

The Recovery Process

The Recovery Process
Bruce Sewick
College of DuPage Press, 2023.



The Recovery Process Copyright © 2023 by Bruce Sewick is licensed under a Creative Commons Attribution 4.0 International License, except where otherwise noted.

CONTENTS

License & Attributions	ix
Accessibility Statement	x
Dedication	xi
Introduction	xii

Part I. Unit 1: Recovery Principles

10 Guiding Principles of Recovery	3
Perceptions of Recovery While Delivering Medicaid Covered Rehabilitation Services	8

Part II. Unit 2: Mental Health & Substance Misuse Terminology and Overview

An Overview of Mental Illness	13
<i>Supporting Individuals with Intellectual Disabilities & Mental Illness</i>	
Still Stigmatized? People's Beliefs and Attitudes about Mental Illness and Dangerousness	30
The Addicted Human Brain: An Overview of Imaging Studies and Their Treatment Implications	45
Drug Addictions: A Historical and Ethological Overview	55

Part III. Unit 3: Treatment Models for Mental Health and Substance Abuse

History of Psychiatry: Asylums to Community Care	75
The Clubhouse Model	76
Psychosocial Interventions for Older Adults With Serious Mental Illness	77
Intensive Outpatient Treatment	101
Recovery Oriented System of Care in Addiction Recovery	133

Part IV. Unit 4: Ethical Guidelines for Peer Recovery Services

Guide to Equity Terminology: Promoting Behavioral Health Equity through the Words We Use	137
Code of Ethics for CRSS Professionals	140
Cultural Humility Primer	144
<i>Peer Support Specialist and Recovery Coach Guide to Serving and Supporting Diverse Individuals and Their Recovery Journeys</i>	
Recommended Resource: Developing Cultural Humility - Seeing Ourselves in Others	177

Part V. Unit 5: Impact of Trauma on Mental Health and Addiction

Addiction and the Brain: Development, Not Disease	181
Practical Guide for Implementing a Trauma-Informed Approach	200
The effect of trauma on the brain and how it affects behaviors John Rigg TEDx Austin	241
Compassion Doesn't Make You Tired: Unmasking and Addressing Compassion Fatigue	242
Addressing Stress and Trauma in Recovery-Oriented Systems And Communities	304

Part VI. Unit 6: Supported Employment, Education, and Peer Delivered Support

Core Principles of Supported Employment/Individual Placement & Support: The Evidence-Based Practice	355
Supported Employment: Helping people with mental illnesses find and keep jobs	359
Road to Recovery: Employment and Mental Illness	361
Supporting People in Recovery to Access and Engage in Education	362
What Are Peer Recovery Support Services?	363

Part VII. Unit 7: The Role of Family in Recovery

Family-Based Services	379
Substance Use Disorder Treatment and Family Therapy: Treatment Improvement Protocol	396

Part VIII. Unit 8: Skill Building and the Role of Mental Health Treatment Team Members

Evidence-Based Practice and Recovery-Oriented Care	409
Whole Health and Recovery	410
Building Competencies and Skills Among Service Providers Working with Young People who Experience Serious Mental Health Conditions: State of the Science	411

LICENSE & ATTRIBUTIONS

Copyright © Bruce Sewick 2023. This work is licensed under a Creative Commons Attribution 4.0 International License, except where otherwise noted.

This textbook was created for HUMAN 1141: The Recovery Process at the College of DuPage with funding from the Faculty OER Support Grant.

ACCESSIBILITY STATEMENT

This text is under technical review at the time of publication (August 2023).

DEDICATION

I dedicate this book to my daughter Rebecca Sewick, who left this world before her time in March of 2019 at the young age of 38. She taught me a lot in her years on this earth, including how to live fully in the present moment. Her compassion for the downtrodden and her *joie de vivre* for the simple things in life was an inspiration to me. The world is less bright without her in it.



INTRODUCTION

The Recovery Process describes the approaches used in community settings to help people establish and maintain recovery. It incorporates research and best practices across multiple disciplines, including mental health and addiction. The role of treatment teams and Recovery Oriented Systems of Care (ROSC) are examined along with their role in supporting the recovery process. Pathways to recovery that have proven to be successful are also explored.

PART I

UNIT 1: RECOVERY PRINCIPLES

Peer Support has emerged as a major resource for people in recovery from mental health and substance use problems. With this development, the need arose to come up with a unified definition of recovery that could apply to both and help advance recovery opportunities. SAMHSA met with leaders in the field to come up with a unified working definition of recovery to simplify discussion: “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.”

Services provided to those in recovery must also follow insurance definitions of recovery (including Medicaid) and what constitutes a billable service. This can differ from how service recipients define recovery and limit choices.

The unit reading provides SAMHSA’s 10 guiding principles of recovery and four major dimensions that support a life in recovery. This gold standard is seen through the lens of insurance service delivery criteria.

Unit Objectives:

- Summarize SAMHSA recovery principles
- Examine how service delivery funding impacts the way recovery is interpreted

10 GUIDING PRINCIPLES OF RECOVERY

Background

Recovery has been identified as a primary goal for behavioral health care. In August 2010, leaders in the behavioral health field, consisting of people in recovery from mental health and substance use problems and SAMHSA, met to explore the development of a common, unified working definition of recovery. Prior to this, SAMHSA had separate definitions for recovery from mental disorders and substance use disorders. These different definitions, along with other government agency definitions, complicate the discussion as we work to expand health insurance coverage for treatment and recovery support services.

Building on these efforts and in consultation with many stakeholders, SAMHSA has developed a working definition and set of principles for recovery. A standard, unified working definition will help advance recovery opportunities for all Americans, and help to clarify these concepts for peers, families, funders, providers, and others.

Definition

Working definition of recovery from mental disorders and/or substance use disorders:

A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Through the Recovery Support Strategic Initiative, SAMHSA has delineated four major dimensions that support a life in recovery:

Health

Overcoming or managing one's disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem— and for everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing.

Home

A stable and safe place to live.

Purpose

Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society.

Community

Relationships and social networks that provide support, friendship, love, and hope.

10 Guiding Principles of Recovery

Recovery emerges from hope

The belief that recovery is real provides the essential and motivating message of a better future—that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them. Hope is internalized and can be fostered by peers, families, providers, allies, and others. Hope is the catalyst of the recovery process.

Recovery is person-driven

Self-determination and self-direction are the foundations for recovery as individuals define their own life goals and design their unique path(s) towards those goals. Individuals optimize their autonomy and independence to the greatest extent possible by leading, controlling, and exercising choice over the services and supports that assist their recovery and resilience. In so doing, they are empowered and provided the resources to make informed decisions, initiate recovery, build on their strengths, and gain or regain control over their lives.

Recovery occurs via many pathways

Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds— including trauma experience — that affect and determine their pathway(s) to recovery. Recovery is built on the multiple

capacities, strengths, talents, coping abilities, resources, and inherent value of each individual. Recovery pathways are highly personalized. They may include professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches. Recovery is non-linear, characterized by continual growth and improved functioning that may involve setbacks. Because setbacks are a natural, though not inevitable, part of the recovery process, it is essential to foster resilience for all individuals and families. Abstinence from the use of alcohol, illicit drugs, and non-prescribed medications is the goal for those with addictions. Use of tobacco and non-prescribed or illicit drugs is not safe for anyone. In some cases, recovery pathways can be enabled by creating a supportive environment. This is especially true for children, who may not have the legal or developmental capacity to set their own course.

Recovery is holistic

Recovery encompasses an individual's whole life, including mind, body, spirit, and community. This includes addressing: self-care practices, family, housing, employment, transportation, education, clinical treatment for mental disorders and substance use disorders, services and supports, primary healthcare, dental care, complementary and alternative services, faith, spirituality, creativity, social networks, and community participation. The array of services and supports available should be integrated and coordinated.

Recovery is supported by peers and allies

Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play an invaluable role in recovery. Peers encourage and engage other peers and provide each other with a vital sense of belonging, supportive relationships, valued roles, and community. Through helping others and giving back to the community, one helps one's self. Peer-operated supports and services provide important resources to assist people along their journeys of recovery and wellness. Professionals can also play an important role in the recovery process by providing clinical treatment and other services that support individuals in their chosen recovery paths. While peers and allies play an important role for many in recovery, their role for children and youth may be slightly different. Peer supports for families are very important for children with behavioral health problems and can also play a supportive role for youth in recovery.

Recovery is supported through relationship and social networks

An important factor in the recovery process is the presence and involvement of people who believe in the person's ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change. Family members, peers, providers, faith groups, community members, and other allies

form vital support networks. Through these relationships, people leave unhealthy and/or unfulfilling life roles behind and engage in new roles (e.g., partner, caregiver, friend, student, employee) that lead to a greater sense of belonging, personhood, empowerment, autonomy, social inclusion, and community participation.

Recovery is culturally-based and influenced

Culture and cultural background in all of its diverse representations—including values, traditions, and beliefs—are keys in determining a person’s journey and unique pathway to recovery. Services should be culturally grounded, attuned, sensitive, congruent, and competent, as well as personalized to meet each individual’s unique needs.

Recovery is supported by addressing trauma

The experience of trauma (such as physical or sexual abuse, domestic violence, war, disaster, and others) is often a precursor to or associated with alcohol and drug use, mental health problems, and related issues. Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.

Recovery involves individual, family, and community strengths and responsibility

Individuals, families, and communities have strengths and resources that serve as a foundation for recovery. In addition, individuals have a personal responsibility for their own self-care and journeys of recovery. Individuals should be supported in speaking for themselves. Families and significant others have responsibilities to support their loved ones, especially for children and youth in recovery. Communities have responsibilities to provide opportunities and resources to address discrimination and to foster social inclusion and recovery. Individuals in recovery also have a social responsibility and should have the ability to join with peers to speak collectively about their strengths, needs, wants, desires, and aspirations.

Recovery is based on respect

Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems—including protecting their rights and eliminating discrimination—are crucial in achieving recovery. There is a need to acknowledge that taking steps towards recovery may require great

courage. Self-acceptance, developing a positive and meaningful sense of identity, and regaining belief in one's self are particularly important.

