"Vocab Rehab" –Rethinking the Words We Use to Communicate Better with Clients, Clinicians and the Community

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A. From Pathology to Participant

- 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" –as much a knowledge, skills and attitudes "clinician" problem as it is a "client" problem
- "Don't try to fix the students; fix ourselves first…When our students fail, we, as teachers, too, fail."
- "There are some things I know for sure: labels are destructive to children."
  (Marva Collins (b. 1936), American educator)

B. Natural Change and Self-Change

(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. Guildford 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)

1. What Works in Treatment - The Empirical Evidence

(a) Extra-therapeutic and/or Client Factors (87%)

(b) Treatment (13%):
- 60% due to "Alliance" (8%/13%)
- 30% due to "Allegiance" Factors (4%/13%)
- 8% due to model and technique (1%/13%)

(Wampold, B. (2001). *The Great Psychotherapy Debate*. New York: Lawrence Erlbaum.
Miller, S.D., Mee-Lee, D., & Plum, B. (2005). Making Treatment Count. In J. Lebow (ed.). *Handbook of Clinical Family Therapy. New York: Wiley).*

2. What Works in Treatment - More 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.

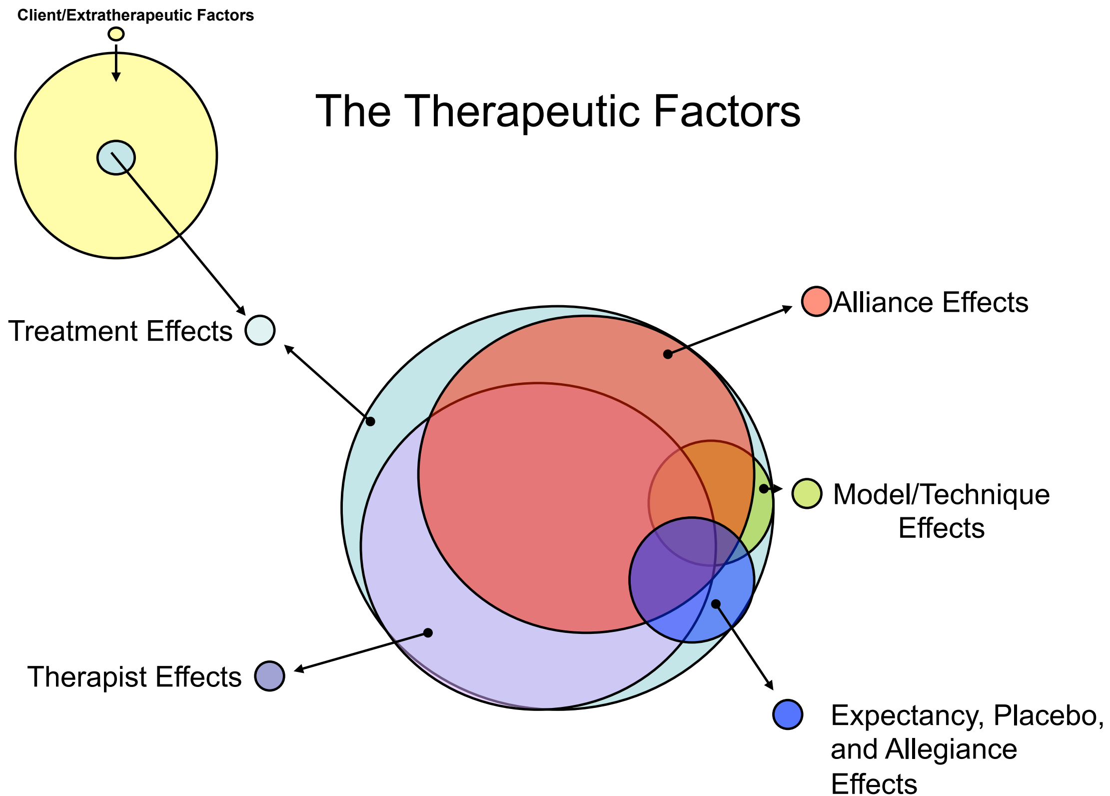
* **Treatment**'s contribution to the outcome is important but proportionally much less (13 to 20%).

* **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).



