Classic Practices in Addiction Counseling

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Disclaimer. Nothing in this document should be taken or held as clinical instruction, clinical supervision, or advisory concerning patient care.

To the reader. Some of the material in this monograph was previously published as individual posts at *Recovery Review*.

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A Key Question

My clinical graduate internship was in a residential addiction treatment program from 1988-1989. And I started my first job as an addiction counselor in 1989. What clinical methods were addiction counselors using back then? And which, if any, of those methods are worth preserving now? This work attempts to answer those questions by reviewing some of what was taught to me back in the late 1980s by addiction counselors that came before. In doing so, the monograph will briefly introduce some things we addiction counselors did **before:**

- Sublocade was approved by the FDA for treatment of opioid use disorder in 2017,
- *DSM-5* was published in 2013,
- *Motivational Interviewing in Groups* was published in 2012,
- Vivitrol was approved by the FDA for treatment of opioid use disorder in 2010,
- broad dissemination of the Community Reinforcement Approach (CRA/CRAFT),
- the first pilot efficacy trial of mindfulness-based relapse prevention in 2009,
- development of Seeking Safety in 2002,
- Subutex and Suboxone (buprenorphine) were approved by the FDA in 2002 for treatment of opioid use disorders,
- invention of recovery coaching in the early 2000s,
- Ken Minkoff's 2001 guideline for medication management of co-occurring disorders,
- publication of the classic Acceptance and Commitment Therapy (ACT) text in 1999,
- dissemination of the Matrix Model in the late 1990s,
- publication of the Project MATCH results in 1997,
- Gorski's Relapse Prevention Therapy workbook in 1995,
- *DSM-IV* was published in 1994,
- oral naltrexone was approved for treatment of alcohol use disorders in 1994,
- the Cognitive-Behavioral Coping Skills manual published in 1994 for project MATCH,
- early dissemination of Acceptance and Commitment Therapy (ACT) in the mid-1990s.
- Motivational Enhancement Therapy (MET) in 1993,
- TIP 1 *State Methadone Treatment Guidelines* and TIP 2 *Pregnant Substance-Using Women* were published by CSAT in 1993,
- publication of the Global Appraisal of Individual Needs (GAIN) in 1993,
- publication of the Twelve Step Facilitation (TSF) manual in 1992 for project MATCH,
- the law that formed SAMHSA was passed in 1992,
- publication of the Addiction Severity Index (ASI) in 1992,
- publication of Miller and Rollnick's book *Motivational Interviewing* in 1991,
- NIDA's "Decade of the Brain" from 1990-1999,
- dissemination of Prochaska and DiClemente's model of change published in 1986,
- initial publication of urge surfing in 1985,
- and dissemination of Marlatt's Relapse Prevention Therapy from 1985.

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Part 1: Four Actions to Take Each Day (Micro-Level Baseline)

There's a classic practice in addiction counseling that I've seen implemented for decades but have never seen written up in the clinical-applied literature, practice guidelines, research studies, or anywhere else I can think of.

Here it is. Educate the person with chronic, severe, and complex addiction illness, during the active treatment phase of their care, on the value of doing each of these each day:

- **Read** in the literature from their chosen support pathway.
- **Talk with someone** who has what they want.
- **Do** some kind of behavioral activity that develops a spiritual connection or spiritual capacity.
- **Check yourself** at the end of the evening (how you did during your day) and set a plan for tomorrow.

As I consider those, the following things come to mind:

> **Reading** gets *outside input*, and the content gets in through the *intellect/cognition*. And it can be done privately.
>
> **Talking** with someone gets *outside input,* but it's also a *transactional* back-and-forth method. The material gets in through *human transaction* and *mirroring*.
>
> **Practicing** the types of behaviors that develop spiritual connection helps to "strike while the iron's cold" That's a whole different kind of practice from trying these behaviors for the very first time on our worst day. These behaviors can be done *privately* and some versions can be done *in real time*. Sometimes this is experienced as *dumping something and getting relief*, and at other times it's experienced as *gaining something* quite particular.
>
> **Reviewing** the day and setting a plan for tomorrow sets up *improved self-awareness* over time. Eventually, the circular model of this activity (review, revise, do; review, revise, do; and so on) gets internalized and people start *adjusting in the moment* rather than adjusting for tomorrow very late in the day today.

Having grown up for my first 19 years simultaneously in a long-term residential (Therapeutic Community) program and an outpatient Methadone Maintenance program, I have seen first-hand the giant impact of doing these 4 things on a single day. And an even bigger impact from doing them daily for weeks, months, or even longer.

One thing I've always liked about these 4 things is that they're independent of any chosen pathway of personal improvement. And by nature, they're super-adaptable.

Another thing I've always thought was super important about these is that taken together they're a self-efficacy building way of driving one's own personal improvement. Doing these for just one day is far less daunting than imagining doing well every day from now until you're 90 years

old. And such a daily regimen really imparts the basic idea and method of “Illness Self-Management”.

