

## **Sticks and Stones: Words and Terms that Will Help You Ruin a Therapeutic Alliance**

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### **Pre-Test Questions**

Select and Circle the Best Answer:

1. Prochaska's Transtheoretical Model of Change:
  - a. Can apply to addictive disorders as well as to mental health disorders.
  - b. Requires extensive training to understand.
  - c. Provides a linear model of stages that are fixed and static.
  - d. Recommends that only motivated people should receive treatment.
  
2. Assessment of resistance and denial is important to:
  - ⌘ Match treatment to the client's readiness to change.
  - ⌘ Ensure residential care is not wastefully utilized.
  - ⌘ Avoid confrontational approaches that alienate the client.
  - ⌘ Individualize the referral and treatment plan.
  - ⌘ All of the above.
  
3. To ask a consumer what s/he really wants:
  - ⌘ Is unnecessary as their judgment is so poor.
  - ⌘ Is as important as assessing what the consumer needs.
  - ⌘ Gives a false impression that they should have choice about treatments
  - ⌘ Leads to disrespect of the clinician's authority and expertise.
  - ⌘ Usually reveals unrealistic goals that should be ignored.
  
4. Identify what stage of motivational readiness to change corresponds with each of the following client statements:

Client: "I guess this is making my life difficult, but it's just too hard to change."

Stage of Change:

Client: "I've been sober now for eight months."

Stage of Change:

Client: "I don't have a problem with weed, I can quit any time."

Stage of Change:

**Indicate True or False**

- |                                                                                                                                                                                 | T   | F   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|-----|
| 5. Because of denial, confrontation is more important than collaboration.                                                                                                       | ( ) | ( ) |
| 6. If a person is ambivalent, it is best to talk persuasively about the healthy choices.                                                                                        | ( ) | ( ) |
| 7. Motivational Interviewing values empathy and rolling with resistance.                                                                                                        | ( ) | ( ) |
| 8. Clinicians often view mental illness relapse very differently from addiction relapse                                                                                         | ( ) | ( ) |
| 9. Self efficacy means to be more interested in your own needs than others' needs.                                                                                              | ( ) | ( ) |
| 10. If a client comes back after a pass into the community having had two beers that day, they should be told to leave and that they can be reconsidered for readmission later. | ( ) | ( ) |
| 11. If a client disagrees with your assessment or recommendations, it is best to gently remind him or her that you are the professional and they are the client.                | ( ) | ( ) |
| 12. Resistance is as much an interpersonal phenomenon as it is client pathology.                                                                                                | ( ) | ( ) |
| 13. The counselor's role is to facilitate the client's natural self-change process.                                                                                             | ( ) | ( ) |
| 14. Clients in early stages of change need relapse prevention strategies                                                                                                        | ( ) | ( ) |

**A. Why This Topic?**

1. What Works in Treatment - The Empirical Evidence

\* **Client/Extratherapeutic Factors** plus **Treatment Effects** is everything and anything that contributes to a therapeutic outcome (100%).

\* **Client/Extratherapeutic Factors** encompass all that affects improvement, independent of treatment.

\* **Treatment's** contribution to the outcome is important but proportionally much less (13 to 20%).

\* **Treatment Effects -Therapeutic Factors: Alliance, Therapist, Expectancy, Placebo and Allegiance, and Model/Technique Effects.**

\* **Alliance** (5 to 7% of overall outcome or 38-54% of the variability in treatment effects i.e. 5 to 7% divided by 13%)

\* **Therapist Effects** (8 to 9 % or 62-69% of the variability in treatment effects) contribute most to the Treatment Effects.

\* **Model/Technique** contributes least (1% or 8% of the variability in treatment effects).

“In reality, the common factors are not invariant, proportionally fixed, or neatly additive.....they are independent, fluid, and dynamic....In short, the role and degree of the influence of any one factor are dependent on the context: who is involved; what takes place between therapist and client; when and where the therapeutic interaction occurs; and ultimately, from whose point of view these matters are considered.”

(p. 34 "The Heart & Soul of Change" Eds Barry L. Duncan, Scott D.Miller, Bruce E. Wampold, Mark A. Hubble. Second Edition.)

## 2. What is a Therapeutic Alliance and Relationship?

The therapeutic alliance refers to the quality and strength of the collaborative relationship between the client and therapist (Norcross, 2010). The alliance is comprised of four empirically established components: (1) agreement on the goals, meaning or purpose of the treatment; (2) agreement on the means and methods used; (3) agreement on the therapist's role (including being perceived as warm, empathic, and genuine; and (4) accommodating the client's preferences.