For counselors/clinicians, note down:
1) A client's behavior that significantly irked you
2) A labeling-type name you thought (or actually said) because of that behavior
3) What you contemplated saying or doing (or actually said or did) because of that name
4) A more engaging and helpful thought and action for that situation, either contemplated or done

For consumers, note down:
1) A labeling-type name you've been called by a counselor/clinician
2) Your behavior or the situation that prompted the name-calling
3) What your reaction (cognitive, emotional, and/or behavioral) was to that name
4) What would have been a more helpful response from your counselor/clinician in that situation

3. Definitions of Compliance and Adherence

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.

4. 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.

C. **<u>Here is what probation officers see and do (in no particular order</u>):**

How do mandated clients feel?

Fearful, resentful, defensive, unsure, angry, nervous, denying, aggressive, passive, agitated, skeptical, frustrated, uncertain, reserved, depressed, blame others, closed, annoyed, overwhelmed, confused, scared, distressed, anxious, aggravated, ambivalent, manipulated, irritated, ashamed, hostile, intimidated, embarrassed, curious, furious, panicked, afraid, apprehensive.

What methods work to engage clients? Suggestions from Probation Officers

--> Use a tone of voice that is not threatening

--> Assess from their body language what the client might be feeling

--> Make the client feel comfortable and that you are interested in them; conversation about what the client likes e.g., hobbies etc.

--> Get them to talk about themselves and what they like to do

--> Adopt a posture that is not intimidating; rearrange the desk so you are sitting beside the client or at least not behind the desk

--> Be genuine and convey that you care about the client as a person - "I am here to help you" - Give tools to complete probation; convey compassion - "I understand"

--> Compliment them for coming - it's a first step; compliment them for appropriate dress and promptness if it is clear they have made the effort to dress respectfully and to be prompt

--> Discuss responsibilities and roles; give them knowledge and not in legalese; "I understand how you feel about all these questions"; use language they understand

--> Use humor to break the ice: Ask "Why are you here? The client may answer: "I don't know". You may answer jokingly: "I don't know either, so let's go." But then actually explain to the client why he is here and listen for any misunderstandings.

--> Listen and not cut them off; let them vent to begin with if necessary. Be respectful and non-judgmental. Be proactive and matter-of-fact to help the client move forward.

--> Create a comfortable climate of respect and dignity; create a relationship explaining expectations; negotiate with the client, but also explain limits and boundaries.

--> Ask open-ended questions -"What is your understanding of why you are here today?" rather than "Do you know why you are here?" The latter closed-end question can be answered in one word 'yes' or 'no' and doesn't open up conversation.

What methods work for you to engage clients?

You probably do your own version of these. The first principle of Motivational Interviewing- express empathy - is always a good place to start. If in doubt about where to start with a client, start with empathy.

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D. **Vocab Rehab about Addiction**

1. **What's the difference between Recovery, Abstinence and Sobriety**?

Recovery -- A process of sustained action that addresses the biological, psychological, social and spiritual disturbances inherent in addiction. This effort is in the direction of a consistent pursuit of abstinence, addressing impairment in behavioral control, dealing with cravings, recognizing problems in one's behaviors and interpersonal relationships, and dealing more effectively with emotional responses. Recovery actions lead to reversal of negative, self-defeating internal processes and behaviors, allowing healing of relationships with self and others. The concepts of humility, acceptance and surrender are useful in this process.

Abstinence – intentional and consistent restraint from the pathological pursuit of reward and/or relief that involves the use of substances and other behaviors. These behaviors may involve, but are not necessarily limited to, gambling, video gaming, spending, compulsive eating, compulsive exercise, or compulsive sexual behaviors.

Sobriety – a state of sustained abstinence with a clear commitment to and active seeking of balance in the biological, psychological, social and spiritual aspects of an individual's health and wellness that were previously compromised by active addiction.

2. **What's the difference between Remission and Relapse**?

Remission – a state of wellness where there is an abatement of signs and symptoms that characterize active addiction. Many individuals in a state remission state remain actively engaged in the process of recovery. Reduction in signs or symptoms constitutes improvement in a disease state, but remission involves a return to a level of functioning that is free of active symptoms and/or is marked by stability in the chronic signs and symptoms that characterize active addiction.