Why something like this (that’s so practical, behavioral, individualizable by the person served, and foundational) has not been written up in the professional literature (to the best of my knowledge) I’ll never understand.

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Part 2: The Concept of "Mental Relapse" (Meso-Level Threat Monitoring)

During my first two and a half decades working in addiction treatment, I was surrounded by the term *mental relapse*.

Let's talk about that term.

What is mental relapse? How is it defined?
For starters, mental relapse identifies relapse as a **process**, not an event. It's the process that begins and continues before using resumes.

To be clear, mental relapse occurs while someone is managing their recovery. It's not the set of events or processes that occur during periods of abstinence within the active phase of addiction illness. And so, being in recovery is part of the inclusion criteria for mental relapse to apply.

Mental relapse can be described as a *pattern* consisting of two things: a relatively long, slow
1. degradation of recovery, and the
2. return of symptoms.

Degradation of recovery refers to a diminishment of wellbeing indicators and self-care–related activities. Return of symptoms refers to an increase in problem indicators—the gradual return of active illness. These two patterns can occur simultaneously or in any order.

Does mental relapse always end in using?
The process of mental relapse *might* end in using. Or it might not.

In that way, *mental relapse* differentiates a return to using from the return of *other aspects* of the illness that re-emerge before using occurs.

The patterns of the mental relapse process tend to be common across people, while the signals also tend to be specific to each stage in the process.

By learning the signs and routinely self-inventorying against them, patients can gradually clarify their individual relapse signature. That awareness can be strengthened further by incorporating personal identifiers drawn from feedback from peers and addiction counselors on the treatment team.

Learning to refine this list over time—and doing a daily self-check against a personalized version of it—is empowering.

Ultimately, the ongoing clarification of personal identifiers and daily inventorying of them supports self-efficacy.

How so?

Over time, the personal signs of mental relapse can come to be experienced as ego-alien and ego-dystonic. When that happens, and the process begins to emerge, the patient can name their mental relapse in group and "tell on the disease." Doing so greatly reduces its power.

In recent years, well-meaning advocates and critics alike have argued that *recovery* has a single objective identifier: abstinence. And that *relapse* has a single objective identifier: return to use.

Both of these perspectives flatten the recovery lifestyle out of its meaning and reduce relapse to a using event devoid of antecedents. In that worldview, *mental relapse* disappears—the idea, the language, and the utility.

For decades, there were several common ways these ideas and practices were used.

One was the positive reinforcement of detecting any signs of mental relapse, even before the broader process seemed to have fully awakened. This could take on a fun, almost gamified quality—comparing one's own awareness to that of counselors and peers.

Another was the enjoyment, relief, and even humor involved in diverting off the mental relapse process, and back into a fuller recovery dynamic, by telling on it. This often enriches the content of therapy and benefits other group members as well.

A third use encoded recovery principles through a repeated script, role play, or similar enactment, such as:

> **Counselor:** "Are you in mental relapse?"
> **Patient:** "No, I'm not."
>
> Which gradually transforms into:
>
> **Counselor:** "Are you in mental relapse?"
> **Patient:** "Let me go ask my peers. I'll be back."

Patients were often coached to ask one or two peers they felt closest to—and one or two who disliked them the most. The range of material gathered through that exercise is pure power.

As one of my clinical supervisors once told me, *"If they take away our terms, they also take away our ability to think about what those terms mean."*

I personally can't remember the last time I saw a CE training offered on this topic or term. Our field is losing the concept of *mental relapse*.

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Part 3: Checking the "We" (Macro-Level Group Culture)

There's a classic practice in addiction counseling I first saw in the late 1980s.

But I've never seen it written up. Not in the clinical-applied literature, practice guidelines, research studies, or anywhere else I can think of.

I ran a weekly group for years in our 9-12 month residential program according to what's described below. The group was held on Fridays. The effects of the group were very significant.

Here it is. Have the group members get together and check how the group is doing as a whole.

Typically, in my experience, this doesn't come naturally for anyone.

It may sound simple. But doing it isn't natural. And it's not easy at first for almost anyone to do.

The Intent
To meet the intent, a counselor will typically have to do some education for the group members. And then guide the process as the group moves along.

The counselor's guidance can include asking questions and having the group respond. Here are some examples of the kinds of questions that can help clarify the intent.

- How are "we" doing as a group?
- What are some indicators of health or recovery – at the level of us as a whole group?
- What are some indicators of problems or concerns – at the level of us as a group?
- Over the last several weeks or days, what direction are we heading in – as a group?
- In the weeks ahead, what can we do to help improve the feel and direction of the group?

During the Process
During the group process no one particular person should be mentioned at all. Not by naming them. And not by saying anything that clearly points them out even without using their name. Also, nothing should point out a small group of individuals within the larger group.

Why not?

Because we are talking about how the group is doing as a group. We are not talking about how any individual members are doing.

The idea is to check the function and vibe and atmosphere of the group, as a group.

