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Chapter 1 : When Managed Care Coverage Runs Out â€" Effective, Ethical Solutions

In addition to orienting clients to treatment programs, case managers can orient treatment programs to the clients they refer. Sharing information gathered during the pretreatment phase can provide support for the treatment process that ensues upon program admission.

Like most people, counselors become upset or angry when they hear about children getting hurt or being abused. Some counselors are recovering from substance abuse disorders and were themselves abused or neglected as children, and they may find themselves in a professional situation where they have to confront their own abuse experience and its impact on their lives. As a consequence, counselors who were abused or who had substance-abusing parents may experience feelings that interfere with their efforts to work effectively with adult survivors. For example, counselors may find it difficult to relate to clients effectively and to reach a balance of providing enough--but not too much--support and distance. Survivors of abuse may pose many relational challenges to the counselor. These clients are often mistrustful at the same time that they need a trustworthy relationship, and a "push-pull" dynamic may result. Counselors must be mindful of these possible reactions and develop appropriate strategies to ensure effective care of the client. Because child abuse and neglect reflect the ultimate violation of trust, it is critical that counselors maintain a professional relationship with appropriate boundaries and limitations in place. This chapter reviews some of the challenges posed by transference and countertransference issues with this treatment population and discusses possible secondary traumatization in counselors. The Consensus Panel recommends that counselors establish and maintain clear boundaries from the outset, as well as establishing a "treatment frame. Transference, Countertransference, and Secondary Traumatization The counselor-client relationship is a crucial component of all therapy. Its importance is highlighted in work with abuse survivors because of the nature of the injury caused by the abuse--it was often caused by someone in close relationship to the client, on whom she was dependent, and from whom she should have received care and protection. The counseling relationship is therefore instrumental in providing the client with the necessary support to address and work through issues related to abuse including substance abuse while modeling a healthy, nonexploitive relationship. Transference Transference generally refers to feelings and issues from the past that clients transfer or project onto the counselor in the current relationship. When clients interact with other persons, they are likely to respond in ways that repeat old patterns from their past. These transference reactions have specific implications for survivors of childhood abuse, who may perceive the counselor as threatening or abandoning in the same way as the perpetrator of the abuse. Conversely, clients may idealize the counselor, seeing him as the warm and loving parent they always wanted. Many survivors have enormous shame and low self-esteem and feel responsible and guilt-ridden about the abuse. This may lead to attempts to distract the counselor from abuse-related issues so that they are not discussed or examined, or to respond to the counselor in ways that replicate the past e. The counselor must be aware of and prepared for possible responses of this sort and must work to bring them to clients, attention for discussion. The counselor must also avoid replicating relational patterns from the past even if clients expect them and act in ways to encourage them. For example, the counselor should not allow clients to be overly caretaking toward him, nor should he be so overinvolved with clients that objectivity is lost. These issues are discussed in more detail below in the section "Establishing the Treatment Frame and Special Issues. Although countertransference occurs in all therapy and can be a useful tool, an unhealthy countertransference occurs when the counselor projects onto clients her own unresolved feelings or issues that may be stirred up in the course of working with the client. For example, if clients act seductively, the counselor may feel uncomfortable or threatened. Counselors must pay close attention to their own feelings to protect their clients and to learn more about them. At the same time, the counselor should keep in mind that the feelings clients evoke in a counselor are likely to be feelings that clients are evoking in their daily interactions with others. For the same reason, a counselor might discourage the client from talking about

abuse issues, saying it is not the right time. However, it is very important to let the client determine when and at what pace to work on the issues, especially when dealing with child abuse and neglect. Effective treatment will be severely diminished if the counselor is unaware of her countertransference feelings toward a client. In these cases, the counselor should be closely supervised, or the client may need to be referred to another counselor. Counselors must also be cautious not to see signs of childhood abuse in every symptom. Not everyone in treatment has been abused, and counselors should be aware of the possibility of clients recovering nonexistent repressed memories, especially from clients who are eager to please their counselor. This is especially important for counselors who are themselves survivors of childhood abuse or neglect. Secondary Traumatization Many counselors find the level of violence and cruelty they are exposed to in working with adult survivors of abuse upsetting and incomprehensible. The counselor who is repeatedly confronted by disclosures of victimization and exploitation, especially between parent and child, may experience symptoms of trauma, such as disturbing dreams, free-floating anxiety, or increased difficulties in personal relationships. He may also experience anger or helplessness, which are detrimental to both the counselor and the client. Or, after a day of dealing with intense material in client sessions, a counselor may seem unaffected until strong emotions emerge--seemingly out of nowhere. The stress and "burnout" that may result from working with such clients can even produce symptoms similar to those of posttraumatic stress disorder PTSD e. Counselors can have these reactions even if they have no personal history of childhood abuse. Counselors experiencing these symptoms may lose perspective and become either over- or underinvested in a client Briere, ; Pearlman and Saakvitne, Counselors who are underinvested may become numb to feelings that would otherwise cause anxiety, anger, or depression. This reaction represents an attempt to avoid and distance oneself from the uncomfortable issues raised by the abuse. He may respond to the client coldly and clinically. Those counselors who overinvest, on the other hand, become extremely involved with their clients, going beyond the appropriate boundaries of the relationship. They may respond by becoming parental and doing problematic things such as lending their clients money, trying to solve their problems for them, or seeing them too frequently. They may also fail to confront clients when they behave inappropriately or destructively. When working with a client who was abused as a child, an overinvested counselor may have rescue fantasies or feel inappropriate anger directed at former therapists, child protective services CPS workers, and parents or caretakers. In extreme cases, the relationship can cease to be beneficial as it becomes overly personal, with the attendant loss of objectivity that is necessary in a professional relationship Briere, Burnout As mentioned above, working with clients who have chronic mental health disorders, severe substance abuse disorders, or a history of childhood abuse and neglect can often lead to "burnout. These secondary trauma responses have been called "compassion fatigue" Figley, , referring to the toll that helping sometimes has on the helper. Burnout affects many counselors and can shorten their effective professional life Grosch and Olsen, If the counselor sees a large number of clients many with trauma histories , does not get adequate support or supervision, does not closely monitor her reactions to clients, and does not maintain a healthy personal lifestyle, counseling work of this sort may put her at personal risk Courtois, This situation is even more serious in the current financially focused managed care atmosphere that requires health care workers to assume larger and more complex caseloads. These complex cases often involve previously traumatized clients who present the counselor with many personal and treatment challenges Grosch and Olsen, Counselors can minimize the likelihood of burnout. As much as possible, they should not work in isolation and should seek to treat a caseload of individuals with a variety of problems, not only those who have experienced childhood trauma. Discussing feelings and issues with others who are working with similar clients can decrease isolation through a process of shared responsibility Briere, Counselors also should try to keep a manageable caseload. They should deliberately set aside time to rest and relax, keep personal and professional time as separate as possible, take regular vacations, develop and use a support network, and work with a supervisor who can offer support and guidance. Some treatment settings have established in-house support groups for counselors who work with abuse and trauma survivors. Working as part of a treatment team can be a natural way to facilitate