Relapse – a process in which an individual who has established abstinence or sobriety experiences recurrence of signs and symptoms of active addiction, often including resumption of the pathological pursuit of reward and/or relief through the use of substances and other behaviors. When in relapse, there is often disengagement from recovery activities.

Relapse can be triggered by exposure to rewarding substances and behaviors, by exposure to environmental cues to use, and by exposure to emotional stressors that trigger heightened activity in brain stress circuits. The event of using or acting out is the latter part of the process, which can be prevented by early intervention.

Clinical Considerations for Dimension 5: Relapse, Continued Use, or Continued Problem Potential

It is not always apparent and thus often goes unrecognized even by treating professionals working with a patient, exactly how to respond to relapse clinically. There is not universal consensus. Some parties view relapse as occurring when there is a return to any substance use after a period of abstinence. Researchers view relapse as occurring when an adequate number of diagnostic criteria for substance use disorder are present; thus, an individual can have resumed substance use, but if one or two criteria of substance use disorder were present, the case was considered one of "partial remission" (interestingly, never termed "partial relapse"), and only if three or more criteria of substance use disorder were present would a case of "active disease" (i.e., no longer "in full remission") be identified.

Others view relapse as a complex biopsychosocial process, with its onset prior to the resumption of any substance use (i.e., when cognitive structures have reverted to those in the active disease state, such as "telling oneself" that one is "cured" and that "I can avoid getting into trouble if "I have just one" dose of alcohol, tobacco, or another drug. Most would argue that the "potential for relapse" is ubiquitous in addiction and never fully gets back to zero.

Further, there is a range of responses to relapse: some clinicians view it as such an inevitability that, when it arises, they use it as "clinical material" and a basis to explore cognitions, feeling states, motivations, and cravings with a patient but to otherwise not change the treatment plan. Other clinicians may view relapse to any substance use as highly significant clinically: it can be used as a reason to discharge a patient from low-intensity residential care (such as a halfway house), or to discharge a patient from an Opioid Treatment Service.

In the treatment of persons who work in safety sensitive occupations, any return to substance use at all can result in significant clinical contingencies as well as other contingencies (continued ability to work, continued ability to have an unrestricted license to practice). In any event, relapse—be it cognitive or emotional, or the behavioral relapse in which actual return to "use" (the pathological pursuit of reward or relief through the use of substances or other addictive behaviors)—should gain the attention of the clinician, who then should thoughtfully consider what, if any, change is indicated in the patient's treatment plan (intensity or "dosage" of treatment). To fail to respond at all to relapse is generally considered substandard clinical practice.

Future Directions on Terminology

The term "relapse" has generally been assigned to the resumption of use once abstinent (See Glossary for ASAM definition of relapse). It may no longer be appropriate for ASAM to use the term in this manner when we describe an illness that has symptoms that can be suppressed through the use of anti-addiction medicines. In addition, ASAM's understanding of addiction as a chronic illness recognizes that recurrences of symptoms are normal in chronic diseases, and managing those recurrences is what disease management is all about. When a person with hypertension or diabetes becomes unstable and exhibits signs and symptoms, they are not described as having relapsed.

However, if a person with addiction drinks or uses substances and exhibits signs and symptoms of addiction, there is often a pejorative and disapproving tone to say the patient has relapsed, and then a discharge or suspension of the patient from treatment at the very time of crisis when continuity of care is most needed. In addition, the very concept of "relapse" implies that there are only two possible states: "clean" and "dirty," "sober" and "relapsed." In this view, if the patient has used any substance, he or she has relapsed, is no longer in recovery, and his or her sobriety clock restarts again with a new sobriety date.

In attempts to soften the definition of relapse, some have talked of "slips" and "lapses." However, how severe does a slip or lapse need to get before it becomes a relapse? How many days of drinking or drugging are required, or does one drink or drug experience suffice? How many days or weeks does a patient have to be abstinent before his or her next use qualifies as a relapse? Is being abstinent for six weeks or six months needed before any further use qualifies as a relapse?