How are "we" doing?

How is the "we", the collective as a whole, doing?

Are we moving in the right direction?

What can we as individuals do, or take responsibility for, that will help the group improve even more as a group?

Learning to take the inventory of the group as a whole is a stretch for some. It can seem too abstract initially for some people to "get it". That's ok. Just stay at it, and the newer members will come along and eventually improve in this skill.

As I reflect on this, various things come to mind:

- Individual recovery depends on group unity.
- Our "street sense" can work for us.
- We can connect to our intuition, and give it a voice.
- We can build the culture and the climate around us.
- Thinking about our thinking.
- Thinking about our thinking – at the level of the group.
- We can learn to take an inventory.

And lastly, I especially think about self-efficacy in building one's own (shared) ecology.

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Part 4: Mutual Aid Pathways (Macro Community Pathways)

I built a list of some addiction-related mutual-aid groups to use as an easy reference.

I wanted it to reflect variety across various domains: primary substance(s), abstinence, moderation, medication status, the presence of co-occurring mental disorders, gender, cultures, agnosticism/atheism, family members, etc.

And I wanted it to be a start, rather than try to make it exhaustive.

In case the reader didn't know, for the LGBTQIA+ community, one can look up and use search terms such as Lambda meetings or LGBTQ meetings as a part of the service structure of, for example, AA or NA. That's a way to find those specific meetings.

Here's the list I've built thus far.

AA Agnostica https://aaagnostica.org/	Medication-Assisted Recovery Anonymous https://www.mara-international.org/
Alcoholics Anonymous https://www.aa.org/	Moderation Management https://moderation.org/
Celebrate Recovery https://celebraterecovery.com/	Narcotics Anonymous https://na.org/
Cocaine Anonymous https://ca.org/	Nicotine Anonymous https://nicotine-anonymous.org/
Congress 60 https://www.congress60.org/EnUs/Congress-60-Human-Revivification-Society-The-Addiction-Treatment	Recovery Dharma https://recoverydharma.org/
Crystal Meth Anonymous https://www.crystalmeth.org/	Sex Addicts Anonymous https://saa-recovery.org/
Drug Addicts Anonymous https://daausa.org/	Sex and Love Addicts Anonymous https://slaafws.org/
Dual Diagnosis Anonymous https://ddainc.org/online-dda-meetings/	SMART Recovery https://smartrecovery.org/
Dual Recovery Anonymous https://draonline.org/	White Bison https://whitebison.org/
Gamblers Anonymous https://gamblersanonymous.org/	Women For Sobriety https://womenforsobriety.org/
Heroin Anonymous https://heroinanonymous.org/	Adult Children of Alcoholics and Dysfunctional Families https://adultchildren.org/
Ketamine Anonymous https://ketamine-anonymous.com/	Al-Anon Family Groups/Alateen https://al-anon.org/
LifeRing Secular Recovery https://lifering.org/meeting-menu/online-meetings/	Co-Dependents Anonymous https://coda.org/
Marijuana Anonymous https://marijuana-anonymous.org/	Nar-Anon Family Groups https://www.nar-anon.org/

Back in the early 1990s, we would send people in Phase 2 of their 3-phase residential treatment up to the AA Intergroup office. This would happen after the "therapeutic day" and before dinner. Having an hour or two to go for a walk was rewarding on its own. But the intent was for the person to come to learn what a "meeting list" was. And what "Intergroup" was. And to become aware of the vast array of home groups available in the city. And how they differed by location, gender, meeting type (such as open/closed, literature study, etc.) and other differences. The essence of the assignment was to go up to the Intergroup office, with the opportunity to stop in a store or two along the way and pick up a snack if they wanted to, and bring back two of the most updated meeting lists: one for themselves, and one for me to have to help others.

But by going to the Intergroup office a few blocks up the hill from our treatment program, during regular business hours, on certain days of the week, *we knew* they were going to meet "Jane" (her name has been changed here for the sake of privacy).

She had been volunteering (I guess volunteering) on the desk at Intergroup for years and years. She had a keen working knowledge of most of the home groups, who did core service in each one, and how to get a ride to a meeting from some of the best people ever, in the safest way ever. She had a contagious kind of recovery. And she had a well-being that was better than well. She was easy-going and clear in her thinking and communication. And had a practical, down-home quality

We always learned a lot about any patient when they came back from their day pass out of the house to go up to Intergroup. It was absolutely not uncommon for someone to come back and talk about Intergroup and Jane for a half an hour or more.

What an amazing person she was.

And it was not uncommon for someone to begin to give a number of various club houses a try, on various days and times. And to find their people and settle in. Or to get energized about getting into the literature. And to ask for another day-pass to go up and meet with Jane again.

And now, we jump ahead to 2026. As follows:

- Patient: "I don't need to go to the Intergroup office. I can download the meeting list."

If it was up to me, we would preserve these living elements of our work as addiction counselors, and have real people build living connections to real living people in the personally present recovery community.