Citation

Substance Abuse and Mental Health Services Administration. 10 Guiding Principles of Recovery. SAMHSA, 2012. <https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf>

This work resides in the public domain, unless otherwise indicated.

PERCEPTIONS OF RECOVERY WHILE DELIVERING MEDICAID COVERED REHABILITATION SERVICES

Many states have shifted to Medicaid reimbursement methods to cover behavioral health services. In doing so, state mental health authorities have incorporated the concept of recovery into mental health policy. Integrating recovery into mental health policies provides a framework that, if applied, can lead to both cost benefits and valuable behavioral health outcomes (Jacobson & Curtis, 2000). Not surprisingly, practitioners play a critical role in the implementation of recovery policies and practice approaches. Emerging best practices in supporting recovery stress the importance of the individual practitioner viewing recovery as central to practice rather than an additional responsibility (Slade et al., 2012). Thus, gaining a better understanding of practitioners' perceptions of recovery in a new fiscal environment is warranted and can have implications for future practice.

In 2011, the Centers for Medicare and Medicaid approved a State Plan Amendment for New Jersey to provide Medicaid covered mental health Community Support Services (CSS; State Plan Amendment, 2011). CSS consists of mental health rehabilitation services and supports that help individuals achieve identified recovery goals, community integration, and remaining independent in the community (State Plan Amendment, 2011). Additionally, CSS is grounded in psychiatric rehabilitation goals and values such as self-determination, the promotion of valued social roles, recovery, and quality of life (Pratt et al., 2014). Many CSS programs in the state welcomed the clear focus on recovery and would argue that their policies and practices emphasized recovery approaches. Nevertheless, the state mental health authority contracted with an east coast University to facilitate a statewide training and consultation initiative in New Jersey to ensure that the workforce delivering CSS acquired the knowledge and skills necessary to deliver recovery-oriented services.

Recovery in Mental Health

The recovery movement began in the 1970s, placing focus primarily on individual experiences of people living with a mental illness (Davidson, 2016). Following this movement, recovery was defined in many different ways, with overlapping themes focusing on recovery as person and choice focused, a fluid process, strengths-based, and individualized (Slade et al., 2014). Although there is an agreement that recovery is multidimensional and rooted in choice and hope, there are competing views of recovery from service recipients and service providers (Frost et al., 2017). Frost et al. (2017) points out that many mental health services are medically focused, and in fee for service environments, billable services may be geared towards what Medicaid constitutes as billable

services, shifting focus away from individual need and individual definitions of recovery, towards fulfilling service criteria requirements (Slade & Longden, 2015).

With the deinstitutionalization movement in the 1970s, definitions of recovery began to shift, as individuals with a mental health diagnosis desired more than a reduction in their symptoms, as they sought education, vocational, and social opportunities (Anthony, 1993). By the end of the next decade, long term research altered previous ideas of quality of life for individuals with a mental illness, as it showed that, regardless of psychiatric diagnosis, people were able to fully participate in their lives through recovering from symptoms or adapting to their illness (Davidson, 2016). With the passing of the Americans with Disabilities Act in 1990, the language adopted characterized individuals diagnosed with a mental illness as those with disabilities, in turn granting them the same rights as individuals with physical disabilities, conveying inclusivity for people, regardless of physical disability or mental health diagnosis (Davidson, 2016). By the end of the century, Surgeon general David Satcher outlined the need for services driven by the individual, focusing on recovery (Davidson, 2016). By 2010, the US Substance Abuse and Mental Health Services Administration further focused on recovery by introducing its Recovery Support Strategic Initiative, which focused on recovery topics like hope, community, and strengths (Pincus et al., 2016).

Over the last five decades, the overall definition of recovery has deviated from concentrating on medically oriented definitions of recovery, focused on individual diagnosis, towards the notion that a person is more than their diagnosis and should be treated as a person, as opposed to a person with a mental illness (Anthony & Mizock, 2014). Psychiatric rehabilitation philosophy further disputes more traditional ideas and perceptions of individuals with a mental illness, as it focuses on respect, choice, strengths, and the thought that recovery is achievable and individualized (Frost et al., 2017). With this change in the definition of recovery, service models of recovery are shying away from focusing on concepts within the medical model, instead of acknowledging a person's individual goals, life roles, and wellness (Ahmed et al., 2016). Ahmed et al. (2016) further state that recovery-oriented models can focus on various interventions, including services provided by peers, illness self-management strategies, a focus on individual strengths, and a focus on employment.

Recovery focused service models may also support providers in shifting their focus toward more person-centered thinking as opposed to focusing on medical aspects, altering provider's definition of recovery away from one rooted in the medical model (Dalum et al., 2015). In the past, professionals have emphasized recovery through their viewpoint and have not focused as much on individual definitions of recovery (Slade et al., 2014). Certain professionals, like nurses, may have medically oriented definitions of recovery due to their education, training, and work experience or define recovery as a process dictated by service provision to individuals as opposed to a process that individuals experience (Aston & Coffey, 2012). Along with the competing views of recovery from professionals and individuals receiving services, there is also competition between service recipient's ideas of recovery and types of services that will help promote their recovery, with provider's desire to provide individualized recovery-oriented services while staying within Medicaid's definition of billable services (Spitzmueller, 2014).

Spitzmueller (2014) acknowledges that since the 2000s, community mental health providers have

transitioned from funding services through state grants to funding services through Medicaid fee-for-service contracts, as a result of Medicaid expansion and reform. Some fee-for-service models are conceived to reduce government spending, opening up funds that can then be repurposed in other ways within the mental health system (Clay et al., 2016). Medicaid funded programs must follow Medicaid definitions of recovery and what constitutes a billable service, which can differ from how service recipients define recovery and limit their choice in the services that may help further their recovery (Spitzmueller, 2014). Medicaid funded fee-for-service programs follow a structured format, whereas service recipients have found that unstructured services are comfortable to engage in, as they are individually driven and emphasize choice (Spitzmueller, 2014).

Citation

Clay, Zakia; Zazzarino, Anthony; Banz, Emilie; and Reilly, Ann. (2020). "Perceptions of Recovery While Delivering Medicaid Covered Rehabilitation Services," *Journal of Human Services: Training, Research, and Practice*: Vol. 6 : Iss. 1 , Article 1. Available at: <https://scholarworks.sfasu.edu/jhstrp/vol6/iss1/1>

This work is distributed under a CC-BY-NC-ND license.

PART II

UNIT 2: MENTAL HEALTH & SUBSTANCE MISUSE TERMINOLOGY AND OVERVIEW

There is stigma and a perception that the mentally ill are dangerous people. This unit will begin with an examination of how these perceptions impact those with mental illness and those supporting them. This continues to be an issue and, in the study cited, specific disorders and dual diagnosis are the conditions most associated with dangerous behavior in the population surveyed. The study supports other findings and is something to consider as we look at terminology used in the field and how it can impact the people we work with. Remember as professionals, clients are **NOT** their diagnosis and we must adopt a person first wording for describing people who are the focus of recovery-based care.

An overview of mental illness is included in this unit to familiarize you with the vocabulary of a paradigm modeled after its medical counterpart.

Next, we consider the mechanisms of addiction in order to better understand how addiction as defined by the DSM develops. This understanding helps reduce stigmatization as “choice” model is not substantiated by current addiction research. Part of the problems associated with addictive behavior is what drugs society considers cause problems and the neurobiology of addiction. Behavioral addiction is discussed along with treatment approaches.

Drug use is put in a historical perspective through the lens of approaching it as an evolutionary selection of an efficient reward system to maintain species survival. These perspectives help place the addict on a continuum that we are all part of.

Unit Objective:

- Discuss the terminology used in mental health and addiction treatment and how it can impact client recovery.

AN OVERVIEW OF MENTAL ILLNESS

Supporting Individuals with Intellectual Disabilities & Mental Illness

Introduction

People who are mentally ill can have considerable difficulty with their thinking, their mood, or their behaviour. Mental illness is not the same as experiencing normal stress and sadness. One main difference is that mental illness causes significant distress and impairs functioning, making it difficult to cope with the demands of everyday life (Canadian Mental Health Association CMHA, n.d; Mental Health Foundation, n.d; Mental Health Foundation of Australia, n.d; National Alliance on Mental Health, n.d; Public Health Agency of Canada PHAC, n.d.). In other words, when people are mentally ill, they can't manage activities of daily living, work effectively, or maintain relationships. Their overwhelming distress is not just a reaction to daily events, and they are not behaving that way on purpose. Just like a physical illness, when a mental illness is not recognized and treated, it can worsen and will last for an unnecessarily long time.

It is not easy to recognize when the distress experienced by a person with an intellectual disability is actually a symptom of mental illness. The stigma associated with mental illness makes most people reluctant to talk about their experiences of having strange thoughts or deep sadness. For individuals with intellectual disabilities who already struggle to find the right words to express themselves, talking about their unusual experiences can be overwhelming.

When health professionals diagnose psychiatric disorders, they rely on information obtained during interviews with clients. However, clients with intellectual disabilities may not have the language or memory skills needed to explain what has been happening. When these clients have had only limited opportunities to socialize with others, they may be unsure about whether their experiences are “normal” or not. People in their lives may have ignored their symptoms of mental illness because they believed these symptoms were simply part of the disability.

In this chapter, we describe indicators of mental illness in three key areas: disorders of thinking, disorders of mood, and disorders of behaviour. Although only qualified clinicians can diagnose psychiatric disorders in individuals with disabilities, all those who care for them can help report the kinds of indicators that could be symptoms of mental illness. The chapter begins with a brief background of mental health care; identifies key indicators associated with disorders of thinking, mood, and behaviour; and emphasizes relevant observations that caregivers must report.

Background of Mental Health Care

History

Until the 17th century, most people who were considered to be insane were viewed as sinful, weak, or possessed by demons. Cast out of most societies, they were incarcerated in jails or poorhouses. Although asylums or mental hospitals were eventually created to house people with mental illness, early treatment approaches were crude.