### (a) Practice Implications from Research on what Clients believe helped them in therapy (Norcross, 2010):

- *Listen to Clients* – cultivate and customize the therapeutic relationship.
- *Privilege the client's experience* = it is the client's experience of empathy and collaboration that best predicts treatment success, not the therapist's.
- *Request feedback on the therapy relationship* – this empowers clients, promotes explicit collaboration, allows for real time adjustments to treatment plans and enhances outcomes.
- *Avoid critical or pejorative comments* – avoid negative communication patterns that detract from outcome, especially with difficult clients. This includes comments or behaviors that are critical, attacking, rejecting, blaming or neglectful. Difficult clients do this to the therapist, but shouldn't get this back.
- *Ask what has been most helpful in this therapy* – towards the conclusion of a successful course of treatment e.g., “You listened carefully”, “I could tell you anything”. Or other actions that demonstrated respect, listening and support: “You returned my phone calls”; or offered me a bottle of water.

### (b) Repair of Alliance Ruptures (Norcross, 2010):

A rupture in the therapeutic alliance is a tension or breakdown in the collaborative relationship. Clients often do not tell you, they “vote with their feet” and dropout of treatment.

- Causes of ruptures: rigid adherence to a treatment manual; and an excessive number of transference interpretations.
- Repairs of ruptures can be facilitated by the therapist's responding non-defensively, and addressing directly the alliance and adjusting his or her behavior.

*Self-disclosure* = therapist statements and behaviors that reveal something personal about the practitioner.

- Research suggests that therapists should disclose infrequently and do so to: validate reality, normalize experiences, strengthen the alliance, or offer alternative ways to think or act.
- Avoid self-disclosures that are for their own needs, remove the focus from the client, or blur the treatment boundaries.

*Manage Countertransference* = reactions in which the unresolved conflicts of the therapist, usually but not always unconscious, are involved.

- Manage countertransference by: self-insight, self-integration, anxiety management, empathy and conceptualizing ability.

*Quality of Relational Interpretations* = interpretations are therapist interventions that attempt to bring material to consciousness that was previously out of awareness.

- Making connections for clients, going beyond what the client has overtly recognized, and pointing out themes or patterns in the client's behavior.
- High rates of transference interpretations lead to poorer outcomes.
- Better outcomes are achieved when the therapist addresses central aspects of client interpersonal dynamics and themes

(c) What Does Not Work (Norcross, 2010):

What should be avoided:

- *Confrontations* – a confrontational style is ineffective. By contrast, expressing empathy, rolling with resistance, developing discrepancy and supporting self-efficacy have large positive effects.
- *Negative Processes* – avoid comments and behaviors that are hostile, pejorative, critical, rejecting, or blaming. Don't attack the person. Distinguish attacking the client's dysfunctional thoughts, relational patterns or behaviors. Learn relational and self-soothing skills.
- *Assumptions* – don't assume you know what the client's perceptions of the alliance, empathy and satisfaction are. Specifically, respectfully and frequently inquire about the client's perceptions.
- *Therapist Centricity*– (DiClemente CC (2006): "Natural Change and the Troublesome Use of Substances – A Life-Course Perspective" in "Rethinking Substance Abuse: What the Science Shows, and What We Should Do about It" Ed. William R Miller and Kathleen M. Carroll. Guilford Press, New York, NY. pp 91; 95.)

The Transtheoretical Model (TTM) illuminates the process of natural recovery and the process of change involved in treatment-assisted change. But "treatment is an adjunct to self-change rather than the other way around." "The perspective that takes natural change seriously...shifts the focus from an overemphasis on interventions and treatments and gives increased emphasis to the individual substance abuser, his and her developmental status, his and her values and experiences, the nature of the substance abuse and its connection with associated problems, and his or her stage of change." (DiClemente, 2006)

- *Rigidity* – Being inflexible and excessively structured in treatment makes it harder to be empathic attentive to the clients' experiences. If you dogmatically rely on particular relational or therapy methods that are not a good fit for the client, outcomes are poorer.
- *Ostrich Behavior* – Don't bury your head in the sand and hope against hope that early signs of rupture in the working alliance will just go away. Address the alliance problems even though it is challenging and difficult.
- *Procrustean Bed* – One size does not fit all

Reference: Norcross, John C (2010): "The Therapeutic Relationship", Chapter 4 in Section I, What Works and What Does Not: The Empirical Foundations for the Common Factors in "The Heart & Soul of Change" Eds Barry L. Duncan, Scott D. Miller, Bruce E. Wampold, Mark A. Hubble. Second Edition. American Psychological Association, Washington, DC. pp 113-141.

### 3. Development of the Alliance is the Highest Priority in the Opening Phases of Therapy

In the last thirty years there have been over 2,000 research publications and papers on the concept of the alliance. Here are some of the conclusions about developing the alliance that can help in your therapeutic practice with clients:

- **Develop a strong alliance early in treatment** – "Early" is relative to the length of therapy. But there is a convergence of evidence that points to sessions 3 to 5 as a critical window. In some ways this is not surprising if you have ever gone to therapy yourself. Would you likely go back to a therapist who you didn't feel was helping; and whose methods and fit with your style seemed ineffective?  
Would you really be interested in hanging in for five or more sessions? Of course if you have excellent retention rates, then you can ignore this point as you must be doing this well already.