support and reduce stress. In some cases, counselors may want to seek personal help through therapy that will allow them to work more successfully with this population. Among its other potential benefits, psychotherapy can help counselors come to terms with their own limitations. Counselors who are satisfied with their personal and professional lives are less likely to experience secondary trauma symptoms. Establishing the Treatment Frame and Special Issues Counselors should develop and maintain a treatment frame--those conditions necessary to support a professional relationship. Setting and maintaining boundaries is especially critical in treating survivors of childhood abuse and neglect. Several parameters of the treatment frame are discussed below, as well as special issues that may arise. Because childhood abuse is a profound violation of personal boundaries, adult survivors of abuse or neglect may never have developed healthy and appropriate boundaries, either for themselves or in their expectations of others. They often need a great deal of affection and approval, and counselors must make clear that they are not responsible for directly meeting all of those needs. The counselor must maintain a calm, optimistic interest in his clients, recognizing that getting overly involved will rob clients of the opportunity to identify and build upon their own inner resources. Other parameters of the counseling relationship, or treatment frame, set by many mental health professionals Briere, include Making regular appointment times, specified in advance Enforcing set starting and ending times for each session Declining to give out a home phone number or address Canceling sessions if the client arrives under the influence of alcohol or psychoactive drugs Not having contact outside the therapy session Having no sexual contact or interactions that could reasonably be interpreted as sexual Terminating counseling if threats are made or acts of violence are committed against the counselor Establishing and enforcing a clear policy in regard to payment These are general guidelines, and the specific arrangements between a counselor and client will vary according to a number of circumstances. For example, a client may arrive under the influence of drugs or alcohol. Also, for some clients, telephone contact outside the therapy session is necessary and fosters a working alliance between client and counselor. Some clients may need ongoing support for dealing with difficulties with their children or suicidal feelings. A rigid rule stating no contact outside of therapy may be harmful for very needy clients. Clients may feel abandoned if a telephone call is not returned, damaging the therapeutic alliance. In smaller communities, a counselor may expect to encounter clients in public places. It is wise to discuss in advance with clients the confidentiality and boundary issues that could arise in these situations. Clients may prefer that the counselor not acknowledge them or may wish to be greeted with a simple hello. Building Trust Building trust has been described as the earliest developmental task and the foundation on which all others are built Erikson, Establishing trust is broadly accepted as fundamental to the development of a therapeutic relationship. However, because adults who were abused or neglected by their parents have experienced betrayal in their most significant relationships, they often find it difficult to trust others. Clients who were not abused by persons close to them also experience problems with trust, but for those who have been betrayed by people on whom they were dependent, issues of confidentiality and privacy are especially critical. Trust makes an individual vulnerable to criticism, abandonment, and rejection. Clients may therefore be mistrustful and suspicious of the counselor, making the development of a trusting relationship a potentially long and difficult task. Reflecting the transference discussed above, they may fear the counselor or see him as abusive, manipulative, or rejecting. The counselor must not personalize these feelings but be consistent and reassuring, never taking trust for granted Courtois, As clients deal with childhood abuse and neglect issues, they may face a series of crises. These crises give the counselor opportunities to build trust. Many tenets of a good therapeutic relationship unconditional positive regard, a nonjudgmental attitude, and sincerity are also essential for establishing a foundation of trust. When the Client "Falls in Love" With the Counselor Because of the difficulties many abused clients have with intimacy, the new experience of having someone who listens and whom they can trust can sometimes lead them to believe that they are in love with the counselor. Sadly, many survivors of abuse are so accustomed to negative feelings shame, fear, guilt, anger that positive feelings joy, trust, contentment, playfulness are unfamiliar to them. Such clients may not understand their own feelings, and they may not have the skills to differentiate them. In some

cases, if a client has recently stopped abusing drugs or alcohol, romantic obsession or sexual fantasies can substitute for the substance addiction as a way of reducing tension. Powerful romantic feelings may be directed toward the counselor, threatening the therapeutic relationship. The counselor must, above all, avoid transgressing the boundaries of the relationship and continue to emphasize the guidelines discussed when the counselor established the treatment frame. He should not consent to personal requests, even if they seem innocent e. Second, even if he only suspects a client of harboring sexual feelings for him, he should immediately bring the matter to the attention of a colleague.

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Chapter 2 : How to Maintain Professional Boundaries in Social Work: 15 Steps

Although some women may feel safe only with a female counselor, many male counselors can provide effective treatment if they give adequate attention to abuse issues and their own reactions to clients.

Not all therapists will see every patient that walks through their office door. Therapists seek to avoid dual relationships, so if they are already your friend, business associate, or whatnot, they will refuse to become your therapist as well this also works in reverse â€" your therapist should never offer to become your friend, lover, business associate, etc. Therapists will often avoid seeing certain people for these reasons to ensure the patient is treated with proper respect and dignity. This is where the therapist discounts his or her hourly rate based upon your annual income. It never hurts to ask. Your therapist has an existing relationship with you, your family, or a shared mutual friend. As mentioned in the introduction, a professional therapist will almost always seek to avoid dual relationships â€" especially where they have a pre-existing relationship with you in a nonprofessional capacity. Who then do you turn to? This is also a good time for a reminder that therapists nearly always seek to avoid entering into a relationship of any kind with a past client as well. Because therapists share a unique therapeutic bond with that person , it has the potential to harm the patient if a new type of relationship is transposed on top of it later on. While different professional ethics vary on this topic, most therapists seek to avoid any kind of relationship â€" whether it be a friendship, romantic interest or business partnership â€" with an ex-patient. Your therapist is seeing someone else in your family, a close friend, or has a close relationship with one of those people. Unless the therapist is specifically doing family, child or couples counseling, most therapists try to avoid seeing people who know one another in a close or intimate manner. Doing so can cause all sorts of troublesome problems for both the therapist and the patient, as the therapist will hold secrets about the two parties that they may have a hard time not inadvertently divulging. This can be especially difficult if you were first seeing a therapist and recommended the therapist to a close friend or family member. The therapist ends therapy with you and starts with a new patient, who is your friend or family member. The therapist may not agree to see you again while they are seeing this other person. It may not seem fair, but therapists may do this in order to keep their boundaries well-defined and avoid conflicts of interest. You have a personality trait, physical trait, or component of your history that the therapist chooses not to work with. It could be as something as simple as body odor, or as complex as you remind them of their mother. Therapists will probably not share with you the specific issue that prevents them from working with you. Some feel ineffective working with certain types of people or those with certain kinds of problems. I know therapists, for instance, who refuse to see anyone with a personality disorder, because of the complications it can bring to treatment. A therapist may just not feel safe around a certain type of client, or clients who have certain types of concerns. This may feel like they are not being fair to you, or that they should take on past clients no matter what. But therapists sometimes have to make a decision about who to see, and whether the person will benefit from additional psychotherapy. While most therapists will gladly open their doors to see an ex-patient again, not all will. He is an author, researcher and expert in mental health online, and has been writing about online behavior, mental health and psychology issues -- as well as the intersection of technology and human behavior -- since Grohol sits on the editorial board of the journal Computers in Human Behavior and is a founding board member and treasurer of the Society for Participatory Medicine. You can learn more about Dr.