Individuals with intellectual disabilities, traditionally referred to as *mentally retarded*, were often housed in these asylums as well. Distinctions between insanity and retardation were not always clear. Those named as *mildly retarded* were believed to be worry-free and therefore mentally healthy. Those with the label *severely retarded* were believed to be unable to express feelings and therefore not able to experience emotional distress (Werges, 2007). Inmates in the asylums were not viewed as people with an illness; rather, they were considered untreatable and were punished for any unusual behaviour.

By the early 20th century, mental health care became viewed as a public responsibility, and insane asylums were replaced by hospitals providing medical care. During the 1950s and 1960s, research led to an increased understanding of mental illness, and specific psychiatric disorders and associated treatments were identified. As it became clear that psychosocial factors can contribute to mental illness, psychiatric disorders became more normalized, or viewed as conditions that could happen to anyone. However, advances in understanding mental illness in individuals with intellectual disabilities occurred at a much slower pace. Separate institutions were established for these individuals and unusual behaviour was still not always considered a symptom of mental illness.

By the 1970s, a movement toward de-institutionalizing people with mental illness began to grow. Admissions to hospital beds were decreased and community agencies were expected to provide care. Unfortunately, for many individuals the expected help from community agencies still remains elusive. Today numerous individuals with mental illness find refuge only in jails and homeless shelters. Those with severe and persistent mental illness present in general hospital emergency rooms and yet, if admitted at all, may be discharged within days without having received the help they need. These shorter hospital stays and limited community supports have made it even more difficult to understand the unique needs of those diagnosed with both intellectual disability and mental illness (dually diagnosed).

Reversing the Trend

In an effort to reverse the international trend of neglecting health services and care for people who are mentally ill, the World Health Organization (2013) presented their *Mental Health Action Plan 2013–2020*, calling for governments to find better ways to recognize mental illness and improve treatment. Similarly, the National

Institutes of Mental Health (2008) in the United States, the Mental Health Commission of Canada (2012), the Mental Health Council of Australia (n.d.), and the government of the United Kingdom (Her Majesty's Government, 2011) all developed strategic plans to improve mental health. It is hoped that these strategic plans will be the start of changing society's perceptions of mental illness.

Diagnosis

Throughout history, the process of classifying different types of mental illness and finding ways to consistently explain people's unusual experiences has taken many forms. Today, psychiatrists and clinicians use two manuals to classify and diagnose psychiatric disorders. The first is the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5, American Psychiatric Association, 2013). The DSM was first published in 1952 and has been revised several times. The DSM-5 is a reference manual that outlines a set of criteria that health professionals can use to provide consistent treatment of mental illness, including symptoms, descriptions, markers, and treatments of mental disorders.

The second is the *International Statistical Classification of Diseases and Related Health Problems, 10th Revision* (ICD-10, World Health Organization, 2010). This manual uses a system of coding created by the World Health Organization to track health interventions. More than 40% of people with intellectual disabilities are dually diagnosed with a psychiatric disorder (Cooper et al., 2007; Lunskey, Klein-Geltink, & Yates, 2013).

For clinicians to use diagnostic manuals and other assessment tools to accurately diagnose psychiatric disorders, they need in-depth descriptions of how clients are thinking, what their mood is like, and how they are behaving. Knowing that people with intellectual disabilities may not be able to provide all the information needed, their caregivers can contribute by sharing relevant observations. In the following sections, we highlight indicators known to be associated with common psychiatric disorders.

Indicators Associated with Disorders of Thinking

Schizophrenia

According to the World Fellowship of Schizophrenia and Allied Disorders (n.d.), schizophrenia strikes 1% of the world's population. Individuals with intellectual disabilities are affected by schizophrenia more frequently than the general population, and they are more likely to be hospitalized for their symptoms (Balogh et al., 2010). Schizophrenia affects people from all walks of life and usually first appears between the ages of 15 and 30. Not everyone will experience the same symptoms, but some symptoms are common to many, such as withdrawing, hearing voices, talking to oneself, seeing things that are not there, neglecting personal hygiene, and showing low energy.

Schizophrenia refers to a group of severe, disabling psychiatric disorders marked by withdrawal from reality, illogical thinking, delusions (fixed false beliefs that cannot be changed through reasoning), hallucinations (hearing, seeing, smelling, tasting, or feeling touched by things that are not there), and flat affect (lack of observable expressions of emotions, monotone voice, expressionless face, immobile body).

Distinguishing between positive or hard, and negative or soft, symptoms is particularly important with schizophrenia. Notice that in this context, the word *positive* is not the same as *good*. Rather, positive symptoms are psychotic and demonstrate how the individual has lost touch with reality. Positive symptoms are those that do exist but should not exist, such as delusions, hallucinations, and disorganized thinking and behaviour. Delusions fall into several categories. An individual with a persecutory delusion may believe he is being tormented, followed, tricked, or spied on. An individual with a grandiose delusion may believe she has special powers. An individual with a reference delusion may believe that passages in books, newspapers, television shows, song lyrics, or other environmental cues are directed to him. In delusions of thought withdrawal or thought insertion, the individual believes others are reading her mind, her thoughts are being transmitted to others, or outside forces are imposing their thoughts or impulses on her.

In contrast, negative symptoms are those characteristics that should be there but are lacking. For example, negative symptoms include apathy (lack of interest in people, things, and activities), lack of motivation, blunted affect (reduced displays of emotion), poverty of speech (brief terse replies to questions that lack content), anhedonia (lack of interest in activities once enjoyed), and asociality (avoidance of relationships). Keep in mind that the inability to show emotion associated with a blunted affect does not reflect an inability to feel emotion. Similarly, it is helpful to understand that withdrawing from others is a coping mechanism for an individual with schizophrenia and not a rejection of those who initiate contact.



Indicators Associated with Disorders of Thinking: Schizophrenia

Key Points for Caregivers

- With schizophrenia, all those who care for verbal clients must try to **know the content of any hallucination or delusion** their client is experiencing or has experienced. A typical hallucination might involve a deep, loud commanding male voice repeatedly telling a client that he or she is “worthless and must die.” Caregivers are expected to pose a clear question, such as “Are you hearing voices right now?” when clients are talking to themselves.

- Caregivers of non-verbal clients must try to **determine if hallucinations or delusions are occurring**. Indicators of hallucinations include:
 - Staring to the side and nodding and making hand motions as though listening to a conversation others do not hear
 - Physically attacking an unseen other person
 - Staring with an angry or frightened expression at strangers or well-liked companions in a situation that does not require those emotions
 - Covering the eyes or ears as if to protect oneself, when threats are not present
 - Frowning as though something smelled or tasted foul
 - Dressing in protective ways such as wrapping on extra scarves or blankets when the weather does not require it
- The nature of schizophrenia prevents the client from understanding that the voices or other hallucinations or delusions are not real. The only treatment that is effective in decreasing the thought changes in schizophrenia is antipsychotic medication. Without medication, trying to orient clients to reality can bring on profound anxiety and even aggressive actions. Caregivers must **know what psychiatric medications have been prescribed**.
- The major side effects of psychiatric medication are a further challenge to treating schizophrenia. Hallucinations and delusions often include the belief that antipsychotic medication is *poison*. In response to this belief, psychotic clients frequently pretend to swallow pills, or *cheek*. Given this unchangeable reluctance to swallowing pills, clients often receive long-acting antipsychotic medications intramuscularly during monthly clinic visits. However, caregivers must **always watch clients swallow their psychiatric medications**.

Psychosis

Traditionally, explanations of psychiatric disorders were introduced as conditions considered either psychotic (not in touch with reality, such as schizophrenia) or neurotic (in touch with reality but deeply troubled, such as anxiety). However, as research extends knowledge within the field, the experience of psychosis is now understood to be associated with a number of non-psychiatric conditions. Both children and adults with intellectual disabilities may engage in self-talk and conversations with imaginary friends. These fantasy

conversations can appear as though they are indicators of psychosis such as delusions or hallucinations. When clients are able to indicate some awareness that these conversations are imaginary, and when clients seem to be directing or controlling them, they are not considered indicators of psychosis. Psychotic symptoms may be present with clients who are dehydrated, experiencing seizure disorders, on new medications, or taking street drugs.



Indicators Associated with Disorders of Thinking: Psychosis

Key Points for Caregivers

- With psychosis, determine whether clients know that **fantasy conversations** are not real.
- Rule out **dehydration**, particularly in clients who are elderly.
- Ask whether the client has been having seizures or has a **seizure disorder**.
- Note whether a **new medication** or new medical condition is present.
- Document any **street drug use**, as many drugs induce psychotic-like behaviour.

Dementia

Dementia is not a specific disease; rather, it is a group of symptoms that affect thinking and social abilities enough to seriously interfere with daily functioning (Alzheimer's Association, n.d.). Dementia occurs at a higher rate in people with intellectual disabilities than it does in the general population (Janicki & Dalton, 2000; Jokien et al., 2013; National Task Group on Intellectual Disabilities and Dementia Practices, 2013; Shooshtari et al., 2011). Adults with Down syndrome are particularly susceptible to Alzheimer's disease as they approach middle age (Wilkinson & Janicki, n.d.).

Progressive memory loss that occurs over a period of time is often associated with Alzheimer's disease and other dementias. However, in clients with intellectual disabilities, indicators may be seen first in symptoms of physical deterioration. Previously mastered skills with daily living may become a problem. Clients may have difficulty with their sight, hearing, and speech. They may remain inactive for long periods of time. Their gait (the way they walk) may change. They may lose their sense of balance and fall frequently. Seizures may occur in those previously unaffected. As their condition worsens, clients find it very hard to learn new information.

They become disoriented and no longer recognize caregivers and family. During all stages of dementia, feelings of intense anxiety and fearfulness are common.

When memory loss occurs, most people feel frightened, frustrated, and angry. When they can't answer a question they once could, they may confabulate (unintentionally make up) a reply. Keep in mind that confabulating is not lying and people are not deliberately being deceitful.