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Part 5: Recovery-Oriented Methadone Maintenance (Systemic Delivery)

Our methadone maintenance program began operation in either 1968 or 1969. I was told a first-hand story of its founding, but don't remember the year. (By the way, the first journal article describing methadone maintenance as a clinical practice was published in 1965, so those were some "early adopters" indeed).

When I began work in the 12-month residential drug-free therapeutic community in 1989, the methadone maintenance program was operated in the first few offices in the front of that residential program. And the two programs shared the same nursing and counseling staff.

Believe it or not but when I started there the first nurse (RN) approved by the State to dispense methadone (who began work in 68/69), was still working in that program. And more amazingly, she continued to work there for at least my first decade working in that program.

Upon my arrival in 1989, our methadone maintenance program practices included:

- Patient limit of 50 total people on the program.
- No minimum or maximum dose limit.
- No minimum or maximum time on the program.
- 7-day RN coverage on-site, 365 days per year, providing medication dispensing.
- Phase system based on developmental milestones of improvement (stabilization, diminishment of clinically relevant problems, gains in practical life goals, sustainability of improved quality of life, etc.).
- Use of substances other than opioids was addressed according to clinical relevance (e.g. a moderate to severe problem in its own right; or use of a substance class that was not another use disorder, but represented a general relapse process; or seemingly no real relevance at all).

Later in my time there, our agency undertook a multi-year (1998-2007) change-project across the dozens of programs in our organization. That effort was called the Behavioral Health Recovery Management (BHRM) Project. We used the BHRM Principles to direct specific changes. At other times we would pick a Principle and use that Principle as a goal toward which we would make many changes at once or in a row.

During those years we made vast changes to policies and procedures at both the organizational and program levels. We went as far as wholesale elimination of the entire clinical guts of some programs and total replacement of their methods with new practices.

For the methadone maintenance program, we adopted changes that included:

- Budgeting 10-15 blood draws per year. We did these to check the circulating methadone level both one hour before and four hours after, one dose. We used these levels to see if the patient's body was metabolizing the medication properly (rather than us not believing the patient that their medication was not "holding" them).
- Viewing an addiction to another drug class (like alcohol, for example) as a co-occurring disorder. We would eventually refer the patient up to a short- or long-term residential level of care if necessary. But we would continue their methadone maintenance while

they were there if they wanted to, and it was not clinically contra-indicated. In doing so we would hold their slot on the methadone program if they wanted to stay on the medication and continue in outpatient methadone maintenance after completing residential treatment.

- Adding a "Family Night with the Doc" quarterly. We had patients invite and bring their family members at least once, but it was optional after the first time. The night included elaborate snacks, beverages and desserts in a casual but organized format. The program physician would share some brief educational comments, take questions, and respond to any discussion topics raised by the family members and the patients in an open format.
- Having our patients continue to come to the very same group therapy for their entire first year off of methadone – if they chose to taper off the medication.
- Obtaining methadone dosing privileges at our County Jail. Our nurse would personally bring them an off-site dose each day, with the idea you would naturally stay on the program if you wanted to when released.
- Obtaining methadone dosing privileges inside all of our own drug-free short and long-term residential addiction treatment programs. Our nurse would personally bring them an off-site dose each day with the idea you would naturally stay on the program if you wanted to when you completed residential treatment.
- Buying the starter kit, and providing free use of a large comfortable room in our program, during off-hours (no groups happening), for the patients to start and hold meetings of *Methadone Anonymous*. I personally worked with our patients on this idea for four years before the idea "took" and they started the meetings. I didn't think it would take that long, but we just kept encouraging it. We knew that they needed to start and run it, as service, if they chose to. And that if we started it, or controlled it, that it wouldn't work and wouldn't last.
- Finding out which 12 step, faith-based, and other meetings in town (very specific days/times of certain meetings) were friendly toward the idea of methadone maintenance patients being "in recovery" and also allowing them to share – if they fit into the meeting and followed the guidance of the Chair. We tended to suggest they attend these meetings
- Finding out which 12 step, faith-based, and other meetings in town were openly hostile to that, and tended to suggest they avoid those meetings.
- Adding patient education and counseling that incorporated basic principles and practices from the Advocates for the Integration of Recovery and Methadone (AFIRM).

Some of our ideas and efforts made it into print. And so did some extensions of these efforts.

The reader of this section can take inspiration from these innovations/changes (some of which are practical in a person-centered sense, while others are mainly technically-derived) and adopt evidence-based practices, best practices, and promising practices – with the needs and preferences of the local person/people served as a focus-grouped co-producer of the system.

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Part 6: Atmosphere, Clinical Radar, and Reading the Room (Implicit Field Dynamics)

When I first entered clinical work as an addiction counselor in addiction treatment programs, it was routine for counselors to pre-brief and de-brief group therapy. The counselors did this if there were two counselors running group as co-therapists, or if one counselor was running group alone.