Observing the terminology used with other chronic illnesses can be informative for addiction illness. "Relapse" is used rarely in other chronic illnesses, if at all. Possible terms that would be less value-laden and disapproving in tone could be:

- A recurrence of signs and symptoms
- An exacerbation of signs and symptoms
- A flare-up of the person's addiction illness
- Acute instability of the patient's addiction illness

The ASAM Criteria maintains the current terminology of "relapse." But further consideration of this term is needed in the context of recurrences and remissions in other chronic illnesses. Relapse, Continued Use, or Continued Problem Potential - as used in Dimension 5 of *The ASAM Criteria*, the patient's attitudes, knowledge, and coping skills, as well as the likelihood that the patient will relapse from a previously achieved and maintained recovery and/or stable and healthy mental health function. If an individual has not yet achieved recovery and/or stable and healthy mental health function, this dimension assesses the likelihood that the individual will continue to use alcohol, tobacco, and/or other drugs and/or continue to have addictive behavior or mental health problems.

3. **What's the difference between Maintenance Treatments, Harm Reduction and Medication Assisted Treatment and Recovery (MAT or MAR)?**

Maintenance Treatments– pharmacotherapy on a consistent schedule for persons with addiction, usually with an agonist or partial agonist, which mitigates against the pathological pursuit of reward and/or relief and allows for remission of overt addiction-related problems.

Maintenance Treatments of addiction are associated with the development of a pharmacological steady-state in which receptors for addictive substances are occupied, resulting in relative or complete blockade of central nervous system receptors such that addictive substances are no longer sought for reward and/or relief. Maintenance Treatments of addiction are also designed to mitigate against the risk of overdose. Depending on the circumstances of a given case, a care plan including Maintenance Treatments can be time-limited or can remain in place life-long. Integration of pharmacotherapy via Maintenance Treatments with psychosocial treatments generally is associated with the best clinical results. Maintenance Treatments can be part of an individual's treatment plan in abstinence-based recovery activities or can be a part of harm reduction strategies.

Harm Reduction – a treatment and prevention approach that encompasses individual and public health needs, aiming to decrease the health and socio-economic costs and consequences of addiction-related problems, especially medical complications and transmission of infectious diseases, without necessarily requiring abstinence.

Abstinence-based treatment approaches are themselves a part of comprehensive Harm Reduction strategies. A range of recovery activities may be included in every Harm Reduction strategy.

Medication Assisted Recovery (MAR) – a transitional term to help the general public, recipients of health care services, and professional health care service providers understand that pharmacotherapy can be helpful in supporting recovery. The manifestations of addiction-related problems are addressed in their biological, psychological, social and spiritual dimensions during addiction treatment, in treatment approaches that are abstinence-based, and in treatment approaches that are harm-reduction-based. MAR is one component of the treatment and recovery process.

Medication Assisted Treatment (MAT), another variation on the concept of MAR, may involve pharmacotherapy alone. It is essential that addiction treatment and recovery approaches address the various aspects of biological, psychological, social and spiritual dimensions for optimum health and wellness. It is hoped that as the public and professionals recognize that recovery and treatment need to be holistic, appropriate pharmacotherapy would be well accepted as part of treatment and recovery, such that the terms MAR and MAT would be deemed unnecessary.

E. Vocab Rehab about the Spectrum of Unhealthy Substance Use and Related Terminology

This aim of this section is to provide definitions for terms that address the entire spectrum of alcohol and other drug use associated with health consequences. The focus is on terms that do not describe "addiction" or DSM-5 "substance use disorder," though it is recognized that addiction and substance use disorders are included in the spectrum and are of course harmful to health. Terms that are not preferred, and the rationale for not using them in professional discourse, appear at the end of this section.

Terms to describe various non-addictive states of substance use:

Overview of Preferred Terms for the spectrum of alcohol and other drug use:

1. **Low or lower risk use** (and non-use)
2. **Unhealthy** (alcohol, other drug) use
    - a. **Hazardous use or at-risk use**
    - b. **Harmful use**
    - c. **Addiction** (not defined in this section

Note: "Unhealthy" covers the entire spectrum including all use related to health consequences including addiction. Hazardous and harmful are mutually exclusive of each other, and of diagnosable disease (i.e. addiction).

Note also: The terms herein have been largely defined, studied and used for substances (alcohol and other drugs). They also include prescription (and non-prescription or over-the-counter drugs). However, although there has been less theoretical discussion of and empirical evidence accumulated for other potentially addictive behaviors (e.g. gambling), the framework and preferred terms in this document are also applicable to those behaviors (e.g. low or lower risk gambling, unhealthy gambling, hazardous gambling, harmful gambling).