Sundowning, or sundown syndrome, is expected in clients with dementia. In this state, clients show increased agitation, restlessness, and confusion in the late afternoon, evening, and night (Khachiyants et al., 2011). At sundown, clients may become more anxious and disoriented. They may pace, wander, and even become aggressive and yell or scream as the day comes to a close. Clients can be more difficult to redirect at this time. It is important to note that dark, quiet rooms may be frightening to sundowning clients.



Indicators Associated with Disorders of Thinking: Dementia

Key Points for Caregivers

- **Keep records of changes in behaviour and loss of previous abilities.** This is especially important to health care workers diagnosing dementia. Therefore, maintaining clear records of how clients function throughout their adult life is useful. These records can be formal medical charts obtained from physicians, or they can be informal records obtained from family members or clients themselves. Scrapbooks, photo albums, video home movies, and audio recordings will illustrate how clients spoke, moved, and responded when they were well and healthy. Comparing a previous picture, audio, or video with a current cell phone capture of a client can clarify changes that are happening.
- **Record specific examples of physical weakening, particularly in speaking and walking.** For example, identify how a client's gait (or how they walk) is changing. Keep a record of any falls, stumbles, or times when clients seem to lose their balance.
- **Prepare for and seek medical help immediately if seizures occur.** A seizure in someone previously unaffected and that is not part of a medical condition can indicate dementia.
- **Understand and identify how often confabulation answers are occurring. *Confabulation* means making up answers without intending to lie.** Knowing that clients with dementia are not lying or making things up on purpose can

help caregivers understand that this behaviour is part of a psychiatric disorder and not acting-out behaviour.

- **Understand and identify how often sundowning is occurring. *Sundowning* means increased agitation in the evening.** Clients may seem to be expressing anger by behaviours such as screaming and yelling, but it is important to understand that this behaviour is likely a response to an intense and constant inner fear that clients are unable to escape.
- **Create and communicate supports that help memory lapses.** People with dementia are forgetful, get lost, and can have difficulty recognizing friends, family, and staff. Whenever possible, create cues to help with memory loss, such as calendars of events, photo collections, or scrapbooks. Ensure that these cues are consistent and that as many people as possible in the client's life know about them.

Differentiating between Dementia, Delirium, Dehydration, and Depression

Dementia should not be confused with delirium, dehydration, or depression, even though all these conditions can leave clients feeling confused. Dementia, as explained above, is a progressive disorder where people become confused over a long period of time. Delirium is a disorder where people become confused quite suddenly and it can be caused by a medical condition such as an infection. Dehydration is also a condition where people become confused quite suddenly; it is caused by not taking in enough fluids. Depression, as explained in the following section, is a mood disorder where deep sadness can make people seem as though they are confused.

Indicators Associated with Disorders of Mood

Depression

Depression is a mood disorder where people feel very sad even when things are going well. Mood disorders are disturbances in the regulation of mood, behaviour, and affect that go beyond the normal ups and downs that most people experience. Mood refers to a pervading feeling (a feeling that is there all the time) that lasts for more than two weeks. With depression, a person's mood becomes so intense that others just cannot help

to cheer them up. Medications, such as antidepressant drugs, are needed to treat depression when it is serious enough to be diagnosed as a psychiatric disorder.

One out of every five people experiences depression during his or her life, and the rate of depression among people with intellectual disabilities is significantly higher (Shooshtari et al., 2011). Many people with mood disorders have coexisting mental and physical disorders. For example, about half of those with a depressive disorder also suffer from an anxiety disorder.

Health care providers rely heavily on descriptions of clients' affect to diagnose depression. *Affect* refers to the outward expression of emotion on people's faces, their bodies, and the way they speak. People cannot usually control their affect. Even when people who are depressed try to smile, their affect may seem "flat" or without any real emotion. People who are depressed sometimes have a restricted affect where they do not seem to show any emotion at all. They may also have an inappropriate affect where the emotions that they show do not match the content of what they are saying; for example, laughing when describing a loved one's recent death. Affect can also be labile (change quickly) with no apparent connection to events in the environment.

Types of depression include major or unipolar depression, dysthymia, and bipolar affective disorder.

Major or unipolar depression is a mood disturbance in which the major symptoms—depressed mood and loss of interest or pleasure in all or almost all activities—occur daily for at least two weeks and severely incapacitate a person's usual ability to function. In extreme cases, psychosis can be present in depressive disorders. When people with intellectual disabilities experience major depression, they may try to stay in bed all day, become mute, eat too little or too much, and refuse to wash or even use the toilet.

Major or unipolar depression can be further described as *agitated* or *retarded*. An agitated depression is accompanied by psychomotor agitation such as restlessness, sobbing, and excessive talking. A retarded depression is accompanied by slowed or absent psychomotor activity.

Depressive disorders can be exogenous or endogenous. *Exogenous* means that the illness follows a clearly defined stress such as a death or unexpected change in living arrangements. *Endogenous* means that no obvious stressors exist. It is important to emphasize that an endogenous major depression is NOT a reaction to loss. A lively approach by caregivers or others seeking to cheer up clients is ineffective.

Dysthymia is a mood disorder where people do feel sad for most of the day but they can still function, particularly toward the end of the day. Dysthymia can last for years and often goes unrecognized.

Bipolar affective disorder, formerly known as manic depressive illness, is marked by serious mood swings. Typically, clients experience extreme highs (mania or hypomania) alternating with extreme lows (depression). People feel normal only in the periods between the highs and lows. For some people, the cycles occur so rapidly that they hardly ever feel a sense of control over their mood swings.

In the manic phase of their bipolar illness, clients demonstrate grandiosity (feeling grand and better than others), jocularity (joking more than is appropriate), flight of ideas (rapidly skipping from one idea to the next in conversation), and decreased impulse control. They may go several days without sleeping at all. They may demonstrate problematic social behaviours such as aggression, property destruction, fecal smearing, stripping off clothing, and urinating in inappropriate places (McKee et al., 2004). People with intellectual disabilities

may demonstrate grandiosity by believing they can drive a car when they cannot, for example. They may demonstrate decreased impulse control by spending all their money instead of saving in a planned way. They may engage in risky sexual activity that results in pregnancy or sexually transmitted diseases. They can be expected to neglect their needs to eat well, to sleep adequately, and to care for themselves.

Suicide

Thinking about suicide is common in people who are depressed. Caregivers must always ask if clients have ever thought about hurting or killing themselves, or otherwise try to assess clients who are or may be depressed. People who are thinking about killing themselves may engage in risky behaviour, such as walking into traffic with their eyes closed. They may seem preoccupied with the topics of death, of others who have died, and of funerals. It is important to ask verbal clients three questions:

1. Have you considered taking your own life?
2. How do you plan to commit suicide?
3. What stops you?

In clients with little or no ability to express their thoughts of suicide, unusual behaviours may be associated with a wish to stop unrelenting mental distress by dying. A behaviour may not actually seem potentially lethal, such as manual self-strangulation. However, when people intend to die and believe what they are doing will cause death, their attempts to kill themselves must be taken seriously (Byrne, Hurley, and James, 2007)

It is important to emphasize that suicide gestures and attempts are sometimes made when a client appears to be getting better and caregivers believe that the depression has lifted. However, a brighter and more cheerful affect may signify the client's feelings of relief. The client's feelings about wanting to die may not have changed. In fact, when people begin to feel their energy returning, they are more able to follow through on their decision to end their life. Similarly, given that antidepressant medications can be expected to take 7 to 21 days to become fully effective, they may actually provide clients with the increase in energy needed to act on their suicidal ideas.

A further key consideration is to ensure that any items that might be used for self-harm (razors, knives, pills, belts, or cords) on a client's person or in their environment are taken away. Keeping clients who are depressed and suicidal safe requires consistent monitoring. Increased caregiver time, attention, and presence are needed.

Vegetative shift is a term used by mental health professionals to describe problems associated with depressive disorders. A vegetative shift occurs when vegetative signs shift or change. Critical vegetative signs include affect, energy, pleasure, appetite, sleep, and thoughts of suicide. A memory aid for indicators of vegetative shift is "A E P A S S."



Indicators Associated with Disorders of Mood: Vegetative Shift

Key Points for Caregivers

Vegetative shift is a term used by mental health professionals to describe problems associated with depressive disorders. A vegetative shift occurs when vegetative signs shift or change. Critical vegetative signs include affect, energy, pleasure, appetite, sleep, and thoughts of suicide. A memory aid for indicators of vegetative shift is “A E P A S S”: Affect, Energy, Pleasure, Appetite, Sleep, Suicide.

Use the “A E P A S S” memory aid to document a shift in vegetative signs.

- **A—an Affect of sadness and poor concentration.** Identify sad facial, postural, and emotional responses that last for weeks at a time and do not seem to fit the context. Sadness in clients may or may not be a response to something that has happened. Clients may show their depression through crying, becoming withdrawn and non-responsive, or becoming agitated and verbally and physically aggressive.
- **E—Energy loss and fatigue.** Write down the number of times clients are refusing to leave their beds, take care of activities of daily living such as bathing and dressing, and attend work or leisure activities. Include times when either constipation or incontinence occurs in relation to lacking the energy to go to the bathroom. Include the number of hours clients spend sitting or lying down for long periods of time just watching TV or doing nothing.
- **P—Pleasure or interest.** Notice whether clients are no longer taking pleasure in activities they once enjoyed. Notice also when clients with bipolar disorder are cycling into a manic or hyperactive state, when they may carry out pleasurable activities impulsively. In particular, monitor reckless behaviour in spending money and sexual activity.
- **A—Appetite changes.** Appetite can increase or decrease in depressive disorders. Carefully record client weight and identify any gains or losses. Tantrums at meals, and stealing or hoarding food for constant nibbling, can reflect a need to soothe the emotional distress of depression. In contrast, refusing to take the time to eat can reflect the hyperactivity associated with a manic state.