- **The client's experience of being understood, supported, and provided with a sense of hope** is linked with the strength of the alliance in early stages of therapy – clinicians need to be curious about the client's perception of what you are doing to generate empathy, support and hope. The client's interpretation of what you do, especially early on in treatment, can be quite different from what you intended. Message sent may not be the same as message received. Just because you think you are great at engaging people doesn't mean that the client experiences it that way at this point in time with you. In other words, you may be a great clinician, but not necessarily for this particular individual at this time, doing the kind of work you do, which leads to the next conclusion.
- **Progressively negotiate the quality of the relationship** as an important and urgent challenge – You can anticipate that your initial assessment of the client's relational capacities, style, preferences and quality of the alliance may differ from the client's. It is the client's perception of the alliance that is most influential, not yours. If they feel no hope or confidence in what you have to offer, they are the ones who stop coming to treatment either physically and/or energetically (if mandated or incarcerated). Thus it is important to specifically check out their perceptions on whether the relationship in treatment is working for them or not.
- **Techniques and models contribute less to outcome in early stages** of treatment than the quality of the alliance -The alliance should be forged first. This includes a collaborative agreement about the goals of treatment and the important strategies to be used as part of the therapeutic work. Only then can various models and techniques be usefully implemented

**The bottom line:** Developing a good working alliance with the client is not just a nebulous, generic nice thing to work on over weeks and months. It is a specific, early, clinical priority to evaluate and measure.

Reference:

“Psychotherapy Relationships That Work – Therapist Contributions and Responsiveness to Patients” (2002) Ed. John C. Norcross. Oxford University Press, New York. pp 11-14.

Horvath AO, Bedi RP (2002): “The Alliance” in “Psychotherapy Relationships That Work – Therapist Contributions and Responsiveness to Patients” (2002) Ed. John C. Norcross. Oxford University Press, New York. pp 37-69.

## **B. Sticks and Stones**

Consider the following common clinical situations and terms used in clinical work and whether they increase or decrease the quality of your therapeutic alliance with clients:

### **1. Engagement and Attracting People into Recovery**

#### **(a) “Resistant”**

\* Resistance is often perceived as pathology within the person, rather than an interactive process; or even a phenomenon induced and produced by the clinician

\* “Resistance” may be as much a problem with knowledge, skills and attitudes of clinicians as it is a “client” problem

#### **(b) “Unmotivated” or “Not ready”**

\* All people are “motivated” and “ready” if they are talking to you. But what they are motivated and ready for may not be what you think they should be motivated and ready for.

\* That is your problem not their problem. We make it their problem and then call them names like “resistant”, “unmotivated”, “help rejecting”, “oppositional”, “self will run riot”, “stinking thinking”.

(c) “Treatment compliance” versus “treatment adherence” – In the literature, significant parts of the rest of healthcare have been using “adherence” long before the mental health and addiction treatment field has had their consciousness raised to the implications of using “compliance” versus “adherence” terminology. In this age of empowerment and collaborative service planning, it is not for the expert counselor and professional to develop a plan with which the client must comply. It isn’t for the physician to prescribe the medication with which the patient must demonstrate medication compliance.

Webster’s Dictionary defines “comply” as follows: to act in accordance with another’s wishes, or with rules and regulations. It defines “adhere”: to cling, cleave (to be steadfast, hold fast), stick fast.

## 2. When people are not skilled at getting their needs met, don’t call them names

“Manipulative”, attention-seeking”, “entitled”, “acting-out” flow so easily from the clinical tongue. But if you reframe the person’s behavior as unskilled attempts to get their needs met, you can be empathic and help them develop more effective ways to get their needs.

### (a) “Manipulative”

- If you are skilled at asking for what you want and persuading people to meet your needs and collaborate and cooperate with you, we call you “assertive”, or an effective leader”, or “a person of influence”. But if you are not skillful in asking for what you want; try to get what you want from one person and then if that doesn’t work, attempt to get someone else to meet your need, we call you “manipulative” especially if you go about it in an annoying persistent manner.

### (b) “Attention seeking”

\* We all have the need for attention to some extent. Nobody wakes up every day and says to themselves: “I hope no-one notices I am around, ignores me and treats me as if I am a nobody.” So if you are skilled at getting noticed, respected and do that in ways that contribute positively to others’ lives, we call you a “celebrity” or “movie or rock star” or “politician” or “trainer and consultant”!

\* If you are not skilled at getting noticed and regarded and go about seeking that in annoying, intrusive ways, then now you are “attention seeking”. Such people are crying out to be respected and taken seriously, but need skills training on how to get those needs met effectively, instead of calling them names and rejecting them.

### (c) “Entitled”

\* We all have the need for fairness; to receive what is our right to have; to be acknowledged and appreciated for what we have done or deserve. If you are skilled at achieving this recognition and what is rightfully yours, we applaud you for knowing what you want and how to succeed.