Something I've always found interesting is that the pre-brief and de-brief often covered the topic of how the house *felt.* And how that information applied to what the group and its individual members needed to do in group. How the house felt was discussed as a topic on its own, regardless of how well we thought the group might go, who needed or asked for group time, or how the group actually went.

The bottom line was that the sense of the group as a collective was a topic unto itself. And it was a topic that pertained before group, in group, and after group was over.

The addiction counselors that talked me through this kind of thinking, it always seemed to me, were using their street sense of the problem. And it also seemed to me they were using their accumulated sense of the solution – both for the individual and the group as a whole.

I've never known this sensing of the group to be formalized in any academic literature, nor presented in a graduate or post-graduate realm. I've never seen it in any peer-reviewed material (journal article, book chapter, etc.). Nor have I seen it formalized, taught, or dynamically rehearsed in a CE training. Not in any of these, across all the years of my career. And yet, I do find more recent peer reviewed literature that applies to assessment targets, measures, and therapeutic efforts applied to this topic area/domain.

And so, I challenge the reader to consider this topic I am presenting here in Part 6. And to begin to do so by considering the following:

> Can the presence of recovery, or the level of recovery function, be somehow detectable when it is unspoken and not overtly displayed?
>
> Can recovery be intuitively recognized or somehow felt in another person?
>
> Can recovery be intuitively recognized within an interpersonal space?
>
> Can recovery be present and sensed in the atmosphere?

Sixth-sense, Spidey-sense, Radar

When you walk into a room, do you ever pick up on any unspoken content, themes, trends, or the basic agenda of those in the room?

> What is felt? What is perceived? What is apprehended?

In life it seems that sometimes, somehow, we can latch upon and perceive the unspoken content of others. Somehow, in the room we enter, we sometimes register the collective assumptions, world view, goals, or direction of those assembled in the room.

> Our human heritage and social epigenetics have seemingly equipped us by developing within us such radar and radar capacity.

With 38 years of service in residential addiction treatment programs now behind me, I think I can say that I have at times experienced the sensing of the dormant agenda in a group of people – when I come into the room.

Likewise, some with long-time recovery can sense the:

1. presence and level of health/vitality of recovery, or
2. presence and depths of the collective mental relapse process, that is latently present, yet unspoken, in the collective gathered for a meeting.

I'll go ever further and say that sometimes the basic content in the room (of recovery, or of relapse process) can be sensed – even when those in the room that are holding the agenda are seemingly unaware of their own content. Patients pick up on this when returning from a pass.

Objects, Background, and Open Space

In life, objects influence us.

The physical objects around us, the content we consider in our minds (objects of thinking), and our deep assumptions about life that we do not consciously consider (buried mental objects) exude their influence.

Do these objects and the processes related to them affect the atmosphere around us? (And therefore others around us as well?)

I described the importance of the background within a work of visual art in an essay titled Negative space. What is shown other than the main object represented in the art?

A simple solid color, a blue sky, or a complex crosshatch weave of various colors might serve as a background that the object in the art sits on, or sits in front of. These are examples of visually representing "negative space".

In that essay I also highlighted both the concrete content and the aesthetic quality of the background – even of a seemingly plain background.

Paradoxically, the content of the negative space in art – while represented concretely – is itself without an overt object.

The Feel of the Negative Space

Does the group room, meeting room, or counseling office have a negative space? Yes. The negative space is the open atmosphere, in the background. What forms its quality?

Suppose someone experiencing active addiction illness has family members living with them. Do those family members experience the second problem of a toxic negative space within the home?

If the object of the drug itself and the object of the process of active using are removed – a toxic negative space might form. Unless, perhaps, recovery fills the void in the person, the family members, the atmosphere, and the negative space within the home.

Where is the invisible man?
Can we sense addiction illness, or relapse process, or recovery, when we enter a room?

Are there objects deposited by addiction? Are there objects deposited by recovery?

Does a mental relapse process unearth objects prior to use resuming?

What objects does recovery raise?

Toward making these discoveries we can explore locations such as:

- What is non-observable (not visible)
- What is non-discursive (not in shared words)
- What is not symbolized or represented by symbols
- The social system
- The unconscious
- Multi-generational structures

What do the family members and the one with addiction illness experience in the atmosphere during:

- active addiction illness?
- periods of unwanted abstinence?
- recovery?

For the sake of others, I wish our recovery science was sufficient such that we could "throw flour on the invisible man", locate recovery function, and assess recovery quality.

