Denial Management Counseling (DMC)
The Evolution Of An Idea

By Terence T. Gorski; Prepared For The Herald House Resource Guide; May 2000

In early 1998, I began to develop a professional guide and workbook for managing denial in people with substance use disorders. My goal was to take the core clinical processes that had proven so effective in both Relapse Prevention Therapy (RPT) and Relapse Prevention Counseling (RPC) and apply them to managing denial. I created the working title Motivational Recovery Counseling (MRC), which would later be renamed Denial Management Counseling (DMC), and set to work. I soon discovered that this developmental process would not be as simple and straight forward as I first thought. I also discovered how much of our work as clinicians is governed by the principle of *unconscious competence.*

We develop *unconscious competence* when we learn how to do something primarily through role modeling and clinical experience without the benefit of explicit instruction. We intuitively learn, develop, and use many complex interventions that just seem to come to us at key moments in therapy when we need them. The problem is that we're not always consciously aware of what we do when we have these intuitive moments in therapy. Fortunately there is a method called *clinical modeling* that can help us.

Clinical modeling is done by watching experienced clinicians work with clients or in role play sessions to determine what they said and did at key moments in the clinical process. I applied this clinical modeling process to the development of Denial Management Counseling (DMC). Much of the work consisted of recording and

analyzing role play sessions during clinical training workshops. I thought this process would be quick and simple, but I was wrong. Let me explain what happened.

Denial Management Counseling (DMC) was based upon my earlier work on managing denial patterns. The idea was to update a *Denial Pattern Check-List* that I had used, with good results, in individual therapy, group therapy, and psychoeducation sessions. The check-list was used by asking clients to read the denial patterns out loud, identify denial patterns that applied to them, and personalize the denial patterns for use in self-monitoring. This process helped clients to understand what denial is, identify their personal denial patterns, and learn how to manage them.

I updated the *Denial Pattern Check-List* and developed an initial clinical skills training course to teach counselors and therapists how to use it. In field testing the course, participants reported that the process worked well with some clients, but the overall feedback told me that I missed something. Clinicians reported two major problems when trying to use the process. First, many clients had such strong denial that they refused to work with the *Denial Pattern Check-list*. Second, since denial is triggered by thinking and talking about substance use and related problems, many clients could easily avoid or intellectualize the information without seeing how it really applied to them.

From this feedback I developed a second version of the course that linked the recognition and management of denial patterns to the use of a brief structured assessment process. The assessment guided clients through a detailed self-exploration of their alcohol and drug use and its effects upon their life. First, client's identified their presenting problems, determined the relationship of each presenting

problems to substance use, and explored the consequences of continued use in terms of their ability to resolve each presenting problem. Next, clients were asked to make two commitments: to work on resolving the presenting problems; and to stay abstinent from alcohol and other drugs during the treatment process. Finally, the clients compared the denial patterns on the check-list to how they responded to the presenting problem analysis and treatment contracting process. This allowed them to identify their personal denial patterns and the related thoughts, feelings, urges, and actions that they actually used in the session to deny the problem.

By taking a client through this process, the concept of denial shifted, in the client's mind, from a vague intellectual abstraction to a readily identifiable problem that was creating more problems than it solved. Clients could see how denial was triggered automatically when they began to think or talk about the substance use. This motivated many clients to learn more about denial and how to identify and challenge their own denial patterns. They also began to recognize and manage the strong feelings created when denial is activated. Clients then completed a *Brief Life And Addiction History* and an *Addiction Symptom Check-List*. Whenever the clients started to use denial, it was consciously identified and managed before it created serious problems in the session.

This new training format worked well. The feedback was excellent and it seemed like the problems were solved. I went into the second phase of field testing which involved teaching members of The CENAPS Training Team to instruct the courses. However, additional problems developed in this phase of field testing.

In the initial training sessions, I did extensive clinical demonstrations of the denial management process. Students identified the denial patterns that they had observed

during each role play, and evaluated the strategies the trainer had used to manage them. I quickly became aware, however, of the number of skills that were being transmitted through the unconscious role modeling process. In the second version of the course I was bringing more of my own unconscious competence to the training than I realized. Many of the vital principles and practices were not clearly articulated. They were being transmitted primarily through role modeling during clinical demonstrations and the interactions of the participants during the experiential portions of the training.

As I reflected upon this new information, it became apparent that competent clinicians have very different styles in dealing with clients who are using strong denial. I put my skills of clinical modeling to work and developed an explicit series of interactional skills managing denial which I called *The Denial Management Interactional Process*.

The development of the *Denial Management Interactional Process* added new information about managing denial that was not available in the original exercises in The Denial Management Workbook. So I went to work updating these exercises. I also reviewed the project notes that documented this developmental process. These contained useful information that I wanted to make available to other clinicians, so I began writing a *Professional Guide To Denial Management*. As always happens, the work on the professional guide showed gaps and flaws in the workbook, and correcting the workbook exercises showed weaknesses in the professional guide. I recorded the courses that I taught, listened to the tapes, and discussed progress and problems with trainers who were teaching the course. As a result, I found more material for the professional guide that spontaneously emerged during the training.

In all things, however, there comes a time when a work in progress must be deemed ready for publication. That time has come and two new products are now ready for release: (1) *Denial Management - A Professional Guide For Motivating People With Substance Use Problems To Recovery*; and (2) *The Denial Management Workbook – Practical Exercises For Motivating People With Substance Use Problems To Recovery*. Two separate skills training workshops, a one day and three-day version are also available in many cities around the country. An optional competency certification leading to a credential of *Certified Denial Management Specialist* is available for clinicians completing the three-day course and completing a competency certification portfolio.

Thanks for your patience. I hope that the quality and depth of these materials will prove to be worth the wait.

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