- **S-Sleep disturbances.** Keep a record of the number of hours clients sleep each night, including the time they go to bed, the number of times they get up in the night, and the time they wake up. Difficulty falling asleep can be an indicator of anxiety. Waking up early can be an indicator of depression. Sleeping in late can be a response to dysthymia, where people feel sad in the morning but then feel better as the day progresses. Remaining in bed and sleeping or dozing for long periods of time during both night and day can be a way of withdrawing that is often associated with depression. In contrast, going to bed late, getting up frequently in the night, and getting out of bed early can indicate a pattern of hyperactivity associated with a manic state.
- **S-Suicidal thinking.** Ask verbal clients if they have thought about taking their own life, if they have a plan to do so, and what (if anything) stops them. Assess if clients seem to speak often about death when such discussions are out of context. Probe whether the thinking behind self-harming behaviour is related to an intent to commit suicide. **Important: Remove any objects that could be used for self-harm.**

Anxiety

Anxiety disorders are a group of conditions marked by pathological or extreme anxiety or dread. People with anxiety experience disturbances of mood, behaviour, and most systems in the body, making them unable to continue with everyday activities. Many feel anxious most of the time for no apparent reason.

Anxiety is different from fear. Fear is a response to an event or object that a person is aware of. The psychiatric disorder of anxiety occurs when the intensity and duration of anxiety does not match the potential for harm or threat to the affected person. Symptoms of anxiety disorders often include aches and pains throughout the body, and treating these can distract caregivers from recognizing anxiety as a cause of the physical pain.

People with intellectual disabilities struggle with anxiety more often than the general population. In part, this may be due to slightly different brain structures, limited expressive language abilities, and difficulty understanding social situations, which seem unpredictable and scary (Cooray & Bakala, 2005). Anxiety can be expressed with physical symptoms such as stomach aches, headaches, increased heart rate or pounding heart, feeling startled easily, trembling, sweating, and difficulty swallowing. It can be expressed behaviourally through increased agitation, crying, repeating comments about feeling afraid, withdrawing, regressing toward more childlike behaviour, clinging to caregivers, and freezing (not being able to move). As intellectually disabled

people often depend on or feel they are dependent on others for their survival, their feelings of constant vulnerability can lead to frequent expressions of anxiety.

Treatment for verbal clients can include cognitive behavioural therapy. Anti-anxiety medications can help both verbal and non-verbal clients feel a much-needed sense of peace. However, repeatedly probing to find out what clients fear may not uncover a threat that others would recognize or believe is harmful. Therefore, finding ways to offer comfort to clients rather than simply seeking to understand a cause for their anxiety disorder is helpful.

Two disorders commonly suffered by people with intellectual disabilities are post-traumatic stress disorder and obsessive-compulsive disorder.

Post-traumatic stress disorder (PTSD) is a disorder in which an overwhelming traumatic event is re-experienced, causing intense fear, helplessness, horror, and avoidance of stimuli associated with the trauma. Nightmares, insomnia, flashbacks, mistrust, intense psychological distress, and self-medication with substance abuse are common in people with PTSD (Mayo Clinic, n.d.).

People with intellectual disabilities experience PTSD somewhat differently as they may not be able to describe the event that caused the trauma. Caregivers may not be aware of nightmares that are occurring. The flashbacks and memories may be vague and distorted and the memories confused. The flashbacks may seem so real that clients feel they are being traumatized again and again (Byrne, Hurley, & James, 2007). Conversely, flashbacks may be reported as additional traumatic events, with the result that records become inaccurate and make treatment difficult.

In one study, 75% of participants with mild to moderate intellectual disabilities had experienced at least one traumatic event during their lifespan, putting them at significant risk for PTSD (Martorell et al., 2009). Examples of traumas that intellectually disabled people face include physical and sexual abuse, loss of a parent, removal of children, involvement in vehicle or other collisions, and natural catastrophes. Reliving the trauma can result in acting-out behaviour (aggression or fighting back, inappropriate displays of sexuality, withdrawing in fear) that cannot be redirected.



Indicators Associated with Disorders of Mood: Anxiety

Post-traumatic Stress Disorder (PTSD)

Key Points for Caregivers

- Monitor sleeping and **identify whether nightmares are occurring**. When possible,

identify what the nightmares are about.

- **Record situations when clients seem fearful**, particularly when there does not seem to be anything or anyone around who could hurt them. Notice if clients avoid certain situations or individuals by verbal and non-verbal resistance and behaviours.
- Provide records of known traumatic events to caregivers and family members. Exchange information about these events to **determine whether they are new traumas or flashbacks**.

Obsessive-compulsive disorder (OCD), once thought to be simply a response to anxiety, is now considered a biological condition. Obsessions (the thinking component) are uncontrollable, persistent, and repeated thoughts or impulses. They frequently revolve around themes of contamination, aggression, orderliness, sex, and religion.

Compulsions (the behaving component) are the actions people take to try and relieve the pressure of the unrelenting obsessions. Compulsions are ritualistic patterns of behaviour often involving excessive cleaning, washing, counting, repeating, ordering, and arranging, or hoarding and checking. Repeated eye blinking, hair pulling, head banging, unusual behaviours when urinating or defecating, and self-mutilation are common.

People with OCD do not want to have obsessive thoughts, as those thoughts cause overpowering feelings of pressure and anxiety. They do not want to act on the thoughts either. However, because of the biological nature of the disorder, people are driven to believe that the only way to relieve the pressure of the obsessions is to keep acting on the compulsions. When people are in the process of acting on their compulsions, they can become very angry when their actions are interrupted. In essence, interruptions make the pressure and anxiety feel much worse.

People with intellectual disabilities often respond to interruptions of their ritualistic behaviour with aggressive retaliation such as hitting, spitting, and biting. They may not know why they must act this way, but they feel better when they do and desperately distressed when they do not.

In spite of a preoccupation with cleaning-centred behaviours, clients with this disorder may not achieve personal cleanliness and will present with extreme self-care deficits. Experts suggest that interrupting the behaviour simply increases the anxiety. With this in mind, caregivers can help by avoiding interrupting. For example, rather than interrupting a ritual such as repeated hand washing, a caregiver can ensure that hand lotion is available. With this disorder, the goal is not to prevent ritualistic behaviour, but to delay it.

The tricyclic antidepressant clomipramine (Anafranil) can have an anti-obsession effect. Side effects of the drug include a potential for seizures and withdrawal reactions.



Indicators Associated with Disorders of Mood: Anxiety

Obsessive-compulsive Disorder (OCD)

Key Points for Caregivers

- **Delay rather than interrupt ritualistic behaviours.** Expect that clients may respond with aggression when redirected away from their repetitive behaviours. When caregivers view the behaviours through the eyes of clients, caregivers can acknowledge a client's belief that these behaviours are the only possible relief from unbearable anxiety.
- **Prepare for and seek medical help immediately if seizures occur,** particularly if clients have, or have the potential for, seizure disorders and are taking the antidepressant medication clomipramine (also called Anafranil).
- **Make comfort measures available when ritualistic behaviours result in physical symptoms.** For example, keep available hand lotion for excessive hand washing, and padding or helmets for head banging.

Indicators Associated with Disorders of Behaviour

Personality Disorders

In the preceding sections, we have discussed psychiatric disorders that include or could include elements of psychosis (not being in touch with reality). Clients diagnosed with a thought disorder such as schizophrenia can be expected to have psychotic symptoms before they are treated with antipsychotic medications. We now turn our attention to disorders of behaviour, in which psychotic breaks from reality are not expected.

A personality disorder occurs when personality traits—behaviour patterns that reflect how a person perceives and relates to others and self—become rigid, maladaptive, and fixed. The disorder primarily affects the way an individual gets along with others. In the general population, people with personality disorders have a great deal of difficulty getting along with others and functioning well. Their behaviour can be disturbing to those around them. Often a pattern of repeating the behaviour occurs in different situations, despite efforts to make changes. Personality disorders are believed to be present from a young age, and while medications may

be helpful, there are no antipersonality disorder drugs available as there are antipsychotic and antidepressive drugs.

In the intellectually disabled population, clinicians continue to question whether the same diagnostic criteria for personality disorders should be used (Alexander & Cooray, 2003; Chester, 2010). In part, this is because people with intellectual disabilities (especially those who are moderately and severely disabled) can have difficulty getting along with others for a variety of reasons, many of which can be explained in context. Often, caregivers and family members can support clients toward changing their behaviours, but this is not always possible for people diagnosed with a personality disorder. Without diagnostic criteria that have been adapted to the unique needs of the intellectually disabled, clinicians are often reluctant to impose on clients the stigma that can come with this diagnosis.

Borderline Personality Disorder

Borderline personality disorder is characterized by displays of hostility, emotional dysfunction, mood swings, and aggression (Wilson, 2001). Clients who have this disorder can overreact to typical requests and events. They can be verbally aggressive in ways that are very disturbing to victims. This verbal aggression can quickly lead to physical aggression. They frequently engage in self-injuring and suicidal behaviour.

Clients with borderline personality disorder do not seem able to see the connection between their behaviour and consequences. They may have encounters with the justice system. They tend to view people, circumstances, and events in their lives as either all good or all bad—a tendency that is referred to as *splitting*. This tendency can be destructive in that clients often polarize the people working with them into groups of either “good” or “bad.” Clients may become overattached to some people and make serious accusations against others. It is critical for caregivers to avoid siding with clients against other people or caregivers. Let clients know their accusations will be recorded, discussed, and acted on professionally during team meetings. It is important to ensure that communication with these clients does not suggest an alignment of the caregiver and client against any other member of the team.



Indicators Associated with Disorders of Behaviour: Borderline Personality Disorder

Key Points for Caregivers

- Gather as much information as possible about clients' **patterns** of overreacting and behaviour that is harmful to self or others. Identify if the patterns began occurring at a young age and whether any elements of the behaviour have changed and improved over time and with support.
- With borderline personality disorder, **consistent communication among caregivers** is critically important. Divisions among caregivers can occur if clients split or view individuals around them only as all good or all bad.