Chapter 3 : Getting Family Members Involved in Your Client's Recovery | Behavioral Health Evolution

October 30, When it comes to clients, it doesn't matter if you have the most agreeable or the most difficult person in the world, your team should make them happy. In order to do so, they'll want to have these client management skills, which can be applied to many customer interactions.

At the same time, the practitioners help clients to develop and recognize the discrepancy between their drinking behaviors and their personally held goals and values. This involves highlighting the gap between "where they are" and "where they actually are" deploying discrepancy. As a result, the client will be able to present and "own" the best arguments to support change. In addition, emphasis is placed on avoiding disagreements with clients about the severity of their alcohol problems. Argumentation is counterproductive to the change process and defending positions may breed client defensiveness. No efforts are made to persuade clients about the seriousness of their problems or their helplessness, or in getting them to accept the "alcoholic" label-aspects of many traditional therapies. Resistance is a signal to change or shift strategies. Rolling with resistance means: All efforts to change the drinking behavior are affirmed by the practitioner. The client is the most valuable resource for finding solutions to the problems and is responsible for choosing and executing the change strategies. An important ingredient of the motivational model is client choice. Emphasis is placed on obtaining client agreement about the severity of drinking problems and the kinds of strategies to be used for changing the drinking behavior. To this end, clients are offered a variety of options-including doing nothing. Client commitment can be enhanced by facilitating the belief that there is "a way out" of the problem and by enabling the individual to "do something" about it. No significant differences were found among the three MATCH treatments in total health care costs in the post-treatment period. The cost savings associated with MET may place pressure on health care or managed care providers to adopt such methods in settings where individuals with alcohol problems are typically seen. Many treatment modalities are founded on the assumption that the client is ready to take action, ignoring all other stages of the change cycle precontemplation, contemplation, preparation, and maintenance. It also occurs when more treatment is given than a client wants or when barriers to treatment are ignored. Treatment matching allows for varied responses to be matched to client readiness. For example, in response to precontemplation processes, an intervention can increase awareness and raise doubts about the problematic behavior. In response to contemplation, the interventions are designed to help tip the decisional balance toward action and away from inaction. In preparation, intervention should involve the negotiation of a concrete and workable plan for change. Action interventions, the ones with which we are generally most familiar, assist the client in behavior change through achieving a series of small, progressive steps toward a goal. Maintenance interventions are critical in that they help to prevent relapse and help support ongoing lifestyle change. Subjects in the highest third of the anger variable treated in MET had an average of For angry clients, a non-confrontational approach such as MET may work more effectively to defuse anger or resistance than modalities that are typically more directive. Cognitive Behavioral Therapy Cognitive Behavioral Therapy CBT is based on principles of social learning theory, indicating that the problem behaviors are determined by factors in the social environment. As such, the behaviors can be "unlearned" in the same ways that they were first acquired and are now maintained. CBT focuses on learning alternative coping strategies, rather than alcohol use, to deal with potentially high-risk situations. A functional analysis is conducted to determine target areas for intervention. A wide range of goals are identified and prioritized, and a sequence of interventions is employed to achieve them. Interventions might include assertiveness training, mood management, job seeking skills, anger control, communication training, and planning of leisure-time activities. Opportunities are provided to practice skills inside and outside the sessions i. Typical objectives associated with CBT include social skills training, reduced psychiatric symptoms, anger reduction, social support, and job finding. CBT sessions follow a rule Carroll, The first third of each session is devoted to evaluating and discussing drinking behavior during the past week. Other

concerns that might affect drinking behavior, such as marital or family conflict, are also reviewed. The second third of the session is devoted to skills training and rehearsal. For example, a role-play might be used to develop or improve drink refusal skills. The final third deals with planning for the week ahead, including a discussion of relapse prevention techniques. For example, one client spent the latter part of the session practicing how to deal with criticism on the job without drinking. A role-play was used to teach assertiveness skills to defuse the negative moods that result from such criticism. The latter involved creating alternative lifestyles that would be incompatible with drinking. For example, an individual might choose to regularly attend church services with family members, find stable employment, focus on healthy nutrition, save money, and so on. Those with more alcohol dependence symptoms fared better in TSF. These differences were observed across a number of outcomes pertaining to drinking and health care costs Project MATCH, ; Holder et al. This also has not been confirmed by subsequent research. RET involves a variety of different, but related approaches, all aimed at increasing social support for abstinence, buttressing motivational readiness, improving interactional patterns that promote and reinforce sobriety, and establishing and maintaining emotional ties with members of the social network. Although there are conceptual differences among these approaches systems theory versus social learning theory versus Alcoholics Anonymous philosophy , each involves the promotion and active involvement of a supportive significant other in treatment. The SSO could be a child, parent, friend, clergyman, or member of a self-help group e. Toward this end, methods are used to enhance communication patterns that reinforce social support for sobriety. More specifically, RET can help to: With regard to mutual help i. RET enables the individual to obtain ongoing social support for abstinence. This is an important ingredient of change, especially for those whose natural social networks are not supportive of abstinence. In RET, efforts are devoted to reducing interaction patterns that inadvertently reinforce problem drinking. RET helps non-drinking partners to identify behaviors that trigger or reward problem drinking. It teaches the non-drinking partner or SSO about withdrawing positive reinforcement when the client is using alcohol, and about providing positive reinforcement for nonuse. Examples of the former include not making excuses to an employer for the alcohol use problems i. Examples of the latter include verbally acknowledging nonuse and sharing in activities associated with nonuse, such as attending church services together, exercising, going to movies, gardening, photography, or pursuing other active hobbies. RET Goals and Objectives: It is important to note that effective SSO involved therapy requires that both drinking and relationship issues be addressed during the course of treatment. Interventions that include minimal SSO-involvement i. Long-term results demonstrate the advantages of RET approaches over individual-focused alcohol therapy in terms of increasing length of stay Zweben et al. Both factors are associated with sustaining sobriety. In summary, RET studies show superior results over control groups on a number of outcome measures including drinking, marital stability, motivation, and compliance. Concerning mutual help, it is often unclear whether it is AA attendance or AA participation e. Both were found to be positively related to abstinence Tonigan, et al, in press. These findings offer additional support for mutual help involvement. This may be why some researchers suggest that all clients be routinely encouraged not required to attend mutual help groups, especially those clients who lack a support system for abstinence Westerberg, Limitations of Treatment Outcome Studies Maintaining the Purity of the Treatment Models A major limitation of treatments employed in clinical studies has been the necessity to maintain the purity or integrity of the treatment model. Greater emphasis has been placed on adhering to the integrity of the particular treatment i. Unlike "real world" clinical settings, no attempt is made to integrate components of different models to address client problems. In other words, a person in a CBT skill building program would not have motivation enhancement, while a person in MET would not acquire skills training. The models described here are "pure" models, but the clients are not, and the process in reality is far more eclectic. This means that individuals might have had the ability to improve their coping capacities in CBT, but did not have the requisite motivation to use them. In short, the MATCH treatment outcomes were limited by the need to reduce similarities across the three modalities. At the same time, traditional alcoholism treatment programs have not been responsive to the diverse needs and capacities