Specific definitions:

1. **Low risk use** (alternatively, Lower risk use), including no use.

DEFINITION: Consumption of an amount of alcohol or other drug below the amount identified as hazardous (see below), and use in circumstances not defined as hazardous.

DISCUSSION: The term recognizes that risk may not be entirely absent at low levels of consumption. In fact, no amount of use of smoked tobacco has been defined as safe, risk-free or healthy, and no amount of substance use during pregnancy has been defined as safe, risk-free or healthy. The term has been most often applicable to alcohol but may be applied to other drug use, though it is recognized that risks associated with use of specific amounts of other drugs associated with risk are not well-delineated.

2. **Unhealthy use**[1]

DEFINITION: Unhealthy alcohol and other drug (substance) use is any use that increases the risk or likelihood for health consequences (hazardous use), or has already led to health consequences (harmful use).

DISCUSSION: The term is an "umbrella" term because it encompasses all levels of use relevant to health, from at-risk use through addiction. Unhealthy use is a useful descriptive term referring to all the conditions or states that should be targets of preventive activities or interventions. It is not a diagnosis.

The exact threshold for unhealthy use is a clinical and/or public health decision based on epidemiological evidence for measurably increased risks for the occurrence of use-related injury, illness or other health consequences. For some substances, any use is considered unhealthy (i.e. any cocaine use can increase risk for myocardial infarction; one-time use of hydrocarbon inhalants can lead to sudden cardiac death; no known level of tobacco use is considered risk-free; alcohol is a known carcinogen so there is likely no use that is completely risk free). On the other hand, there are thresholds at which the risk increases substantially for alcohol, and these have been specified widely (see "at-risk" use).

Note: the term "unhealthy" (just as with the descriptors "unsafe" or "hazardous" or "harmful" or "misuse") does not imply the existence of "healthy" or "safe" or "non-hazardous" or "harmless" use, or that there is a way to use the substances properly (i.e. without "misuse").

2.a. **Hazardous use** (alternatively, **At-risk use**)

DEFINITION: Use that increases the risk for health consequences.

DISCUSSION: This term refers only to use that increases the risk or likelihood of health consequences. The term does not include use that has already led to health consequences. Thresholds are defined by amount and frequency of use and/or by circumstances of use. Some of these thresholds are substance specific and others are not. For example, use of a substance that impairs coordination, cognition or reaction time while driving or operating heavy machinery is hazardous. Non-medical use or use in doses more than were prescribed of prescription drugs can be hazardous. Any alcohol or nicotine use during pregnancy is hazardous. Any use by youth likely increases risk for later consequences. Use of any potentially addictive substance is more hazardous for persons with a family history or genetic predisposition to addiction than it is to those at average risk in the general population. Use of substances that interact (e.g. two drugs with sedative effects like benzodiazepines and buprenorphine) is hazardous. Use of substances contraindicated by medical conditions is hazardous (e.g. alcohol use and hepatitis C virus infection or alcohol use and post-gastrectomy states). At-risk amounts of alcohol are discussed below.

Hazardous use has been defined previously (consistent with this current definition) as a level or pattern of use that confers a risk of harmful health consequences.[2-4]

The concept of "risk factor" is relevant here. Just like an elevated cholesterol or consumption of excessive calories are risk factors or increase risk for worse health outcomes, hazardous use increases risk for use related consequences.

An acceptable variation in the use of the terms "hazardous use" or "at-risk use" is to refer to hazardous or at-risk *amounts* where these have been defined (as for alcohol). Hazardous (or at-risk) amounts of alcohol consumption including heavy drinking episode/heavy episodic drinking have been defined for the US and elsewhere. In the US, hazardous amounts of alcohol consumption are, for men, 5 or more standard 12 gram drinks (e.g. 1.5 oz 80 proof liquor, 4-5 oz. wine of regular strength, 12 oz regular strength beer) in a day or more than 14 drinks per week on average. Thresholds for women, and for men 65 years and older, are 4 or more drinks in a day or more than 7 drinks in a week on average. A heavy drinking episode occurs whenever a person's alcohol consumption meets or exceeds the daily threshold of 5 drinks or more for men or 4 drinks or more for women, and for men 65 years and older). Heavy episodic drinking is defined as repeated heavy drinking episodes.