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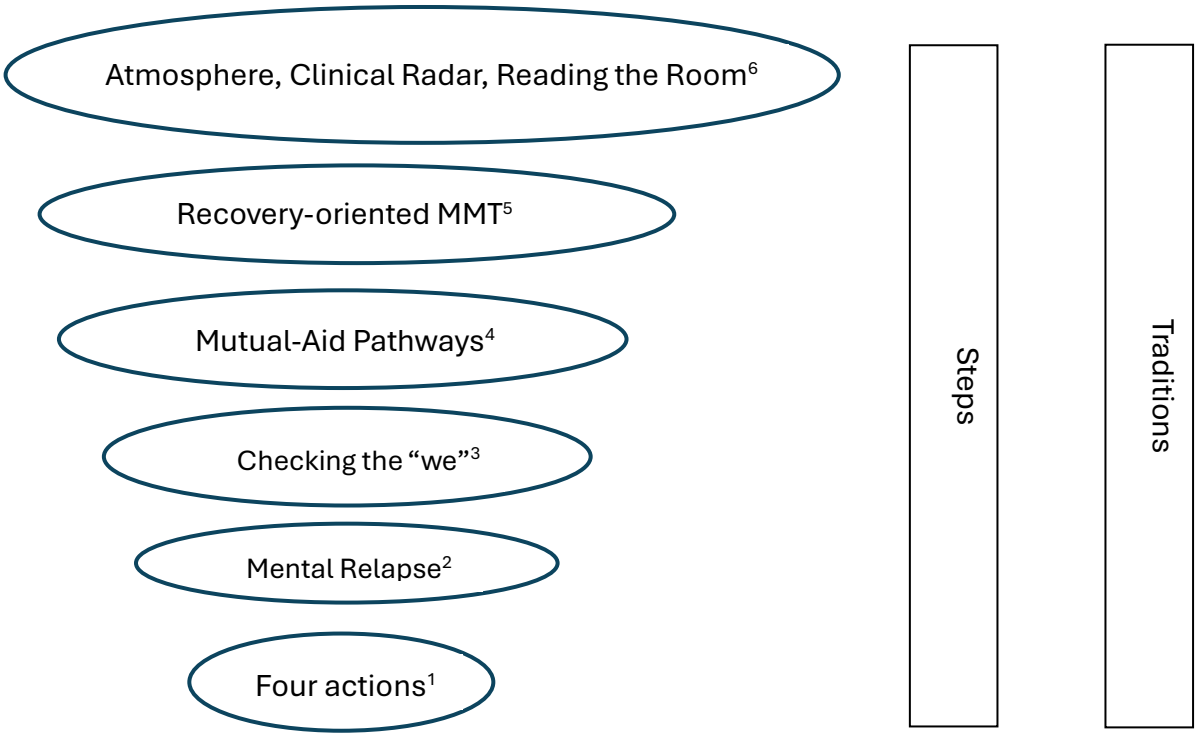
Combining the Elements: A Diagram

In my clinical experience, I've often seen the six elements presented in this monograph eventually circulate, interact dynamically, and even merge. Some or all of the elements might dissolve together and form one solution, or condense out of solution, and so forth – like a lava lamp.

For example, over time, as someone works a personal daily program of the 4 actions to take each day, and does so on a fairly consistent basis[1], these actions and their capabilities are internalized. The same is true of checking against mental relapse by being checked[2]. And of collaboratively contributing to sensing the direction and sustained improving trajectory of the "we".[3] The content and process of each of the six elements are internalized, and six capacities are developed.

Thus, when such a person checks out one particular home group of a fellowship[4], they may return from such a meeting and say something like, "I went to that one meeting[4]. That is the sickest home group or group of any kind I've ever been in.[3,6] That home group is in mental relapse.[2,6] And they don't even know it.[3,6]"

In this way, personal and community-based recovery capital are developed over time. But this growth includes a cyclonic nature expanding from one's own interior (micro) to the outside world (macro) or exterior. As you consider the visual below, remember that the six areas, while shown vertically, are not necessarily in an ascending order of increasing importance.



Appendix: Empathy

I wanted to add "empathy" as a topic for the Appendix of this material.

Why?

For lots of reasons – and I'll outline a few of them.

First, contemporary critics often dismiss classic versions of addiction counseling due to a supposed **lack of empathy** demonstrated by previous generations of addiction counselors. It is true that if one looks back in time toward the early 1970s, addiction counseling looks generally and increasingly more confrontational. I can personally attest to this in part, as I began my clinical work in the addiction counseling profession (in 1988) three years before the Miller and Rollnick book titled Motivational Interviewing was even published (1991).

The second reason has to do with our field's historical **over-reliance on question-asking**. You might know that traditionally, *questions* have been used by addiction counselors as a key part of the counseling method. How so? To pin the patient down in "verbal judo" and help evoke positive change. I have a story about organizational change management that's related to this. I'll never forget our CEO, Mike Boyle, who, during the Behavioral Health Recovery Management Project (BHRM,1997-2007), loved to "create the tension for change" as a key part of change management projects. In those years we were engaged in an agency-wide pursuit of rigorous fidelity to Motivational Interviewing (MI), among other initiatives. In this context, Mike was well known for saying "Asking questions is the crack cocaine of addiction counseling". One day Mike announced a decision he had made. He decided that all clinical direct service staff (counselors, clinical psychologists, etc.) must abandon the use of any and all questions for a 12-month period. Yes, this was discussed and debated by our leadership, but it did happen. Coincidentally, we were one of the agencies Mike Dennis was using to finish his development of the GAIN (around 2001, 2002, etc.). To use the GAIN, the staff in our SUD central screening and intake office had to learn to say things such as "Tell me what it's like to be you" – and then flip through the pages of the GAIN and fill in the answers as they fit questions on the form.