\* If you are not skilled at getting respect and what you have a right to have; or if you have not been taught the value of hard work and diligent effort to reach a goal, then now your counterproductive interpersonal skills result in labels like “entitled” or “narcissistic”.

### (d) “Acting out”

\* When you have the skills to deal with frustration, disappointment and stress, then no one is offended by your behavior and coping mechanisms.

\* If you are not skilled at managing your stress, frustration, and needs for love and acceptance, then your ineffective attempts to cope with those troubling feelings and needs ends up with being noticed and targeted as “acting out” behaviors to be subdued and controlled.

### 3. Technical psychological constructs and terms are just that, not code words to describe people you don't like

“Borderline”, “splitting”, “passive aggressive”, “Axis II” are some of the terms that have specific psychological meaning or are constructs with a defined meaning. However, listen into a team treatment-planning meeting and see if you can distinguish when clinicians are using these terms to describe the specific psychological term or construct and when they are actually using these words as shortcuts to describe a client they find annoying or difficult to work with.

- “She is so borderline and manipulative!”
- “Look at all those admissions and how thick the chart is. Must be a borderline”
- A client is not getting along with his assigned therapist but lacks the assertiveness skills and self esteem to deal with that directly with his clinician. Unfortunately the therapist does not seek out feedback from the client on whether the methods used are a good fit for the client so is unaware of the client's dissatisfaction. When the therapist discovers that the client has talked to another clinician, seeking to be on her caseload, the client is accused of “splitting” and manipulating.
- A similar client is intimidated by the counselor and has some transference authority issues that prevent them from disagreeing with the counselor's advice and directives. So rather than dealing directly with his concerns about the treatment plan, he simply doesn't follow through, hoping the counselor won't notice. When the counselor does notice the non-adherence, the client is confronted for being “passive aggressive”.
- “Oh he is so Axis II. Can someone else take his case?”

#### Implications:

1. Incorrectly used words and terminology create barriers that inhibit and even prevent joining therapeutically with people.
2. Using such words can give ourselves permission to not listen to clients and see their important feelings and needs: “She is so borderline and acting out, that you can't believe a word she says.”
3. When we label clients in this way, it puts the problem within the client, instead of seeing that the problem is an interactive one, influenced by the clinicians' attitudes, beliefs and behavior.

(Ronald J. Diamond, MD, Professor at the University of Wisconsin School of Medicine and Public Health in Madison presented thought-provoking ideas that the title of his talk says it all: “From Bad-mouthing to Good-mouthing the Customers: Alternatives to pathologizing and put-down labeling of people.”)

### 4. Documentation and the attitudes our assessments and progress notes reveal

- (a) “More willing to follow rules and be compliant with treatment activities.”

Clinicians usually believe they know what is best for their clients to do and set about getting them to comply with treatment recommendations. Even if your recommendations are worthy, the focus is not on cajoling a person into being “willing” to comply with treatment. Treatment is about helping people in their self-change process (unless you plan to live with a person 24/7 and tell them what to do all the time.) Tracking progress in a client's treatment is focused on improvement in function to achieve their goals – not the success or not of getting a client to do obey rules and comply with others' wishes and recommendations.

- Alternative Progress Note: “Able to redirect his anger from punching others and demonstrate sufficient stability to transition more quickly out of the hospital back to the community.”

(b) “Client admitted that alcohol and marijuana use sometimes interferes with her school grades.”

“Admitted” implies the client was withholding the truth and somehow the clinician got the person to finally admit what they have been hiding in the assessment. While it is true that client’s can lie and hide information, there is no need for them to do that if you have created an accepting environment that invites openness. There is nothing for a client to defend and admit to, if you are willing to start wherever the client is at. We are not trying the client to say the right answer. We want to know honestly what they think and believe.

- Alternative Assessment Note: “Client does not think alcohol and marijuana is a problem except sometimes when it did interfere with studying.”

(c) “Client minimizes the extent of his methamphetamine use.”

Related to the phrase above, “minimizes” implies we know the client is lying and what information the client does admit to is half the truth anyway. Again, there is nothing for a client to shave the truth about if you are open to whatever the client is doing. When you approach the client with an attitude that you assume they are lying, it comes across whether you say it directly or not.

- Alternative Assessment Note: “Client does not think his methamphetamine use is very great. And does not feel that the affects on his life are very troublesome.”

(d) “Client denied any previous addiction or mental health treatment.”

“Denied” implies the client was again lying about her past history and that the clinician knows the real truth. Even if the clinician is not documenting this history with that attitude and is merely saying that the client said they had not been in previous treatment, why is it necessary to use the word “deny”? If your spouse or partner did not go to the store to buy milk on the way home, we don’t say “Joe denied he did not buy the milk.” We just say: “Joe didn’t get the milk.”

- Alternative Assessment Note: “Client said he has not had any previous addiction or mental health treatment.”

(e) “He claims current daily usage is 5 - 7 beers on weekdays and up to 12 beers/day on the weekends.”