Conclusion

In this chapter we have discussed the psychiatric disorders of thinking, mood, and behaviour. These disorders cause so much distress that clients cannot function and enjoy their lives. We have described key indicators of these disorders and emphasized relevant observations that caregivers must watch for and attend to.

Disorders of thinking include schizophrenia, dementia, and psychosis. Disorders of mood include depression (for example, major depression or bipolar affective disorder) and anxiety (for example, post-traumatic stress disorder and obsessive-compulsive disorder). Disorders of behaviour include borderline personality disorder. None of the indicators that are present with these disorders are displayed on purpose. Just as the nature of physical illnesses causes people's minds and bodies to act in certain ways, mental illness does as well. Understanding the links between difficult behaviours and diagnosed psychiatric disorders can make all the difference in supporting dually diagnosed clients toward success.

Citation

Supporting Individuals with Intellectual Disabilities & Mental Illness by Sherri Melrose, Ph.D. (Nursing) is licensed under a Creative Commons Attribution 4.0 International License, except where otherwise noted.

STILL STIGMATIZED? PEOPLE'S BELIEFS AND ATTITUDES ABOUT MENTAL ILLNESS AND DANGEROUSNESS

Introduction

What do you think of when you visualize a person with a mental illness? Do you picture a person talking to himself and acting very bizarre and erratic? Do you imagine a woman with scabs on her face, missing teeth, and marks on her arms from shooting up? The reality is that most people with mental illnesses look and act pretty much like everyone else. There are subtle differences, but one will usually not really notice anything at first glance. There are also more extreme and relatively rare examples whereby people are clearly suffering from severe mental disturbances and are not in touch with reality. There is a wide spectrum when it comes to people's experiences with mental disorders. People are not the same, their disorders are not the same, and their experiences and realities are not the same. With this said, it still appears as though many in the general public still have some pretty stereotypic and limited understandings of what the different mental illnesses are and how they really affect people's lives, thinking, and behaviors. Having a mental illness can also have a significant impact on how others perceive and treat a person. This is a reality that hundreds of millions of people around the world have to deal with on a daily basis. According to the World Health Organization¹, around 450 million people suffer from mental illnesses at any given point in time making this a leading cause of disability worldwide. Mental illness is a serious issue that demands much more attention and focused application.

What does seem to be fairly clear is that those with mental disorders are often treated quite differently from those that do not have a known mental health issue. Those that are dealing with any kind of severe mental health issue are often rejected and prevented from full social participation. This subsequent rejection and poor treatment can often exacerbate their health issues and send them down a darker and more troublesome path than they would have otherwise experienced. Prior studies have demonstrated how this social stigma can have

1. World Health Organization (2001) Mental Disorders Affect One in Four People: Treatment Available but Not Being Used. http://www.who.int/whr/2001/media_centre/press_release/en/

real consequences on people's overall functioning and health²³⁴. It is important to try and better understand why so many people think in these negative ways about those with mental illnesses and how this way of thinking subsequently influences how they ultimately treat those individuals.

One of the most clear-cut ways in which people are harmed by this negative thinking is in how they are socially isolated from others because they are so often looked at as if they are destined to act violently at some point. Even though most individuals with mental illnesses do not act violently toward others, they are very often seen this way and pushed aside.⁵⁶ It is very common for people in the general public to believe that those with mental health disturbances are in some way dangerous.⁷⁸ It is the aim of this study to get a better understanding of how people feel and think about those with mental illnesses. The primary purpose is to try and capture what people think about the level of dangerousness that those with mental illnesses may pose. An additional goal is to try and parse out how people feel about different kinds of mental disorders and the different levels of danger that each is perceived to pose. Issues with stigma, negative attitudes, social distancing, and harmful stereotypes will all be addressed in the work. It is hoped that the final product will yield some additional information and insight that is useful across various academic and professional domains.

Literature Review

One of the most problematic issues that those with mental disorders often have to deal with in regard to their interactive experiences has to do with being socially stigmatized. A stigma prevents one from full social acceptance and participation. Stigmas can arise from just about anything that deviates from social norms, values, and behavioral expectations. Even though approximately half of the population will be diagnosed with

-
2. Boyson, G.A. (2011) Biological Explanations and Stigmatizing Attitudes: Using Essentialism and Perceived Dangerousness to Predict Antistigma Intervention Effectiveness. *The Journal of Social Psychology*, 151, 274-291. <https://doi.org/10.1080/00224545.2010.481689>
 3. Mannarini, S. and Boffo, M. (2015) Anxiety, Bulimia, Drug and Alcohol Addiction, Depression, and Schizophrenia: What Do You Think about Their Aetiology, Dangerousness, Social Distance, and Treatment? A Latent class Analysis Approach. *Social Psychiatry and Psychiatric Epidemiology*, 50, 27-37. <https://doi.org/10.1007/s00127-014-0925-x>
 4. Pescosolido, B.A., Fettes, D.L., Martin, J.K., Monahan, J. and McLeod, J.D. (2007) Perceived Dangerousness of Children with Mental Health Problems and Support for Coerced Treatment. *Psychiatric Services*, 58, 619-625. <https://doi.org/10.1176/ps.2007.58.5.619>Enter your footnote content here.
 5. Magliano, L., Read, J., Rinaldi, A., Costanzo, R., De Leo, R., Schioppa, G. and Petrillo, M. (2016) The Influence of Causal Explanations and Diagnostic Labeling on Psychology Students' Beliefs about Treatments, Prognosis, Dangerousness, and Unpredictability in Schizophrenia. *Community Mental Health Journal*, 52, 361-369. <https://doi.org/10.1007/s10597-015-9901-5>
 6. Barnhorst, A. (2015) California Firearms Laws and Mental Illness. *Behavioral Sciences and the Law*, 33, 246-256. <https://doi.org/10.1002/bsl.2177>
 7. Price, J.H. and Khubchandani, J. (2016) Firearm Violence by the Mentally Ill: Mental Health Professionals' Perceptions and Practices. *Violence and Gender*, 3, 92-99. <https://doi.org/10.1089/vio.2015.0045>
 8. Reavley, N.J., Jorm, A.F. and Morgan, A.J. (2016) Beliefs about Dangerousness of People with Mental Health Problems: The Role of Media Reports and Personal Exposure to Threat or Harm. *Social Psychiatry and Psychiatric Epidemiology*, 51, 1257-1264. <https://doi.org/10.1007/s00127-016-1215-6>

a mental illness at some point in their lives, people still often seem to be uncomfortable being around these diagnosed individuals and will often distance themselves from them.⁹¹⁰¹¹ Some of the main reasons given for this social distancing seem to revolve around the belief that mentally ill individuals are unpredictable and dangerous¹²¹³¹⁴. Mannarini and Boffo¹⁵ studied the reasons that people will often distance themselves from those with mental illnesses and they found that it fundamentally boils down to negative stereotypes and attitudes that reinforce the belief that these individuals are a potential threat to their safety. Nee and Witt¹⁶ found the same things in their work on people's perceptions toward those with mental illnesses. They concluded that people often have a sense that there is some kind of threat posed to them when they are in the presence of these individuals. This perceived sense of danger often leads to social avoidance and rejection of those with mental illnesses.¹⁷¹⁸¹⁹

To better understand where these feelings and attitudes come from, we must look at larger social and cultural forces. One of the main reinforcers of these negative attitudes and perceptions towards those with mental illnesses is the mass media. The media like to portray those with mental disorders as often being prone to violence and erratic behaviors.²⁰²¹ The media like to sensationalize and play up stories to try and garner

-
9. Mannarini, S. and Boffo, M. (2015) Anxiety, Bulimia, Drug and Alcohol Addiction, Depression, and Schizophrenia: What Do You Think about Their Aetiology, Dangerousness, Social Distance, and Treatment? A Latent class Analysis Approach. *Social Psychiatry and Psychiatric Epidemiology*, 50, 27-37. <https://doi.org/10.1007/s00127-014-0925-x>Enter your footnote content here.
 10. Quintero Johnson, J.M. and Riles, J. (2018) "He Acted Like a Crazy Person": Exploring the Influence of College Students' Recall of Stereotypic Media Representations of Mental Illness. *Psychology of Popular Media Culture*, 7, 146-163. <https://doi.org/10.1037/ppm0000121>
 11. [10] Marie, D. and Miles, B. (2008) Social Distance and Perceived Dangerousness across Four Diagnostic Categories of Mental Disorder. *Australian and New Zealand Journal of Psychiatry*, 42, 126-133. <https://doi.org/10.1080/00048670701787545>
 12. [11] Stuber, J.P., Rocha, A., Christian, A. and Link, B.G. (2014) Conceptions of Mental Illness: Attitudes of Mental Health Professionals and the General Public. *Psychiatric Services*, 65, 490-497. <https://doi.org/10.1176/appi.ps.201300136>
 13. [12] Magliano, J., Punzo, P., Strino, A., Acone, A., Affuso, G. and Read, J. (2017) General Practitioners' Beliefs about People with Schizophrenia and whether They Should Be Subject to Discriminatory Treatment when in Medical Hospital: The Mediating Role of Dangerousness Perception. *American Journal of Orthopsychiatry*, 87, 559-566. <https://doi.org/10.1037/ort0000217>
 14. Frailing, K. and Slate, R. (2016) Changing Students' Perceptions of People with Mental Illness. *Applied Psychology in Criminal Justice*, 12, 54-70.
 15. Nee, C. and Witt, C. (2013) Public Perceptions of Risk in Criminality: The Effects of Mental Illness and Social Disadvantage. *Psychiatry Research*, 209, 675-683. <https://doi.org/10.1016/j.psychres.2013.02.013>
 16. Nee, C. and Witt, C. (2013) Public Perceptions of Risk in Criminality: The Effects of Mental Illness and Social Disadvantage. *Psychiatry Research*, 209, 675-683. <https://doi.org/10.1016/j.psychres.2013.02.013>
 17. Nee, C. and Witt, C. (2013) Public Perceptions of Risk in Criminality: The Effects of Mental Illness and Social Disadvantage. *Psychiatry Research*, 209, 675-683. <https://doi.org/10.1016/j.psychres.2013.02.013>Enter your footnote content here.
 18. Corrigan, P.W., Powell, K.J. and Rusch, N. (2012) How Does Stigma Affect Work in People with Serious Mental Illness? *Psychiatric Rehabilitation Journal*, 35, 381-384. <https://doi.org/10.1037/h0094497>
 19. Corrigan, P.W., Powell, K.J. and Rusch, N. (2012) How Does Stigma Affect Work in People with Serious Mental Illness? *Psychiatric Rehabilitation Journal*, 35, 381-384. <https://doi.org/10.1037/h0094497>
 20. McGinty, E.E., Webster, D.W., Jarlenski, M. and Barry, C.L. (2014) News Media Framing of Serious Mental Illness and Gun Violence in the United States, 1997-2012. *American Journal of Public Health*, 104, 406-413. <https://doi.org/10.2105/AJPH.2013.301557>
 21. Theriot, M.T. and Lodato, G.A. (2012) Attitudes about Mental Illness and Professional Danger among New Social Work Students. *Journal of Social Work Education*, 48, 403-423. <https://doi.org/10.5175/JSWE.2012.201000079>