For those that might be interested, we eventually *gave up* on fidelity to MI and the general pursuit of MI across our agency as well. Instead, we turned to Motivational Enhancement Therapy (MET). Fidelity to MET *was* achievable. And MET helped evoke change with our severe, chronic, and complex addiction illness population in a way that MI never did, and seemingly never could.

Regardless, yes, empathy matters in addiction treatment. And the material related to empathy is presented in three parts, as described below.

I've previously posted a short essay that consists entirely of questions about empathy. Even the title is in the form of a question. I worded it that way for two reasons. One is to evoke empathy in the counselor for what it's like to be barraged by questions. I want the reader to struggle forward in recognition of what it's like to endure questions. The other is that the content

of the title and each question listed are valuable. They are not merely rhetorical. And I want the reader to ponder the material presented by each question – and by doing so improve their craft.

I've also previously posted three models of how to think about the content and process of the session (technique vs empathy). Should the counselor hold the notion that their technique is correct and the patient must adapt? Or should the counselor adapt their technique to the patient? Or, should the counselor hold the view that they should neither lead nor follow the patient, but rather that they should seek to empathize? In doing so I help the reader wrestle with this material such that each of these capacities can be seen as potentially valuable, depending on the current presenting picture of the patient and their circumstances. And to hold each option lightly, and to mindfully oscillate as needed between and among these options in real time.

And finally, I've previously posted a work about simple and concrete techniques the counselor can use to: 1) develop their own interiority; 2) improve their attunement; 3) raise their capacity for mindful self-awareness; and 4) both diminish their counseling impulses and their enactment.

Why do I present this material in the Appendix? Some older psychotherapy techniques (from the psychoanalytic tradition, Gestalt therapy, and others) were present during older versions of addiction treatment. And were eradicated later during the evidence-based practice movement, but in hindsight seem validated by today's empirical methods and findings.

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Classic Practices in Addiction Counseling

Epilogue. Historically, in the USA, help for drug addiction developed separately from the treatment for alcoholism. This is because originally, the problems of drug addiction and alcoholism were largely seen as fundamentally different and involving different kinds of people. And therefore, the relevant systems of helping were largely formed as separate. The contemporary, formalized, and professionalized "addiction treatment" provided today has its origin in structured systems of peers helping peers. For example, the long-term residential Therapeutic Community model originated as "addicts helping addicts". And shorter-term residential rehabilitation was built by alcoholics for helping alcoholics. Community-based mutual aid also developed separately among those with "alcoholism" and those with "drug addiction". This was due to the long-standing division of people experiencing severe substance use disorders into two groups: those experiencing problems with alcohol, and those using "drugs".

Over time, forces such as cultural changes in society, the advancement of scientific knowledge related to severe substance use disorders, and the professionalization of addiction counseling, led to addiction treatment programs identifying with the evidence-based practice movement and adopting its practices. This co-occurred with an increasingly mechanized and industrialized delivery of publicly funded and commercially insured services. Ultimately, payors in those arrangements functioned as the "customer" and the patient was reduced to the recipient of care. This helped fuel the prosumer movement, patient centered care, and finally, patient-driven care. Together, these forces served to sideline or eradicate classic practices in addiction counseling. Interestingly, some classic practices in addiction counseling, when now viewed through the lens of modern neuroscience, clinical psychology, developmental psychology, social psychology, personality theory, epigenetics and social epigenetics, and illness self-management and recovery-management principles and techniques, *were right all along*.

This monograph attempted to outline some classic practices in addiction counseling. It described the historical, contemporary, theoretical, and empirical contexts supporting them. And it was meant to do so in a way that is agnostic with respect to the substance taken, the treatment of choice, and one's personal recovery pathway. It focused on: 1) Four actions to take each day; 2) The concept of "mental relapse"; 3) Checking the "we"; 4) Mutual aid pathways; 5) Recovery-oriented methadone maintenance; and 6) Atmosphere, clinical radar, and reading the room.

Hopefully by now the reader can better appreciate:

1. the value of reading, relating, building spiritual capacity, and self-checking;
2. relapse, as a process of diminishing recovery and returning symptoms, aside from use;
3. social processes in group therapy that develop collective recovery capital;
4. a relatively wide range of mutual aid fellowships and related inclusion criteria;
5. program change management intersecting social capital and available science;
6. and development of counselor interiority by improvement of pre-conscious attunement.