Like “client minimizes the extent of his methamphetamine use”, “claims” suggests that the clinician believes and knows the client is lying about how much alcohol he is using. “Claims” translates into:

“I know you are drinking much more than you are willing to admit, so although you claim to be drinking only 5-7 beers on weekdays and more on weekends, we all know that you are lying.”

Now you may not mean any ill-will in writing “claims” and you most likely didn’t verbalize the dialogue above. But we can create a person-centered environment of acceptance so there is no reason for a client to shave the truth about how much he is drinking. When you approach the client with an attitude that you assume they are lying, it comes across whether you say it directly or not.

Imagine your supervisor listening to you describe the hours you spent in doing paperwork and then documenting in your personnel file: “The counselor claims she spent three hours doing paperwork and wants me to consider decreasing her caseload.” Would you consider that unsupportive and even suspicious that your supervisor mistrusts you?

- Alternative Assessment language: “He describes his current daily usage as 5 - 7 beers on weekdays and up to 12 beers/day on the weekends.”

This doesn’t mean you are naive about how people with a stigmatized illness of addiction can lie about their alcohol or other drug usage. And with evidence from collateral sources that the client uses more than he says, your assessment summary will document the discrepancy between what the client describes and what other evidence shows. But in our attitude towards the client and in the language we document it more likely to attract a person into recovery if we approach people with acceptance.

(f) “He is not willing to admit that he is alcoholic in spite of previous treatment with successful outcome (18 months abstinence.)”

“Not willing to admit” suggests that the client knows good and well that he has an alcohol problem but is just being stubborn and “not willing to admit” the truth. From the client’s perspective he does not have an alcohol problem no matter how obvious it may be to you and others around him. Person-centered language rather than clinician-centered or diagnosis-centered language looks at the world through the client’s eyes. This is what the principle in Motivational Interviewing, “Express Empathy”, means.

“Admit” implies the client is refusing to tell the truth and somehow the clinician has to get the person to finally admit that they know they are an alcoholic and be willing to confess. While it is true that client’s can lie and hide information, there is no need for them to do that if you have created an accepting environment that invites openness. There is nothing for a client to defend and admit to, if you are willing to start wherever the client is at. We are not trying to get the client to say the right answer. We want to know honestly what they think and believe.

- Alternative Assessment Note: “Client does not believe that he is alcoholic in spite of previous treatment with successful outcome (18 months abstinence).”

Imagine you are telling your supervisor how your large caseload makes it difficult to get all the paperwork done in a timely fashion. Then you read the supervisor’s documentation in your personnel file: “Counselor is not willing to admit her time management problems and how inefficient she is in documentation.” How likely would you confide in your supervisor next time and come to him or her for support?

### **C. Clinicians from Mercury and Clients from Saturn**

1. What client issues, feelings, needs or perceptions do clinicians misunderstand or not tune into?

For example: “I just wish counselors would be more.....”  
“If only therapists would.....”  
“I hate it when counselors.....”  
“What therapists don’t seem to understand is.....”  
“Clinicians need to be more aware of.....”

2. What clinician issues, feelings, needs or perceptions do clients misunderstand or not tune into?

For example: “I just wish clients would be more.....”  
“If only clients would.....”  
“I hate it when clients.....”  
“What clients don’t seem to understand is.....”  
“Clients need to be more aware of.....”

3. What do clinicians do well when working with clients effectively?

For example: “Effective clinicians usually.....”  
“More clinicians need to.....”  
“I admire counselors who.....”  
“What clients seem to appreciate most about therapists is.....”  
“You can tell the clinician is effective when.....”

4. What do clients do that makes working with them gratifying?

For example: “Clients who have a good therapeutic alliance usually.....”  
“More clients need to.....”  
“I appreciate clients who.....”  
“What counselors like most about clients is when.....”  
“You can tell the client is engaged in treatment when.....”

## **D. Other clinical terms and their unintended negative implications**

Check whether you want to convey the meaning these words represent:

