

G: No, she was checking to see if how she set me up worked (smiles). It turned out that she had asked one of the nurses to give the "senior" patient a graduation medallion that they all gave me in the afternoon group. I had no idea that was coming. Each patient took a turn holding the medallion and wishing me well and sharing what they thought of me as a counselor. I sensed something when two of the nurses joined the group but thought maybe they were checking up on me. The patients said some very nice things. Some of it felt sincere, and some were just going through the motions because they were expected to say something, but that was okay.

K: Wow, that's very special. Do you still have the medallion?

G: I think I put it in a little metal box, but now I can't find that. It was a special day, and I felt then that I really was a substance use disorder counselor.

End of Session