higher ratings. They will often exploit horrendous events to accomplish this (e.g., mass shootings, school shootings, serial murder) and seem to give little concern to how it harms wider populations of people that are trying to manage and cope with their existing mental health problems.²²²³²⁴ The media also seems to portray certain kinds of diagnosed individuals as being much more likely to be violent than others, which only serves to reinforce the stigmas and social devaluations that these individuals are already trying to manage.²⁵²⁶

Even though the vast majority of those suffering from mental illnesses are not violent there are some diagnoses that seem to come with higher overall rates of violence than others.²⁷²⁸²⁹ Even though mental illness is only associated with around 4% of all of the violent crimes commit each year people still widely believe that those with schizophrenia, bipolar disorder, substance abuse disorder, and psychotic disorders are prone to violence^{3031 32}. To get a better sense of this we must look at the prevailing evidence and allow the empirical data to inform us on these matters. According to Araten-Bergman and Werner³³ there are some elevated risks when it comes to dual-diagnoses. For example, there appears to be an increased risk of violence when people are dealing with co-existing diagnoses involving intellectual disabilities, psychotic disorders,

-
22. Quintero Johnson, J.M. and Riles, J. (2018) "He Acted Like a Crazy Person": Exploring the Influence of College Students' Recall of Stereotypic Media Representations of Mental Illness. *Psychology of Popular Media Culture*, 7, 146-163. <https://doi.org/10.1037/ppm0000121>
 23. [17] McGinty, E.E., Webster, D.W., Jarlenski, M. and Barry, C.L. (2014) News Media Framing of Serious Mental Illness and Gun Violence in the United States, 1997-2012. *American Journal of Public Health*, 104, 406-413. <https://doi.org/10.2105/AJPH.2013.301557>
 24. Varshney, M., Mahapatra, A., Krishnan, V., Gupta, R. and Sinha Deb, K. (2016) Violence and Mental Illness: What Is the True Story? *Journal of Epidemiology and Community Health*, 70, 223-225. <https://doi.org/10.1136/jech-2015-205546>
 25. Osborg Ose, S., Lilleeng, S., Pettersen, I., Ruud, T. and van Weeghel, J. (2017) Risk of Violence among Patients in Psychiatric Treatment: Results from a National Census. *Nordic Journal of Psychiatry*, 71, 551-560. <https://doi.org/10.1080/08039488.2017.1352024>
 26. Thoits, P.A. (2011) Resisting the Stigma of Mental Illness. *Social Psychology Quarterly*, 74, 6-28. <https://doi.org/10.1177/0190272511398019>
 27. Gross, N.R. and Morgan, R.D. (2013) Understanding Persons with Mental Illness who Are and Are Not Criminal Justice Involved: A Comparison of Criminal Thinking and Psychiatric Symptoms. *Law and Human Behavior*, 37, 175-186. <https://doi.org/10.1037/lhb0000013>
 28. Guimon, J. (2010) Prejudice and Realities in Stigma. *International Journal of Mental Health*, 39, 20-43. <https://doi.org/10.2753/IMH0020-7411390302>
 29. Covarrubias, I. and Han, M. (2011) Mental Health Stigma in Serious Mental Illness among MSW Students: Social Contact and Attitude. *Social Work*, 56, 317-325. <https://doi.org/10.1093/sw/56.4.317>
 30. [16] Corrigan, P.W., Powell, K.J. and Rusch, N. (2012) How Does Stigma Affect Work in People with Serious Mental Illness? *Psychiatric Rehabilitation Journal*, 35, 381-384. <https://doi.org/10.1037/h0094497>
 31. [25] Arkowitz, A. and Lilienfeld, S.O. (2011) Deranged and Dangerous? *Scientific American Mind*, 22, 64-65. <https://doi.org/10.1038/scientificamericanmind0711-64>
 32. [26] Stuart, H.L. and Arboleda-Florez, J.E. (2001) A Public Health Perspective on Violent Offences among Persons with Mental Illness. *Psychiatric Services*, 52, 654-659. <https://doi.org/10.1176/appi.ps.52.5.654>
 33. Araten-Bergman, T. and Werner, S. (2017) Social Workers' Attributions towards Individuals with Dual Diagnosis of Intellectual Disability and Mental Illness. *Journal of Intellectual Disability Research*, 61, 157-167. <https://doi.org/10.1111/jir.12300>

schizophrenia, bipolar disorder, adjustment disorder, conduct disorder, and substance use disorder³⁴³⁵³⁶. Other researchers have found additional clinical disorders to also come with a higher risk of violent behavior, such as with personality disorders (e.g., antisocial and borderline), alcohol addiction, delusional disorder, attention-hyperactivity disorder, and developmental disorders.³⁷³⁸³⁹

We must pay attention to the factors that may cause or contribute to a person with a mental illness acting in a dangerous or reckless manner. The research seems to strongly support that the use of drugs and alcohol are often central to any erratic and dangerous behaviors that may be seen in diagnosed individuals.⁴⁰⁴¹⁴² According to Arkowitz and Lilienfeld⁴³ around one-third of all violent acts committed by patients occur within one year of leaving the hospital and much of this is often attributed to not following the treatment plan (e.g., not taking the prescribed medications). Social rejection and lack of social support are also important factors that seem to contribute to potential acts of violence.⁴⁴⁴⁵⁴⁶ Additional factors that need to be better understood with all of this include issues related to unemployment, lack of housing, homelessness, and poverty.⁴⁷⁴⁸ These factors are

-
34. Corrigan, P.W., Powell, K.J. and Rusch, N. (2012) How Does Stigma Affect Work in People with Serious Mental Illness? *Psychiatric Rehabilitation Journal*, 35, 381-384. <https://doi.org/10.1037/h0094497>
 35. Arkowitz, A. and Lilienfeld, S.O. (2011) Deranged and Dangerous? *Scientific American Mind*, 22, 64-65. <https://doi.org/10.1038/scientificamericanmind0711-64>
 36. [27] Araten-Bergman, T. and Werner, S. (2017) Social Workers' Attributions towards Individuals with Dual Diagnosis of Intellectual Disability and Mental Illness. *Journal of Intellectual Disability Research*, 61, 157-167. <https://doi.org/10.1111/jir.12300>
 37. Pescosolido, B.A., Fettes, D.L., Martin, J.K., Monahan, J. and McLeod, J.D. (2007) Perceived Dangerousness of Children with Mental Health Problems and Support for Coerced Treatment. *Psychiatric Services*, 58, 619-625. <https://doi.org/10.1176/ps.2007.58.5.619>
 38. Varshney, M., Mahapatra, A., Krishnan, V., Gupta, R. and Sinha Deb, K. (2016) Violence and Mental Illness: What Is the True Story? *Journal of Epidemiology and Community Health*, 70, 223-225. <https://doi.org/10.1136/jech-2015-205546>
 39. Osborg Ose, S., Lilleeng, S., Pettersen, I., Ruud, T. and van Weeghel, J. (2017) Risk of Violence among Patients in Psychiatric Treatment: Results from a National Census. *Nordic Journal of Psychiatry*, 71, 551-560. <https://doi.org/10.1080/08039488.2017.1352024>
 40. Pescosolido, B.A., Fettes, D.L., Martin, J.K., Monahan, J. and McLeod, J.D. (2007) Perceived Dangerousness of Children with Mental Health Problems and Support for Coerced Treatment. *Psychiatric Services*, 58, 619-625. <https://doi.org/10.1176/ps.2007.58.5.619>
 41. Nee, C. and Witt, C. (2013) Public Perceptions of Risk in Criminality: The Effects of Mental Illness and Social Disadvantage. *Psychiatry Research*, 209, 675-683. <https://doi.org/10.1016/j.psychres.2013.02.013>
 42. [19] Varshney, M., Mahapatra, A., Krishnan, V., Gupta, R. and Sinha Deb, K. (2016) Violence and Mental Illness: What Is the True Story? *Journal of Epidemiology and Community Health*, 70, 223-225. <https://doi.org/10.1136/jech-2015-205546>
 43. Arkowitz, A. and Lilienfeld, S.O. (2011) Deranged and Dangerous? *Scientific American Mind*, 22, 64-65. <https://doi.org/10.1038/scientificamericanmind0711-64>
 44. Boyson, G.A. (2011) Biological Explanations and Stigmatizing Attitudes: Using Essentialism and Perceived Dangerousness to Predict Antistigma Intervention Effectiveness. *The Journal of Social Psychology*, 151, 274-291. <https://doi.org/10.1080/00224545.2010.481689>
 45. [10] Marie, D. and Miles, B. (2008) Social Distance and Perceived Dangerousness across Four Diagnostic Categories of Mental Disorder. *Australian and New Zealand Journal of Psychiatry*, 42, 126-133. <https://doi.org/10.1080/00048670701787545>
 46. [14] Nee, C. and Witt, C. (2013) Public Perceptions of Risk in Criminality: The Effects of Mental Illness and Social Disadvantage. *Psychiatry Research*, 209, 675-683. <https://doi.org/10.1016/j.psychres.2013.02.013>
 47. Theriot, M.T. and Lodato, G.A. (2012) Attitudes about Mental Illness and Professional Danger among New Social Work Students. *Journal of Social Work Education*, 48, 403-423. <https://doi.org/10.5175/JSWE.2012.201000079>
 48. Varshney, M., Mahapatra, A., Krishnan, V., Gupta, R. and Sinha Deb, K. (2016) Violence and Mental Illness: What Is the True Story? *Journal of Epidemiology and Community Health*, 70, 223-225. <https://doi.org/10.1136/jech-2015-205546>

also often associated with being marginalized in one way or another which can further isolate and stigmatize those with mental health disturbances.⁴⁹⁵⁰⁵¹