Hazardous amounts of alcohol consumption for adults are determined by consensus and epidemiological evidence. Similar definitions exist in other countries (with amounts defined and described in more culturally relevant terms for those countries). These terms have only been defined and are therefore only applicable to alcohol use. The exact definitions may change with evolving epidemiological evidence and can also vary by preferences of those making clinical or public health decisions regarding thresholds. In addition, the thresholds are not individualized and although they are useful guides clinically, they cannot be thought of as absolute. For example, it is not the case that drinking just under the threshold is associated with no risk, or that drinking just above the threshold confers a substantially greater risk. Furthermore, individual factors beyond age, sex and other risks as listed above can affect risk (e.g. weight).

2.b. **Harmful use**

DEFINITION: Harmful substance use is use with health consequences in the absence of addiction.

DISCUSSION: The International Classification of Diseases uses this term as a diagnosis,[4 and see Appendix] defined as repeated consumption that has actually caused some form of physical or mental damage. The ICD 10 definition also implies that the person with harmful use does not have ICD 10 dependence. The full definition appears below the references in an Appendix.

Non-medical use or use more than prescribed of prescription drugs (or of over-the-counter medications not as directed) can be harmful.

Terms that are not preferred to be used in clinical or research contexts:

This list is not exhaustive. Terms that have been used widely were chosen for discussion here.

Misuse

The WHO Lexicon defines misuse as use for a purpose not consistent with legal or medical guidelines.[2] It notes that the term "misuse" may be less pejorative than the term "abuse." In its screening efforts, the US Department of Veterans Affairs describes misuse as the target of screening and intervention. The definition in that context has been the spectrum of use that increases consequences (similar to unhealthy use as defined above). A journal, *Substance Use and Misuse*, has been published in the United Kingdom since 1996. The main reason the term misuse is not preferred is because there is confusion about whether or not it includes addiction or substance use disorders. For example, the Department of Veterans Affairs uses "severe misuse" to mean dependence. But "misuse" is not an appropriate descriptor for "dependence" or "addiction" because it minimizes the seriousness of the disorder and suggests the disorder is due to choice (to "misuse" the substance). "Misuse" also seems to have value judgment at least potentially implied, as if it were an accident, mistake, or alternatively purposeful, neither of which would be appropriate for describing the varied states incorporated in "unhealthy use."

"Misuse" is often used to refer to hazardous or harmful prescription (or non-prescription but potentially addictive) drug use. However, for similar reasons as those described above, it is not a preferred term. "Misuse" of prescription or non-prescription over the counter drugs has been used to describe the spectrum of unhealthy use or to denote hazardous or harmful use but not addiction. In addition, "misuse" in this context is sometimes used to refer to non-adherence to (e.g. non-psychoactive) medication (e.g. missed doses of an anti-hypertensive medication). Therefore to avoid confusion and to clearly describe use of potentially addictive drugs in ways that risk or have caused consequences, ASAM recommends the preferred terminology framework described in this document.

Problem use

The meaning of this term is the same as "harmful" use. The term is not preferred because when used with patients it has connotations that are not helpful and can be seen as pejorative if the patient is viewed as being the problem or having a problem, as opposed to the substance being a problem.

Inappropriate use

The definition of "inappropriate" is unclear and some may find it pejorative. Questions arise as to who determines if use is "inappropriate" and adjudged by what criteria.

Moderate drinking

Moderate drinking is not preferred as a term because it implies safety, restraint, avoidance of excess and even, health. Since alcohol is a carcinogen (and breast cancer risk increases at amounts lower than those generally defined as hazardous, and lower limit amounts harmful to the fetus are not well defined), better terms for amounts lower than at-risk amounts include "lower risk" or "low risk" amounts or simply the term "alcohol use."

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4. Saunders JB, Room R. Enhancing the ICD system in recording alcohol's involvement in disease and injury. Alcohol Alcohol 2012:47(3):216–218.