About the Author

Brian Coon has been working full time in residential addiction treatment programs from the time of his graduate internship in 1988 to the present. Following his internship, his first 19 years were spent serving in a 9-12 month residential Therapeutic Community (TC) that shared a physical plant and staff with an outpatient methadone maintenance program. The TC had a nursery component for children up to 12 months of age to live with their mothers during treatment. In the early 1990's that residential program was improved when the organization won a 5-year Center for Substance Abuse Treatment (CSAT) demonstration grant for pregnant, post-partum, and parenting women including a physical plant and staff expansion in the TC to include a nursery component and capacity for 14 children from newborn to age 4, training and standards for gender-specific and culturally-relevant care, nurturing parenting programming, developmental assessments (cognitive, social, motor) and corresponding manualized therapeutic interventions for the children, and addition of a women's health focus. That grant included various additional improvements across the organization. Brian sat on the steering committee of that effort after funding was concluded. During all of his last 12 years in that organization, he had full clinical and managerial responsibility for the TC and outpatient methadone maintenance program. Later in those 12 years he had additional responsibility to guide a criminal justice halfway house under contract with the Federal Bureau of Prisons (FBOP), an intensive outpatient program provided inside a 300-bed city/county work release detention facility, a one-year outpatient SUD aftercare program for FBOP, an addiction counselor on the city/county adult Drug Court team, and a dedicated agency-wide case coordinator for referrals from US Probation, among other duties.

Notably, that organizational workplace was the community agency within which the Behavioral Health Recovery Management (BHRM) project was begun and operated. Brian served on the BHRM implementation steering committee for the entire 10-year lifespan of the BHRM project starting in 1998. The BHRM project was the living clinical laboratory where the principles and practices of recovery orientation for clinical services, recovery coaching, and approaches that later came to be known as "Recovery-Oriented Systems of Care" and "Recovery Management" were innovated and developed. The BHRM steering committee expanded and sharpened its focus when that workplace was chosen to participate in the Network for the Improvement of Addiction Treatment (NIATx) at the start of Round 2 in the Robert Wood Johnson Foundation-funded portion of NIATx's history. Throughout its 10-year lifespan the BHRM steering committee led change in the area of co-occurring SUD and MH disorders by identification of national experts in best practices and promising practices and contracting those experts in: authorship of clinical practice guidelines for the organization, provision of training within the organization, and on-going consultation in implementation of their protocols in a multi-year state-funded effort within that organization. The steering committee led by taking responsibility for initial clinical fidelity at the clinician, program, and organizational levels based on those protocols, ongoing clinical supervision and sustainability of fidelity in those practices, continuous quality improvement of service delivery, and a focus on change management integrating those clinical practices with BHRM principles and NIATx change methods in the dozens of programs across the organization. In doing so that workplace was chosen to participate as a clinical site in a United Nations project – the International Network of Drug Treatment Resource Centers.

Since 2008 he has worked in a freestanding interdisciplinary program that includes specialized services for public-safety sensitive professionals and young adults. He served as clinical director there for 10 years starting in 2011. He also provided the admission approval vs. referral decision in the substance use and psychiatric domains for all prospective residential admissions across 12 years, totaling more than 4,800 cases. In 2013 he assisted that organization's senior leadership with transformation to a smoke-free approach to treatment, and the successful sustaining of that approach to the present time. His current duties include the clinical supervision of clinical supervision, and of counseling.

Brian holds a BS in psychology and MA in community-clinical psychology. He is a licensed clinical addiction specialist (LCAS), certified clinical supervisor (CCS), and nationally credentialed as a master addiction counselor (MAC). His academic and clinical background is in the scientist-practitioner model, cognitive-behavioral psychology, and evidence-based treatment of co-occurring substance use and mental health disorders in adult populations. He has given over 285 continuing education presentations at state, regional, and national conferences, as well as various clinical organizations. He has authored or coauthored 15 publications including peer-reviewed research, a book chapter, and clinical-applied articles, and contributed to or been acknowledged within 35 additional publications.

Brian has a strong life-long interest in biology and philosophy. His recent years have been marked by an interest in the analytic tradition/depth psychology, the mentoring of clinical supervision, and the impacts of each upon systems of care, individual clinicians, and clinical teams. In his spare time Brian has written over 175 additional articles and 14 monographs as a Contributor at *recoveryreview.blog*, and serves as an Affiliate at *addictionandbehavioralhealthalliance.com*.

To close, I'd like to share a poem I wrote a year or two ago. It's meant to honor those addiction counselors, who at the time were later in career, and taught me everything I ever knew about the practical helping of our population, back in the late 1980s and early 1990s.

The Last Addiction Counselor

The Last Samurai
Warrior ethic
Skill above personal safety
Service to others
Non-attachment

The Last Poet
OG recovery-cultural presence
OG recovery-cultural renown
OG recovery-cultural expression
The culturally-suited spoken word

The Last DJ
Vast knowledge base
Carefully curated
In touch with listeners
Preferences well understood

The Last Jazz Concert
Virtuosic ability
Taste preferences
Societal shifts
New era, new genres
Small audiences