of the broad spectrum of clients seen in these clinical settings Tucker, The "one size fits all" approach has often been the primary method of treating individuals with alcohol problems. However, the evidence suggests that to best serve individuals with alcohol problems, a repertoire of interventions should be developed, tailored to the differential needs and capacities of a heterogeneous client population, and delivered in a manner that is responsive to the complex problems or issues confronting this group Tucker, A phase model of matching may be the means by which this is accomplished-see below. The fact that few matching hypotheses were supported, and that some contrasts were in the direction opposite of what was predicted, suggest that current matching theory is under specified. A more adequate theory should specify the circumstances and conditions under which matching effects might appear. Thus, higher order a priori matching hypotheses await testing. Based on the findings emerging from Project MATCH, it is conceivable that individuals with a profile of high self-efficacy, high motivational readiness for change, and high social support for drinking would benefit most from CBT, whereas those with low self-efficacy, low motivational readiness for change and high support for drinking would benefit most from TSF. Use of a Phase Model of Matching Evidence has shown that individuals vary in patterns of alcohol use and related consequences over the course of relapse and recovery Babor, Longabaugh, Zweben, Fuller, Stout, Anton, et al. Some individuals are able to sustain long periods of abstinence, while others may move in and out of sobriety over a lifetime. Some individuals may continue to experience serious negative consequences, despite achieving abstinence, while others may demonstrate major improvements in various areas of life following abstinence. In this model, a broad array of assessment measures is employed. They deal with individual, interactional, and situational factors. These measures are examined in terms of how alcohol use might be directly or indirectly associated with these different areas. For example, is marital conflict a precipitant or consequence of excessive alcohol use? Can we expect an improvement in the marital relationship to be followed by a reduction of alcohol use or vice versa? Decisions about the kinds of strategies to be employed are based on an understanding of how these individual, interactional, and contextual variables interact with the treatment variables to produce good treatment outcomes. For those clients whose environments were highly supportive of drinking, positive change in treatment was predicated on consequent changes occurring outside of treatment-namely, AA involvement. MATCH treatments may have helped to initiate change, but AA participation was necessary to maintain or consolidate its benefits Longabaugh, et al. Thus, in "phase model" terminology, symptom improvement i. In sum, a phase model might offer us some guidance to determine what kinds of strategies might address special problems linked with the drinking, and how best to deliver these strategies to maximize treatment benefits. Nevertheless, phase model matching requires an ongoing, dynamic process of assessment to work.

Chapter 4 : Why do drug-addicted persons keep using drugs? | National Institute on Drug Abuse (NIDA)

In this way, clinicians see clients in their own environment and can learn more about the clients' situation. Often family members of clients with co-occurring disorders feel stigmatized. They may have given up friends and activities because of embarrassment over the client's behavior.

Seasoned clinicians share professional advice. The article claimed that managed care companies intended to wipe out what they called the New Yorker Syndromeâ€”spending years in psychoanalysis was about to be a thing of the past. Fast forward to Is the New Yorker Syndrome a distant memory or has it prevailed? Has managed care indeed changed the practice of psychotherapy? Only 20 sessions are typically funded by managed care, but then what? Spending years in psychoanalysis may have been over the top, but is a session limit the answer? What do private practitioners do about clients who have exhausted their funding but still need more therapy? Do their choices compromise the ethical demands of their profession? The same survey found that if a managed care company denies reimbursement for care judged to be necessary, most mental health counselors Others would opt to see the client on a pro bono basis Approximately one quarter The code says that you never have to abandon a client because you can make referrals and give the client options. But she explains that the referral options for clients who have no means are few and far between. Referring out also ignores the basis of social work practiceâ€”the relationship. What the psychologist is ethically obligated to do is discuss at the outset of treatment what will be paid for and discuss at the conclusion of treatment possible referrals if the client will benefit from further treatment. Does that mean the APA ethics code allows a counselor to abandon a client when funding runs out? I want to be very clear about this. One would need to ensure that clients receive services that would be necessary in an emergency situation and that they had sources of referrals. The APA ethics code is very much focused on the process by which therapy begins and ends; none of this should be a surprise to the client or the psychologist. Choosing not to play in New York City, where lots of people are used to paying privately for psychotherapy, is an option that may not be available in other locales. There is some consensus in the field that an astute diagnosis is the answer. The response was surprising: No one suggested making a referral. So what do counselors do? Some clinicians tolerate clients who drop out of treatment and then resume later, according to Spevack. Other clinicians may stretch out the allotted number of sessions over a longer period of time. Dasenbrook believes it is important for clinicians to get back to the insurance company and advocate to extend coverage when it is needed. He claims that managed care companies are more flexible today than in the past. Sometimes EAPs have a single case agreement so that even if I am not one of their providers, I can see someone that I have been seeing through a managed care plan. Dasenbrook and Alie agree that having the client advocate with their managed care company for more treatment can be effective. And if all else fails, Alie says the therapist can file an appeal to the managed care company, which is often successful in obtaining approval for more treatment. The secret of working with managed care companies is not to get adversarial, according to Dasenbrook. You just go in and advocate for your client. Final Analysis Managed care has changed the practice of psychotherapy in fundamental ways. But in the years since managed care companies vowed that they were going to eradicate New Yorker Syndrome, they have changed too. They have come to realize that long-term psychotherapy is a must for some people to be healthy and is not just palliative care for the neurotic. The gulf between therapists and managed care companies, which at first seemed impossible to bridge, may finally be closing on some middle ground. As a specialist in organizational culture, she supports leaders and organizations in developing mission-driven cultures. Dasenbrook, MS, LCPC, is a guide that includes many aspects of setting up a private practice, such as dealing with managed healthcare, how to handle claim denials, and how to get on closed panels. Psychotherapy Finances is a newsletter written expressly for behavioral health practitioners and provides its subscribers with the latest news and ideas for building strong private practices, including practices in managed care. The newsletter is available at www. S â€” The Mental Health Parity Act of After a long