- (a) “Drug of choice” – Carlton K. Erikson, Ph. D. of the University of Texas in Austin has challenged our innocent use of asking people what is their drug of choice- not everybody with an addiction problem is drawn to the same drug or drug class. Carlton challenged that when a person has developed an addictive relationship to a drug, they are not at choice with the drug anymore – it isn’t their drug of choice, it is their drug of necessity. And he said, for us to think and talk about it as if it is a drug of choice perpetuates that it is willful misconduct that they could choose to do differently.
- (b) “Clean/dirty urines” versus “negative/positive urines” – Even though we have positive associations to being “clean and sober”, consider whether using “dirty” instead of “negative” urine drug screen results only adds to the stigma of drug users as being dirty. Stick with positive and negative results rather than dirty and clean urines.
- (c) “Client, patient, consumer or customer” – I once heard an addiction medicine physician who was deeply committed to serving the sick and suffering person with alcoholism and drug addiction lament the increasing reference to consumers and customers. To him, the field was forgetting the hard won fight to have medicine, society, health insurance, payers and disability policies recognize alcoholism and addiction as a disease and chronic illness. These are patients who are ill and need healthcare; not consumers or customers at a supermarket or hardware store needs butter or light bulbs. It was painful for him to see the shift that consumer advocates and empowerment movements have been promoting.
- We can get so consumed with being politically correct that we forget to be human and real. It’s a bit like a doctor who is so worried about being sued for malpractice that he or she can’t be warm, spontaneous and real with a patient. However, words can reveal and shape attitudes that are almost subliminal and insidious. I raise these so you can choose whether you wish to change your use of these terms or not.
- (d) “Serious and persistent” – This term has no counterpart in general medicine care, which describes general illnesses with similar consequences as “severe” and “chronic” as opposed to “mild” and “acute.” It is not common for example, to talk about “serious” cancers. The term “persistent” could connote a lack of belief in the ability to improve and recover. There is a less pejorative and clinically useful way to categorize individuals with mental illnesses that have chronic functional limitations. It might be to refer to them as having mild, moderate, or severe disability associated with a mental illness symptom or diagnosis, rather than to refer to them as the “seriously” mentally ill.
- (e) “Low functioning” – If you use or hear this term, do you face that person so labeled, with optimism and confidence that you will achieve much with them? Is it easy to assume a more passive stance with very low expectations for recovery or improved function? Would it be more useful to identify what areas a person struggles with and develop a collaborative plan to address which area is most important to the client? For example, would they like to see if they could have more money to use as they wish rather than have a representative payee always control their money? Would they like to aim to live wherever they want, rather than be homeless or be told where to live, what to do when and with whom they can associate?
- (f) “Chronic” -If you use “chronic” to mean a sense of hopelessness about poor outcomes, serious and persistent illness, repeated treatment failures, a non-compliant and low-functioning relapser etc. then I suspect both you and your client’s spirit will be broken. He’s a “chronic” or she’s just “chronic” do not exactly inspire hopeful recovery work. In general health care, when used in contrast to acute illness, “chronic” can be a more neutral term to denote the long-term nature of the illness that will likely need committed treatment or support.

## E. Developing the Treatment Contract

<u>Client</u>	<u>Clinical Assessment</u>	<u>Treatment Plan</u>
<b>What?</b> What does client want?	What does client need?	What is the Tx contract?
<b>Why?</b> Why now? What's the level of commitment?	Why? What reasons are revealed by the assessment data?	Is it linked to what client wants?
<b>How?</b> How will s/he get there?	How will you get him/her to accept the plan?	Does client buy into the link?
<b>Where?</b> Where will s/he do this?	Where is the appropriate setting for treatment? What is indicated by the placement criteria?	Referral to level of care
<b>When?</b> When will this happen? How quickly? How badly does s/he want it?	When? How soon? What are realistic expectations? What are milestones in the process?	What is the degree of urgency? What is the process? What are the expectations of the referral?

### WHAT DO I WANT?

- What do you want that made you decide to come here?** (Say what you want, not what others have said they think you need or should do)
- Why do you want that? How really important to you is that, anyway?** (Think what it would be like if you didn't get your way with what you want)
- Do you know how to get it? What are your ideas about what should be done?** (Be honest and open about your ideas, not what you think others think you should do)
- Where and When do you want to do this plan?** (Think whether or not you want to do this here at this site or program, or whether you had somewhere else in mind)

## F. Skills for changing attitudes and how to engage clients

Here are a couple of tips to encourage the client's "doing treatment", not "doing time":

- (a) "Thank the client for choosing to come to treatment to seek your help"

The client may very well look at you cross-eyed and say: "I'm here because I have to. They made me come. I didn't choose to come here." Genuinely and politely you can answer: "I didn't see anyone force you in the door to sit down and talk to me as you are doing and which I appreciate your doing. You must have come here because you want my help to get something you want very much; or to figure something out that is very important to you." "No, they made me come" he or she may say.

"Then what would happen if you had said, I'm not going? What would have happened to you?"

"Well they would put me in jail or keep me longer". Or: "I'd lose my job or my children".

“Would that be bad for you? So is that what you want me to help you with? – stay out of jail; keep your job; or get your children back?”

Now we have a customer who wants something from treatment and wants your help to get them something important to them.

Most of us have been trained to see only pathology and problems. It can be a tough transition to a strength-based, recovery perspective.

(b) Consider these steps to reframe “pathological” views into recovery and strength-based universal human needs

1. **Look for the feelings, needs and values** behind your pathological (and sometimes judgmental) view of the client’s goals

- e.g., “He just wants to get his benefits so he can get more drugs to get high.” Who among us does not want to feel good and has the need for pleasure?
- e.g., “He is so unrealistic wanting to get a job when he can’t even take his medication as prescribed.” Who doesn’t feel good when productive so you can get financial freedom and security?
- e.g., “She is just here to get her kids back and not really interested in abstinence.” Who doesn’t feel frightened when threatened with losing loved ones and needs love and family togetherness?