Abuse
Harmful use of a specific psychoactive substance. The term also applies to one category of psychoactive substance-related disorders in previous editions of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM). While recognizing that "abuse" is part of past diagnostic terminology, ASAM recommends that an alternative term be found for this purpose because of the pejorative connotations of the word "abuse."

F. Vocab Rehab about Physicians treating Addiction

Addictionist
Also, "addictionologist." A physician who specializes in addiction medicine (usually someone certified by the American Board of Addiction Medicine, ABAM or the American Board of Psychiatry and Neurology (ABPN) in addiction psychiatry).

The preferred term is addictionist or addiction specialist physician rather than the older term addictionologist.

Addiction credentialed physician
Predetermined set of standards, such as certification, establishing that the physician has achieved professional recognition in the treatment of addiction.

Physicians can be certified for their expertise in addiction by two pathways. Any physician may either complete an Addiction Medicine fellowship or meet other eligibility criteria and then by examination, receive certification and Diplomate status from the American Board of Addiction Medicine. A second pathway is exclusive to psychiatrists. A psychiatrist may complete a fellowship in Addiction Psychiatry, and then by examination become certified by the American Board of Psychiatry and Neurology, a member board of the American Board of Medical Specialties.

In situations where a certified addiction specialist physician is not available, physicians treating addiction should have had some specialty training and/or experience in addiction medicine or addiction psychiatry and if treating adolescents, experience with adolescent medicine.

Addiction Psychiatrist
A physician who specializes in addiction psychiatry and is Board Certified in this subspecialty by the American Board of Psychiatry and Neurology

Addiction Specialist Physician
A general term that encompasses addictionist and addiction psychiatrist.

G. Vocab Rehab about People in Treatment

Client
An individual who receives treatment for alcohol, tobacco, and/or other drug and addictive behavior problems. The terms "client" and "patient" sometimes are used interchangeably, although staff in medical settings more commonly use "patient," while staff of nonmedical residential, outpatient, and publicly funded treatment settings refer to "clients."

Patient
As used in *The ASAM Criteria*, an individual receiving alcohol, tobacco, and/or other drug or addictive disorder treatment. The terms "client" and "patient" sometimes are used interchangeably, although staff in nonmedical settings more commonly refer to "clients."

Patient-centered and Person-centered
Assessment that is collaborative and treatment that is tailored to the needs of the individual and guided by an individualized treatment plan. This plan is developed in consultation with the patient and is respectful of informed consent and the preferences of the patient. Patient-centered care establishes a therapeutic alliance with the individual and therefore contributes significantly to treatment outcomes.

Shared Decision Making/Participant-Directed
Treatment adherence and outcomes are enhanced by patient collaboration. Shared decision making engages people in treatment and recovery using informed consent that indicates that the adult, adolescent, legal guardian, and/or family member has been made aware of the proposed modalities of treatment, the risks and benefits of such treatment, appropriate alternative treatment modalities, and the risks of treatment versus no treatment. In this context, the patient collaborates on what services are provided and accepted in the patient-centered treatment plan.

Severe and chronic
These terms are used to describe the high disabling impact, non-acute clinical presentation, and long duration of a person's addiction and/or mental illness. These terms are more descriptive compared with a commonly used phrase of severe and persistent mental illness (SPMI), which is less hopeful and not recovery-oriented. SPMI connotes that the patient cannot recover and will persistently remain seriously ill. Using terminology as with other illnesses, "severe" and "chronic" are descriptive and non-value laden terms compared with SPMI.

Therapeutic alliance
Three components comprise the alliance: a trusting mutually respectful working bond and relationship; agreement on treatment goals developed with the patient; and shared mutually negotiated methods and interventions to reach those goals. The therapeutic alliance contributes greatly to treatment outcomes.

Continuing Care
The provision of a treatment plan and organizational structure that will ensure that a patient receives whatever kind of care he or she needs at the time, particularly at the point of discharge or transfer from the current level of care. The treatment program thus is flexible and tailored to the shifting needs of the patient and his or her level of readiness to change. [This term is preferred to "aftercare."]

H. **Vocab Rehab about Bio aspects of Treatment**

Dependence
Used in three different ways: (1) physical dependence is a state of adaptation that is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist; (2) psychological dependence is a subjective sense of need for a specific psychoactive substance, either for its positive effects or to avoid negative effects associated with its abstinence; and (3) one category of psychoactive substance use disorder in previous editions of the Diagnostic and Statistical Manual of Mental Disorders, but not in *DSM-5*, 2013.