battle, the Senate passed legislation in September requiring equal health insurance coverage for mental and physical illnesses when policies include both. The bill, known as the Paul Wellstone Mental Health and Addiction Equity Act would dramatically change how managed care insurance companies fund mental health treatment if passed by the House. The bill recognizes that mental illness is a disease like any other. Its objective is to require insurance coverage that is equal to, but not superior to, other medical conditions such as cancer, diabetes, or heart disease. With the addition of New York and Ohio in , there are now 41 states with parity laws covering 26 million Americans. These laws vary substantially in their scope and requirements. The federal parity law will only preempt standards in state laws that establish parity for day or visit limits and financial limitations. The mental health parity law in Massachusetts stipulates that medical necessity determines the number of sessions for which a person is eligible, and the sessions are unlimited as long as treatment is medically necessary. And even if it is a nonparity diagnosis, such as an adjustment disorder or an anxiety disorder, subscribers are usually going to get up to 24 sessions since most people come in with some level of distress or impairment that is going to meet the criteria for medically necessary care. A survey of perceptions, practices, and compliance with ethical standards. Journal of Mental Health Counseling, 23 2 ,

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Chapter 5 : How to Keep a Client: 10 Steps (with Pictures) - wikiHow

Motivating Clients for Treatment and Â¾If you can make people feel bad enough, they will change. Â¾clients usually enter treatment with.

Breaking that big goal down into smaller goals, or simply ticking items off a daily checklist can help keep the motivation going over the long haul. Write your goals down! But what if you started at or last year? Even the smallest pieces of motivation along the way can keep us moving in the right direction. Even a subtle reminder of their progress can re-kindle the flame and get the motivation burning again. Cressey Performance has it. Results Fitness has it. Every great gym has a great environment. The environments may be totally different, but at every successful gym other great people surround you. Quite the contrary, this is when many people need you the most! What I am saying is that certain people have no desire to really achieve their goals. They are ok with being miserable, out-of-shape, and have no qualms with bringing you and everyone else around them down. If you have negative people in your gym that are draining you of your energy, or holding back other clients from getting their best results, cut them loose. As trainers and coaches, there are going to be days when we are sick, having family or relationship problems, injured, hurting, or just not feeling all that great. Another key component of bringing your best everyday is for you to get better everyday. Continuing education is a must these days. No longer is it acceptable to learn what you used back in college to get results. You might not have to change how you do things every five years, but you should be constantly educating yourself to improve your skills as a trainer or coach. A positive attitude is infectious â€" your clients and athletes can feel your positivity, and it rubs off on them. Just like you can have bad days, so can they. Summary So those are five of my best tips for motivating clients. What are some of your favorite strategies for keeping clients motivated and achieving success?

Chapter 6 : 5 More Reasons Your Therapist Won't See You Now

Just like you can have bad days, so can they. But if you're positive and upbeat when you walk in the gym, you can turn their day around and make their next workout a great one! Summary.

They can be found in Appendix B. The Substance Abuse Treatment Continuum and Functions of Case Management Substance Abuse Continuum of Care Substance abuse treatment can be characterized as a continuum arrayed along a particular measure, such as the gravity of the substance abuse problem, level of care - inpatient, residential, intermediate, or outpatient Institute of Medicine, - or intensity of service ASAM, The continuum in this TIP is arranged chronologically, moving from case finding and pretreatment through primary treatment, either residential or outpatient, and finally to aftercare. Inclusion of case finding and pretreatment acknowledges the wide variety of case management activities that take place before a client has actually become part of the formal treatment process. For example, a client may need residential treatment for a serious substance abuse problem, but only be motivated to receive assistance for a housing problem. Case management is designed to span client needs and program structure. Case finding and pretreatment The case-finding aspect of treatment is generally of paramount concern to treatment programs because it generates the flow of clients into treatment. Pretreatment has changed enormously in the past five years as programs have closed, resources have dwindled, and services available under managed care plans have been severely curtailed. Many individuals identified as viable treatment candidates cannot get through the gate, and pretreatment may in fact constitute brief intervention therapy. Treatment programs may undertake case-finding activities through formal liaisons with potential referral sources such as employers, law enforcement authorities, public welfare agencies, acute emergency medical care facilities, and managed care companies. Health maintenance organizations and managed care companies often require case finding when hotlines are called. General media campaigns and word of mouth also lead substance abusers to contact treatment programs. Some treatment programs operate aggressive outreach street programs to identify and engage clients. Outreach workers contact prospective clients and offer to facilitate their entry into treatment. Although treatment admission may be the foremost goal of the worker and the treatment program, prospective clients frequently have other requests before agreeing to participate. Much of the assistance offered by outreach workers resembles case management in that it is community-based, responds to an immediate client need, and is pragmatic. A pretreatment period is frequently the result of waiting lists or client reluctance to become fully engaged in primary treatment. In a criminal justice setting, it may be a time to prepare clients who are not ready for primary treatment because they do not have support systems in place and lack homes, transportation, or necessary work and living skills. The pretreatment period may be when clients lose interest in treatment. When the appropriate services are provided, however, it may actually increase the commitment to treatment at a later time. Numerous interventions - role induction techniques, pretreatment groups, and case management - have been instituted to improve outcomes associated with the pretreatment period Alterman et al. Primary treatment Primary treatment is a broad term used to define the period in which substance abusers begin to examine the impact of substance use on various areas of their lives. Whatever the setting, an extensive biopsychosocial assessment is necessary. This assessment provides both the client and the treatment team the opportunity to determine clinical severity, client preference, coexisting diagnoses, prior treatment response, and other factors relevant to matching the client with the appropriate treatment modality and level of care. Aftercare Aftercare, or continuing care, is the stage following discharge, when the client no longer requires services at the intensity required during primary treatment. A client is able to function using a self-directed plan, which includes minimal interaction with a counselor. Counselor interaction takes on a monitoring function. Clients continue to reorient their behavior to the ongoing reality of a pro-social, sober lifestyle. Whether individuals completed primary treatment in a residential or outpatient program, they have at least some of the skills to maintain sobriety and begin work on remediating various areas of their lives. Work is