2. **Reframe to yourself and the client** what you are hearing in his or her request or goal to further assess what the real needs are

- e.g., “So when you use run out of your disability money and use it to buy drugs, are you still getting a good high from the drugs? Or are you needing drugs to get rid of withdrawal problems and don’t get much of a high anymore?”

Versus: “See how drug addicted you are that you are spending all your money and don’t even have enough for food for the month?”

- e.g., “So when you say you want a job, what do you see the job will do for you? Do you want something to do to occupy your time? Or are you wanting more money and frustrated that you have a representative payee who is controlling all your money?”

Versus: “How do you think you can get a job when you can’t even get to your doctor appointments on time and don’t take you medication regularly?”

- e.g., “So when you say you’re here otherwise you won’t get you kids back, are you missing them so much that you’ll do whatever it takes to be with them again? Or is it really hard to make it financially without the child support payments? Or is it both, which I can totally understand too?”

Versus: “You have to comply with the program and be abstinent if you want a good report for child protective services”

3. **Address the universal human and recovery need** of the client, not just your assessed treatment plan

- e.g., “So let’s find a way so you feel better and don’t have to be so uncomfortable and worried about withdrawal.” – the need for comfort; avoidance of pain
- e.g., “Let’s see what would have to happen for you to regain control of your money –the need for autonomy and financial security
- e.g., “Let’s figure out together how to reunite your family; and what people are seeing that makes them think that you are not safe to be with your children – the need for love and connection

**TIP: Every client who is talking to you in an assessment, treatment session or outreach visit is treatment ready.**

That may sound like a far-fetched claim from someone you may think has lost touch with clinical reality – especially after you read this vignette presented by a treatment team that declared her “Not ready for treatment”.

*Inmate Jane Doe is a 23 year old, Caucasian, female, serving a sentence for Possession of Methamphetamine with attempt to Deliver. She is pregnant with her second child, due date August 28. She gave her first child up for adoption after his birth three years ago. She entered residential treatment on March 9. Date of last use of methamphetamine and marijuana was February 1.*

*Her only motive for entering the residential substance abuse program is to meet the requirements to enter the nursery program and have her child remain in the prison with her after its birth. She states she will sign out of the residential treatment program if she is not allowed to be in the nursery program. Jane denies that she has an addiction problem; she states she has been using recreationally and does not see a problem with it. She states she will use after she gets out of prison. Jane has a long history of abusive relationships. Admits that her current partner is physically abusive to her but is unwilling to consider paroling to any place other than his residence.*

Before you dismiss any client as “Not ready for treatment” or “Not treatment ready”, reframe this in your own mind and how you engage her into treatment. Jane is not ready yet for treatment of what we think and know she needs to work on. But she is at action for getting admitted to the nursery program and keeping her new baby. She is ready for treatment to reach that goal, not the goals we think she should want. She is not “recovery ready”. But if she didn’t want treatment/professional help, she wouldn’t be sitting in your office. And remember she will leave, she says, if we aren’t going to help her keep her baby. What would be wrong with helping her work to keep her baby?

In that treatment and motivational enhancement process, she undoubtedly will bump up against the issues of substance use and who she lives with. Treatment will focus on helping her discover the connection between keeping her baby and drugs and partners. But if we stay close to the client’s goal, Jane will be ready for the kind of treatment that helps her decide she needs to change her life and choices if she is to achieve her goal- i.e. succeed in keeping her baby. Or she will discover that her drugs and partner are more important to her. Either way, she is ready for treatment.

**TIP: Stay focused on what the client wants and you will decrease your frustration level and won’t do more work than them.**

*Joshua is a 48 year old, African American, never married, unemployed homeless cocaine-using man with schizophrenic disorder. He was evicted from his apartment and wants housing. He denies a cocaine problem, but does show up for daily medication so long as he gets his \$10 payment. The team has developed this plan to incentivize his adherence to medication.*

The treatment team questions: Should they be helping him get housing when he only comes for medication to get money which he sometimes uses to buy drugs? Should they help him when he only attends groups to obtain shopping coupons from his disability income? In addition his random urine drug screens are often positive even though he denies using.

Assisting him to get (and keep) some housing will only have a chance of sustained success if Joshua can maintain mental health and substance use stability. So I reassured the team they were on the right track. They were correct in linking medication adherence, group involvement and drug screen monitoring to assistance in getting housing.

Joshua wants freedom and independence, and the team is helping him to achieve that. However, if the goal is not freedom and independence but rather shelter and caretaking, then there is a place for providing housing that does not expect the client to work on mental health and addiction stability. “Wet” and “damp” shelters have their place in such a continuum of care.