Detoxification
Usually used to refer to a process of withdrawing a person from a specific psychoactive substance in a safe and effective manner. The term actually encompasses safe management of intoxication states (more literally, "detoxification") and of withdrawal states.

In the third edition of *The ASAM Criteria* (2013), this term has been replaced by the term Withdrawal Management.

Withdrawal Management
This refers to the services required for Dimension 1, Acute Intoxication and/or Withdrawal Potential. Previously referred to as detoxification services, *The ASAM Criteria* more accurately describes services to

assist a patient's withdrawal. The liver detoxifies, but clinicians manage withdrawal. If the person is intoxicated and not yet in withdrawal, Dimension 1 services needed would be Intoxication Management.

I. <u>Vocab Rehab about Insurance, Managed Care and Utilization Review</u>

Failure (as in treatment failure)
Lack of progress and/or regression at any given level of care. Such a situation warrants a reassessment of the treatment plan, with modification of the treatment approach. Such situations may require changes in the treatment plan at the same level of care or transfer to a different (more or less intensive) level of care to achieve a better therapeutic response and outcome. Sometimes used to describe relapse after a single treatment episode—an inappropriate construct in describing a chronic disease or disorder. The use of "treatment failure" is therefore not a recommended concept or term to be used.
Imminent Danger
Three components in combination for addiction can also constitute imminent danger: (a) a strong probability that certain behaviors (such as continued alcohol or drug use or relapse) will occur, (b) the likelihood that such behaviors will present a significant risk of serious adverse consequences to the individual and/or others (as in a consistent pattern of driving while intoxicated), and (c) the likelihood that such adverse events will occur in the very near future, within hours and days, not weeks or months. For example, a person who may drive drunk or continue substance use resulting in serious adverse consequences in some months in the future is not considered in imminent danger in this context.

On the one hand, the concept of imminent danger *does not* encompass the universe of possible adverse events that could happen at some distant point in the future e.g., intoxication with impulsive reckless driving under the influence, combative public intoxication behavior, loss of employment or legal problems from forging prescriptions, or embezzling money for drugs. Its evaluation should be restricted to the three factors listed above. On the other hand, the interpretation of imminent danger should not be restricted to just acute suicidality, homicidality, or medical or psychiatric problems that create an immediate, catastrophic risk. In *The ASAM Criteria,* patients in imminent danger need stabilization in a 24-hour treatment setting until no longer meeting the three components listed above.

Medical Necessity
Pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the patient. It should not be restricted to acute care and narrow medical concerns (such as severity of withdrawal risk as in Dimension 1); acuity of physical health needs as in Dimension 2; or Dimension 3 psychiatric issues (such as imminent suicidality). Rather, "medical necessity" encompasses all six assessment dimensions so that a more holistic concept would be "Clinical Necessity", "Necessity of Care," or "clinical appropriateness."

J. <u>Vocab Rehab about Engagement and Attracting People into Recovery</u>

(a) "<u>Resistant</u>"

* Resistance is often perceived as pathology within the person, rather than an interactive process; or even a phenomenon induced and produced by the clinician. Reluctance to embrace treatment and recovery and a lack of interest in recovery and relapse prevention indicates a person's readiness to change the use of a particular substance or addictive behavior (See Stages of Change). It us as much a knowledge, skills and attitudes "clinician" problem as it is a "patient" problem. A related definition is:

"A term previously used in Motivational Interviewing, now deconstructed into its components: sustain talk and discord." Miller, William R; Rollnick, Stephen (2013): "Motivational Interviewing - Helping People Change" Third Edition, New York, NY., Guilford Press. Page 412

(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".

K. **Vocab Rehab when people are not skilled at getting their needs met**

"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.

L. **Vocab Rehab about technical psychological constructs and terms that are just that, not code words to describe people you don't like**

"Borderline", "splitting", "passive aggressive" 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".

Implications:

1. Incorrectly used words and terminology create barriers that inhibit and even prevent joining therapeutically with people.

2. Using such words can gives 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.")

M. **Vocab Rehab about 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 to12 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 to12 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?

N. **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.

O. **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."

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