intrapersonal and interpersonal as well as environmental. Areas that relate to environmental issues, such as vocational rehabilitation, finding employment, and securing safe housing, fall within the purview of case management. If different individuals perform case management and addictions counseling, they must communicate constantly during aftercare about the implementation and progress of all service plans. Recent findings suggest that the case management relationship may be as valuable to the client during this phase of recovery as that with the addictions counselor Siegal et al. Case Management Functions and the Treatment Continuum In this section, case management functions are presented against the backdrop of the substance abuse continuum of care to highlight the relationship between treatment and case management. Treatment focuses on activities that help substance abusers recognize the extent of their substance abuse problem, acquire the motivation and tools to stay sober, and use those tools. Case management functions mirror the stages of treatment and recovery. If properly implemented, case management supports the client as she moves through the continuum, encouraging participation, progress, retention, and positive outcomes. The fact that not all clients move through each phase of the treatment continuum or through a particular phase at the same pace adds to the variability inherent in case management. The case manager frequently needs to provide services in nontraditional ways, reaching out to the client instead of waiting for the client to seek help. Engagement is not just meeting clients and telling them that a particular resource exists. This initial period is often difficult. Motivation may be fleeting and access to services limited. In many jurisdictions, there is a significant wait to schedule an orientation, assessment, or intake appointment. Third parties responsible for authorizing behavioral health benefits may be involved, and client persistence may be a key factor in accessing services. Additional factors may come into play with clients referred from the criminal justice system. They may be angry about their treatment by the criminal justice system and may resent efforts to help them. Clients who begin treatment after serving time in jail or prison have significant life issues that must be addressed simultaneously such as safe housing, money, and other subsistence issues as well as resentment, resistance, and anger. Others may have active addictions or be engaged in criminal activity. Requirements imposed by the criminal justice system must also be met; these can present conflicts with meeting other goals, including participation in substance abuse treatment. Potential clients may be unfamiliar with the treatment process. Their expectations about treatment may not be realistic, and they may know very little about substance abuse and addiction. It is not uncommon for people at this stage to minimize the impact substance use or abuse has on their lives. These factors often manifest in client behaviors such as missing appointments, continued use, excuses, apathy, and an unwillingness to commit to change. The goal of case management at this stage is to reduce barriers, both internal and external, that impede admission to treatment. Prescreening for program eligibility, coordinating referrals, and working to reduce any administrative barriers can facilitate access to services. The process of motivating a client, beginning the education process, identifying essential needs, and forming a relationship can begin during a prescreening or screening interview. The motivational approaches suggested by Miller and Rollnick encourage client engagement through exploratory rather than confrontational means Miller and Rollnick, Case management can use this framework to engage the client with stage-appropriate services. This means that clients who have not decided to address their substance abuse can often be "hooked" into more intensive treatment by providing basic practical supports. Providing these supports can have the additional effect of reducing the perceived desirability of continued substance use and the lifestyles associated with it. A structured interview provides the client the opportunity to discuss her drug use and history with the case manager and to explore the losses that may have resulted from that use. For some clients, this history may reveal a pattern of increasing loss of control and perhaps loss of freedom. Review and discussion of losses can serve to motivate clients to proceed to treatment. A good initial relationship between client and case manager can also be invaluable when the client experiences difficulties later on in treatment Miller and Rollnick, In addition to information regarding substance abuse and the treatment process, clients must be informed about requirements and obligations of the case manager or case management program, and about requirements they will be expected to meet once they are admitted to treatment. Even at the earliest

stages, clients should be reminded that permanent changes are necessary for recovery. Finally, any questions the client has should be addressed. While case management in the pretreatment phase may be intended to route clients to a particular program, engagement is not just a "come-on" to treatment. Many prospective clients will not formally enter treatment within an agency-defined period, but, within flexible limits, case management services should still be made available to these individuals. The transition from engagement to planning is a gradual one and does not lend itself to agency-created distinctions such as "pretreatment" and "primary treatment. Orientation involves explaining program rules and regulations in greater detail than was possible or necessary during pretreatment. The person responsible for delivering case management to a particular client is in a unique position to assist in the match between individual and treatment. In addition to orienting clients to treatment programs, case managers can orient treatment programs to the clients they refer. Sharing information gathered during the pretreatment phase can provide support for the treatment process that ensues upon program admission. Although discharge plans may have been considered, it is not until discharge that the day-to-day realities of living assume the most urgency. Because of their relationship with their clients and their community ties, case managers are well positioned to help clients make this delicate transition. This coordination occurs within a given treatment program, between the program and other resources, and among these other resources. Clients in aftercare have an array of needs, including housing, a safe and drug-free home environment, a source of income, marketable skills, and a support system. Many have postponed medical or dental care; in recovery, they may seek it for the first time in years. Once an individual is in recovery, physician-prescribed medication for pain management can become a major problem, an issue that may require coordination and advocacy. The findings from the assessment, including specific skill deficits, basic support needs, level of functioning, and risk status, define the scope and focus of the service plan. Case finding and pretreatment Depending on the structure and mission of the program providing case management, assessment may begin when engagement begins. Primary treatment For clients who enter primary treatment, the case management assessment function, which is primarily oriented to the acquisition of needed resources, is merged with an assessment that focuses on problems amenable to therapy - substance use, psychological problems, and family dysfunction. Ideally both assessments are integrated into a biopsychosocial assessment Wallace, Detailed information should be gathered on drug use, drug use history, health history, current medical issues, mental health status, and family drug and alcohol use. This assessment, used in conjunction with the needs assessment, assists the treatment team in developing a formal treatment plan to be presented to, modified, and approved by the client. Whether one person or several conduct these two assessments is largely irrelevant. Where a team approach exists, all members of the team, including the case manager or other professional identified in that role, should bring their expertise to the assessment. Discharge planning and long-range needs identification, particularly with current funding limitations, begins at treatment admission. Because of this, intensive case management for substance abuse clients, regardless of the level of care, is imperative. He also must assess specific areas of functional skill deficits, including personal living skills, social or interpersonal skills, service procurement skills, and vocational skills. Individuals performing this function need to have strong knowledge of and experience in the field of substance abuse. The greater the number of problems the case manager can help the client identify and manage during primary treatment, the fewer problems the client must address during aftercare and ongoing recovery - and the greater the chances for treatment success. A case management assessment should include a review of the following functional areas Harvey et al. These items are not exhaustive, but demonstrate some of the major skill and service need areas that should be explored. The case manager may have to perform many services on behalf of the client until skills can be mastered. Service procurement skills While the focus of case management is to assist clients in accessing social services, the goal is for clients to learn how to obtain those services. The client should therefore be assessed for Ability to obtain and follow through on medical services Ability to apply for benefits Ability to obtain and maintain safe housing Skill in using social service agencies Skill in accessing mental health and substance abuse treatment services Prevocational and vocation-related skills In order to reach the

ultimate goal of independence, clients must also have vocational skills and should therefore be assessed for Basic reading and writing skills Skills in following instructions Manner of dealing with supervisors Timeliness, punctuality Telephone skills The case management assessment should include a scan for indications of harm to self or others. The case manager should also conduct an examination of criminal records.