**TIP: As a clinician, one of the goals in helping people is to make ourselves as obsolete for the client as soon as possible.**

*Wendy is a 37 year old, Caucasian, divorced, unemployed, single parent of two children, both of whom have been diagnosed with Bipolar Disorder. The psychiatric, addiction and social history of this client is long and complicated: it encompasses sexual abuse in her teens, rape as an adult, physical abuse, Child Protective Services, chronic pain with overuse of narcotic analgesics, seven prior detoxification treatments, and notoriously poor adherence to appointments, medication and therapy.*

When I interviewed Wendy, it was so easy to understand the frustration the team experienced. They struggled to get Wendy to comply with appropriate doses of pain medication, consistent parenting skills, alcohol abstinence, disruptive relationships with parents and her ex-husband etc. Her case was so involved: rich with psychodynamics, complicated systems and family issues, and addiction treatment interventions. There were enough significant clinical and case management issues to keep this team occupied for many years to come.

The process with Wendy is likely to be a long and volatile one. However we must continue to balance nurturance with responsibility. How do we give her enough support to satisfy deep longings for nurturance; at the same time, how do we expect enough accountability which maintains safe boundaries, and allays Wendy's fears of rejection and abandonment?

*"I will hang in with you, but I can't do it by myself." "I will work hard to help you with your depression but I can't do that if you are not showing up for appointments."* Nurturance and accountability all in the one sentence.

Clients like Wendy easily have a new crisis each session - if they even make the appointment! They can often say such things like: "I want to keep seeing you and I feel comfortable with you." They forget they are also quite comfortable yelling at you and blaming you when things are not going well. Be cautious of offering what I once heard from an inexperienced clinician: "You can call anytime. We are here for you anytime." Our job is to empower our client to be as independent as possible, and to make us obsolete - as soon as possible. It is better to say something like:

*"That's great that you find our work together helpful. What is the most important thing for me to help you with? What feelings and needs do you get filled in treatment with me? I want to help you identify those needs, and get them met in more than one place, not just in therapy with me. I will hang in with you, but I can't be your main or only support."*

### **A Clinician's Case Documentation**

**Data:** Client arrived 45 minutes late into a 50-minute session. Client was highly agitated; angry, yelling, and threatening to throw items in this writer's office. Client was inappropriate, aggressive and unwilling to lower her voice despite being asked multiple times. The client adamantly denied being asked to show up at 9:00 am for her appointment and informed this writer and the client's daughter, Theresa (also attending) that she would not participate in family counseling if it meant arriving at the office at 9:00 am every Tuesday. When the client was asked why she would not show up, the client reaffirmed that her time for services began at 10:00 am and no one would make her come any earlier. Further, the client stated that no one told her she needed to be here at 9:00 am. She was confronted with information that was not consistent with her recall. The client denied being told to be here at 9:00 am. (Theresa, reported that her sister, Elisa, made a phone call last night reminding her about the meeting. Her mother received a similar phone call.)

The client continued to raise her voice; despite being asked not to yell. The client threatened this writer by asking if he prefers her (the client) to throw things in the office instead of yelling. The client was instructed to lower her voice and directed not to throw anything in the office. The client did not throw anything. This writer attempted to remind the client why there was family therapy and that Ms. Evans (care coordinator) mandated the treatment; the client stated that she did not care what was mandated. She would not show up and participate; "I am 44 years-old and no one will tell me what to do."

The client was informed that her time was up and next week at 9:00 would be her next appointment. The client left. Five minutes later the client was given an appointment slip with the date and time of her next appointment; next Tuesday at 9:00 am.

**Assessment:** Thought process was disturbed, thought content perseverated on the belief that she would not be told or controlled into showing up every week at 9:00 for family therapy. Mood was dysphoric, affect was angry, aggressive, hostile and belligerent.

The client does not possess adequate impulse control skills to be in family therapy. The client has a history of assaulting her daughter, Theresa and given the client's impulse control deficiencies there is a moderate potential that the client would become assaultive in session given the correct stimulus. The client needs intensive individual sessions focused on management of her impulse control deficiencies, her anger and rage, her inability to see the numerous resources wanting to help her but unable to because she lacks the willingness or ability at this time to cooperate.

The client's UA was negative for drug use which leads to the conclusion that the client has co-occurring mental health disorder impeding her ability to interact successfully with her own family members and her current participation in group therapy. The question about this client being able to care for her own six year old son is obvious; at this time, given her deficiencies, this client does not possess the ability to care for a child.

This client needs to return next week to a family session so that this material may be communicated to her as a clinical goal of allowing the client to experience the weight of the consequences of her behaviors. The client has used for quite sometime her anger, rage, yelling and threats of violence (and actual violence) as a means to manage the relationships in her life. Next week will be this client's last family session until she develops better skills to manage her impulse control deficient, anger and rage.

**Plan:** 1. Individual sessions weekly or bi-weekly are necessary for this client. 2. Continue UA weekly-random. 3. Client needs an increased level of care to include parenting classes, impulse control groups, anger management groups as well.

Thank you. This transaction of information needs to take place prior to next Tuesday. Thanks.

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