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Chapter 7 : Therapy Without Force: A Treatment Model for Severe Psychiatric Problems â€" MFIPortal

Some therapists yearn for detailed treatment plans they can easily follow while others scoff at the idea of trying to put on paper what really happens throughout our time with clients.

Buckley It is a pleasure to introduce this special DSM-5 edition of The Professional Counselor, which provides a solid primer regarding changes in the DSM-5 diagnosis process and how these changes will likely impact mental health professionals. Changes within the DSM-5 have prompted counselors to revisit the basics of diagnosis and consider the cessation of certain conventions e. The unprecedented inclusion of various mental health professionals in the development of the DSM-5 is an inherent recognition of how this tool is being used across a wide range of professional disciplines that focus on psychopathology. The manual was originally designed to help mental health professionals within a wide variety of disciplines assess and conceptualize cases in which people were suffering from mental distress. This conceptualization is important in that it facilitates an understanding in a common language toward the development of treatment planning to address complex and entrenched symptomology. The DSM has undergone numerous iterations and represents the current knowledge of mental health professionals about mental illness APA, As with any tool, concerns have emerged about the potential of misuse. It is the professional responsibility of skilled and ethical mental health counselors and other professionals to prevent misapplication of the manual American Counseling Association [ACA], , E. Well before the final revision of the DSM-5, various mental health professionals, organizations and other relevant collaborators helped formulate the manual in unprecedented capacities. Of particular note was the inclusion of national organizations such as the ACA in the form of a DSM-5 task force, which submitted position statements and recommendations to the APA. Much of the data supports the use of more than 60 cross-cutting and severity symptom measures see http: Clinical Utility First reported that utilizing broad and diverse populations of mental health professionals provides rigor for clinical utility. Achieving clinical utility within the DSM diagnostic processes meets the following four objectives: Ultimately, the consideration was whether the revised manual would be accepted and utilized by the practitioners it proposed to serve APA, ; First, First noted that no mandate exists requiring the use of the DSM by any professional, and that other tools used to arrive at an ICD diagnosis exist or are in development e. The DSM-5 workgroups were challenged to revise the manual in order to make it user-friendly and maintain its relevance among mental health professionals. Even though the manual is an imperfect resource, the goal was to enhance clinical utility. Determining a Differential Diagnosis In his primer on diagnostic assessment focused on the DSM-5, Nussbaum offers six considerations in determining a differential diagnosis that serve as an important basis for practice. These considerations or steps include the following: Each of these process steps serves as important reminders for getting back to the basics of rendering diagnoses that help inform treatment. When working with clients, these steps function as points of reference to rule out potential factors influencing misdiagnosis. Additionally, client cultural factors are essential at capturing comprehensive context for assessment and diagnosis. Consider to what extent signs and symptoms may be intentionally produced. Signs and symptoms may be purposely feigned on the part of a client for secondary gain e. Assessing prior mental health treatment including outcomes , cultural factors and potential motives to fake an illness can assist counselors in making an accurate differential diagnosis. Consider to what extent signs and symptoms are related to substances. An important emphasis within the DSM-5 is substance-use and substance-induced disorders, which are included in many relevant diagnostic criteria APA, Counselors are well-advised to make this determination in the initial assessment and continue to assess throughout the course of treatment. Consider to what extent signs and symptoms are related to another medical condition. Clients present with signs and symptoms that may be caused by or coincident with another medical condition in a variety of ways. Counselors should gather medical information from the client and appropriately follow up with medical personnel as needed to ensure proper and accurate diagnosis, which will lead to more targeted and effective

treatment. Consider to what extent signs and symptoms are related to a developmental conflict or stage. A primary strength of counseling professional identity is the focus on human development as a key factor in client distress and resiliency. Counselors must recognize where incongruence exists between what clients present and the expected behaviors or characteristics of their particular developmental stage. Nussbaum stresses the importance of gathering a comprehensive psychosocial history to determine expected developmental milestones. Consider to what extent signs and symptoms are related to a mental disorder. The definition of mental disorder has not changed significantly from previous versions of the DSM: Counselors must be careful to consider the presence of these factors, consult when necessary, and take into account differential diagnosis to determine the most appropriate diagnosis given the verbal and observable data available. Consider whether no mental disorder is present. Sometimes a client may present with symptoms that do not meet the full diagnostic criteria for a mental disorder, despite significant distress in social, occupational or other areas of functioning. In these cases, utilizing the not otherwise specified or unspecified diagnoses may be warranted in order to provide opportunities for deeper inquiry. For example, the symptoms of a disorder may be a secondary reaction to an identifiable social stressor that may justify a diagnosis of an adjustment disorder. The possibility exists that there may not be a diagnosis present Nussbaum, , and in these cases, counselors and other mental health professionals are challenged to make that decision in the face of pressures to diagnose. For the first time, culture in its varied manifestations has been intentionally incorporated into the DSM nosology through a specific assessment instrument. Counselors are encouraged to utilize the CFI as a way to understand their clients more meaningfully and to aid in clinical utility. Readers will find a variety of articles that will assist mental health professionals by providing important context for most of the salient changes within the DSM-5 APA, from the perspective of professional counseling. Inherent in each of these contributions is the theme of getting back to the basics in not only understanding the DSM-5 conceptually, but also providing ideas for putting concepts into practice. An essential element in understanding and using the DSM-5 effectively is exploring the foundational and historical roots of this complex nosology. While there is necessary redundancy on key points e. The authors review the implications of such changes for professional counselors. Gintner provides an excellent context regarding the harmonization of the DSM-5 with the ICD, the inclusion of cross-cutting symptom measures and dimensional assessment, and how the manual is organized. The article focuses on how counselors might respond to these changes. These authors provide an important context for the decision to terminate the multiaxial system including advantages and disadvantages of DSM-5 changes. King describes the practical application of diagnostic criteria and the use of cross-cutting dimensional assessments. This perspective offers a backdrop on which to compare current practice and how it may alter with use of the DSM This article focuses on clinical utility and ensuring that the DSM-5 remains a guide to assessment, diagnosis and treatment. Schmit and Balkin give a comprehensive review of the cross-cutting, dimensional and severity measures from the perspective of psychometric instrumentation, including the practical application of validity and reliability. These authors underscore DSM-5 assessments as soft measures and provide important cautions to counselors using these instruments in their work with clients, including the importance of developing multiple data points. Understanding specific diagnostic categories is essential to good clinical practice. Welfare and Cook ; Kenny, Ward-Lichterman and Abdelmonem ; and Jones and Cureton provide solid descriptions of specific diagnostic criteria and emphasize areas essential to our understanding of developmental and demographic strata. Welfare and Cook tackle chronic and persistent mental illness manifested in diagnoses within the following categories: Clinical examples help contextualize the process of assessing and diagnosing these disorders and provide a detailed example of effectively utilizing each step of the diagnostic process. The authors discuss how diagnostic criteria have been developed for both children and adults and how cross-cutting symptoms e. Another significant change to this category is the acknowledgement of sexual abuse as a traumatic event; this takes post-traumatic stress disorder PTSD out of the often associated realm of combat veterans and into more common and insidious manifestations of trauma. Counselors should consider the aforementioned changes to the DSM-5 in the context of their counselor

identity. Maintaining professional identity and promoting a wellness- and strength-based perspective continues to be an important concern for the counseling profession and the training of counselors. Tomlinson-Clarke and Georges provide an overview of maintaining professional identity in the process of assessment and diagnosis within a system representing the medical model. A particular strength is the inclusion of how multicultural competency is crucial in using the DSM-5 effectively, which is an essential basic foundation to sound practice. Implications for counselor preparation also are a focus. Finally, Frances provides a critical commentary of how the DSM has been used by pharmaceutical companies to leverage significant profits at the cost to consumers of mental health services and our economy. As the former chair of the DSM-IV task force, Frances reminds counselors and other mental health professionals of their essential place within treatment and cautions counselors to use the DSM in a balanced manner. His comments are consistent with advocacy inherent in our profession for treatments that promote client resilience, and address psychosocial and environmental factors that impact client functioning. Conclusions This special TPC issue on counseling and the DSM-5 provides a compilation of articles covering the history of the DSM, structural and categorical changes, the process of diagnosis, implications for practice, and cautions and criticisms. These articles validate the unique and important perspective counselors bring to their work, and challenge all mental health professionals to use the DSM-5 accurately. The DSM continues to evolve, and its advocates have made significant strides in reaching out to a variety of professionals; one manifestation of this outreach is the development of the DSM-5 website see http: Counselors have the opportunity to use the DSM-5, provide feedback directly to the APA, and help shape and influence future editions of this diagnostic tool. This is an important way counselors can advocate for their clients as well as their profession, and shape how the DSM is used to help treat those suffering from mental and emotional distress. References American Counseling Association. Diagnostic and statistical manual of mental disorders 4th ed. Diagnostic and statistical manual of mental disorders 5th ed. Historical underpinnings, structural alterations and philosophical changes: Counseling practice implications of the DSM The Professional Counselor, 4, â€" Clinical utility in the revision of the diagnostic and statistical manual of mental disorders DSM. Research and Practice, 41, â€" DSM, psychotherapy, counseling and the medicalization of mental illness: A commentary from Allen Frances. Innovations, limitations and clinical implications. The book of woe: The DSM and the unmaking of psychiatry. Trauma redefined in the DSM Rationale and implications for counseling practice. The expansion and clarification of feeding and eating disorders in the DSM Clinical application of the DSM-5 in private counseling practice. The removal of the multiaxial system in the DSM Implications and practice suggestions for counselors. Culture and psychiatric evaluation: Operationalizing cultural formulation for DSM The pocket guide to the DSM-5 diagnostic exam.

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Chapter 8 : Module6-Motivation and Treatment Intervention

â€¢ Can't Give Up High - For many addicts, the biggest reason they don't go for treatment is that they can't give up the high. They're so wrapped up in how good they feel, so addicted to the high, that they can't envision living without it.

Here are some tips and guides for getting families involved. Engagement Checklist Clinicians may want to use the Engagement Checklist during the initial contact over the phone. The checklist was developed by the authors of IDDT. Despite the effectiveness of family work, many mental health and addiction programs do not have a family component. Many clinicians never ask clients whether they would like to involve a family member in their treatment. Even when clinicians do ask clients about family, some clients fear involvement would be too stressful or too burdensome for their families. These issues can usually be successfully addressed. Clinicians who lack experience working with families could benefit from practicing with colleagues who have done family work. In addition, clinicians can use motivational techniques to help them in their work with families. Several key principles should guide the family education process to help make it effective. First, information must be provided through a variety of teaching methods to allow for different learning styles. Second, family education must be presented in a low-stress environment; it is easier to learn if everyone in the family is relaxed and feeling safe. Third, there must be an atmosphere of hope, where clinicians express confidence that recovery from co-occurring disorders is possible. This helps the family members feel hopeful as well. Fourth, the focus is always on the present and future, not the past. Finally, family psychoeducation is strengths-based. How to Get Families Involved in Treatment Family involvement begins with a recommendation from the treatment team. This is easier if family clinicians are members of the treatment team and attend meetings regularly to reinforce the relevance of family psychoeducation. In terms of stages of treatment, any stage is appropriate for family psychoeducation. Sometimes a family in crisis may be easier to engage, but families can be involved at any point. Here are the basic steps for involving a family in a treatment plan. Clinicians inform clients about the family psychoeducation program. Clients identify family members that they would like to involve. Clinicians contact the family members to schedule a meeting to discuss the program. Family members and the client meet with the clinician to discuss the program and decide if they want to participate. If there is interest, an orientation meeting is held. At this meeting, the program is described in more detail, any concerns of the family are addressed, and family work begins. Clinicians can help clients see that family psychoeducation will reduce stress by improving communication and problem-solving skills within the family. Some clients worry about family members finding out about their alcohol or drug use or other private issues. Clinicians need to reassure clients that private matters can be kept confidential if they wish. Certain information, such as relapses, will be important to share with the family, and clinicians should encourage clients to do so. Possible family issues The initial contact with a family member is often by phone. The goal of the contact is to get family members interested enough to meet the clinician in person. The personal contact allows family members the opportunity to tell their story. Often family members of clients with co-occurring disorders feel stigmatized. Family members often have built up strong negative feelings and need to vent. By using active and reflective listening, clinicians communicate their understanding to the family members. Clinicians should also convey the message that change is possible. This text is excerpted from Integrated Dual Disorders Treatment:

Chapter 9 : 5 Ways to Keep Your Clients (Or Yourself!) Motivated - Robertson Training Systems

They face myriad issues every day, any one of which can propel them headlong into relapse. Unfortunately, far too many of them will. Add to these numbers the estimated 22 million people who need treatment for addiction and the magnitude of the problem becomes even more significant.