It is also critical to understand how professionals that work with mentally ill individuals think about them and what their attitudes are towards them. Research has demonstrated that even professional social workers often hold negative attitudes and perceptions about those with mental illnesses.⁵² The evidence also seems to indicate that there is a pattern with many social workers where they develop increasingly negative attitudes toward those with certain mental illnesses (e.g., schizophrenia and bipolar disorder) and even develop an increasing fear and sense of anger toward them.⁵³⁵⁴⁵⁵ Kesic and Thomas⁵⁶ found in their research that police officers often have negative attitudes and perceptions toward those with mental disorders. A major reason that this is a concern is because this leads them to be more likely to use force when they are interacting with these individuals. When people view those with mental illnesses to be unpredictable, erratic, and even a threat, they will sometimes act more intolerant or aggressive toward them.⁵⁷⁵⁸ Even studies with college students majoring in areas relevant to this topic (e.g., social work, criminology, and psychology) have shown high rates of negative attitudes and beliefs toward those with mental disorders.⁵⁹⁶⁰ It appears that lack of education and public misinformation are largely to blame for this ongoing mistrust and stigmatization of those with mental illnesses

In the final review it is clear that those with mental disorders have long faced negative treatment in society.

-
49. Magliano, L., Read, J., Rinaldi, A., Costanzo, R., De Leo, R., Schioppa, G. and Petrillo, M. (2016) The Influence of Causal Explanations and Diagnostic Labeling on Psychology Students' Beliefs about Treatments, Prognosis, Dangerousness, and Unpredictability in Schizophrenia. *Community Mental Health Journal*, 52, 361-369. <https://doi.org/10.1007/s10597-015-9901-5>
 50. Corrigan, P.W., Powell, K.J. and Rusch, N. (2012) How Does Stigma Affect Work in People with Serious Mental Illness? *Psychiatric Rehabilitation Journal*, 35, 381-384. <https://doi.org/10.1037/h0094497>
 51. Thachuk, A.J. (2011) Stigma and the Politics of Biomedical Models of Mental Illness. *International Journal of Feminist Approaches to Bioethics*, 4, 140-163. <https://doi.org/10.3138/ijfab.4.1.140>
 52. Araten-Bergman, T. and Werner, S. (2017) Social Workers' Attributions towards Individuals with Dual Diagnosis of Intellectual Disability and Mental Illness. *Journal of Intellectual Disability Research*, 61, 157-167. <https://doi.org/10.1111/jir.12300>
 53. Theriot, M.T. and Lodato, G.A. (2012) Attitudes about Mental Illness and Professional Danger among New Social Work Students. *Journal of Social Work Education*, 48, 403-423. <https://doi.org/10.5175/JSWE.2012.201000079>
 54. Covarrubias, I. and Han, M. (2011) Mental Health Stigma in Serious Mental Illness among MSW Students: Social Contact and Attitude. *Social Work*, 56, 317-325. <https://doi.org/10.1093/sw/56.4.317>
 55. Araten-Bergman, T. and Werner, S. (2017) Social Workers' Attributions towards Individuals with Dual Diagnosis of Intellectual Disability and Mental Illness. *Journal of Intellectual Disability Research*, 61, 157-167. <https://doi.org/10.1111/jir.12300>
 56. Kesic, D. and Thomas, S.D. (2014) Do Prior Histories of Violence and Mental Disorders Impact on Violent Behaviour during Encounters with Police? *International Journal of Law and Psychiatry*, 37, 409-414. <https://doi.org/10.1016/j.ijlp.2014.02.012>
 57. Guimon, J. (2010) Prejudice and Realities in Stigma. *International Journal of Mental Health*, 39, 20-43. <https://doi.org/10.2753/IMH0020-7411390302>
 58. Kesic, D. and Thomas, S.D. (2014) Do Prior Histories of Violence and Mental Disorders Impact on Violent Behaviour during Encounters with Police? *International Journal of Law and Psychiatry*, 37, 409-414. <https://doi.org/10.1016/j.ijlp.2014.02.012>
 59. Frailing, K. and Slate, R. (2016) Changing Students' Perceptions of People with Mental Illness. *Applied Psychology in Criminal Justice*, 12, 54-70.
 60. Covarrubias, I. and Han, M. (2011) Mental Health Stigma in Serious Mental Illness among MSW Students: Social Contact and Attitude. *Social Work*, 56, 317-325. <https://doi.org/10.1093/sw/56.4.317>

They are often rejected by those close to them. They are also often avoided by both peers and professionals, are often rejected by potential employers, and are often denied housing by those that fear what they represent.⁶¹⁶²⁶³ The reality is that the vast majority of individuals suffering from mental health disturbances are not violent or a danger to society.⁶⁴⁶⁵⁶⁶ Even with this being the case, many are still socially rejected and cast aside. They are still viewed as being widely unpredictable and they even produce a level of fear in others.⁶⁷⁶⁸⁶⁹ Even though there are some factors that do seem to increase one's potential for violent and erratic behavior (e.g., substance abuse, criminogenic thinking, impulsiveness, mania, etc.) these should not be conflated with and linked to everyone that is dealing with a mental illness.⁷⁰⁷¹⁷² Being socially stigmatized can make things much worse for anyone trying to cope with a severe mental illness. It is our duty to better understand this ongoing cultural problem and to do our best to improve the lives of those trying to manage a mental health condition.

-
61. Magliano, L., Read, J., Rinaldi, A., Costanzo, R., De Leo, R., Schioppa, G. and Petrillo, M. (2016) The Influence of Causal Explanations and Diagnostic Labeling on Psychology Students' Beliefs about Treatments, Prognosis, Dangerousness, and Unpredictability in Schizophrenia. *Community Mental Health Journal*, 52, 361-369. <https://doi.org/10.1007/s10597-015-9901-5>
 62. [11] Stuber, J.P., Rocha, A., Christian, A. and Link, B.G. (2014) Conceptions of Mental Illness: Attitudes of Mental Health Professionals and the General Public. *Psychiatric Services*, 65, 490-497. <https://doi.org/10.1176/appi.ps.201300136>
 63. Corrigan, P.W., Powell, K.J. and Rusch, N. (2012) How Does Stigma Affect Work in People with Serious Mental Illness? *Psychiatric Rehabilitation Journal*, 35, 381-384. <https://doi.org/10.1037/h0094497>
 64. Reavley, N.J., Jorm, A.F. and Morgan, A.J. (2016) Beliefs about Dangerousness of People with Mental Health Problems: The Role of Media Reports and Personal Exposure to Threat or Harm. *Social Psychiatry and Psychiatric Epidemiology*, 51, 1257-1264. <https://doi.org/10.1007/s00127-016-1215-6>
 65. Stuber, J.P., Rocha, A., Christian, A. and Link, B.G. (2014) Conceptions of Mental Illness: Attitudes of Mental Health Professionals and the General Public. *Psychiatric Services*, 65, 490-497. <https://doi.org/10.1176/appi.ps.201300136>
 66. Magliano, J., Punzo, P., Strino, A., Acone, A., Affuso, G. and Read, J. (2017) General Practitioners' Beliefs about People with Schizophrenia and whether They Should Be Subject to Discriminatory Treatment when in Medical Hospital: The Mediating Role of Dangerousness Perception. *American Journal of Orthopsychiatry*, 87, 559-566. <https://doi.org/10.1037/ort0000217>
 67. Frailing, K. and Slate, R. (2016) Changing Students' Perceptions of People with Mental Illness. *Applied Psychology in Criminal Justice*, 12, 54-70.
 68. Theriot, M.T. and Lodato, G.A. (2012) Attitudes about Mental Illness and Professional Danger among New Social Work Students. *Journal of Social Work Education*, 48, 403-423. <https://doi.org/10.5175/JSWE.2012.201000079>
 69. Araten-Bergman, T. and Werner, S. (2017) Social Workers' Attributions towards Individuals with Dual Diagnosis of Intellectual Disability and Mental Illness. *Journal of Intellectual Disability Research*, 61, 157-167. <https://doi.org/10.1111/jir.12300>
 70. [16] Corrigan, P.W., Powell, K.J. and Rusch, N. (2012) How Does Stigma Affect Work in People with Serious Mental Illness? *Psychiatric Rehabilitation Journal*, 35, 381-384. <https://doi.org/10.1037/h0094497>
 71. Varshney, M., Mahapatra, A., Krishnan, V., Gupta, R. and Sinha Deb, K. (2016) Violence and Mental Illness: What Is the True Story? *Journal of Epidemiology and Community Health*, 70, 223-225. <https://doi.org/10.1136/jech-2015-205546>
 72. Araten-Bergman, T. and Werner, S. (2017) Social Workers' Attributions towards Individuals with Dual Diagnosis of Intellectual Disability and Mental Illness. *Journal of Intellectual Disability Research*, 61, 157-167. <https://doi.org/10.1111/jir.12300>

Findings of the Study

4.1. Informative Descriptive Statistics

Ninety-nine of the respondents stated that they personally know someone with a diagnosed mental illness (62.3%), whereas 58 stated that they did not (36.5%). Two of the respondents (1.3%) failed to answer this question. When asked if people with mental illnesses are more likely to be dangerous 75 respondents (47.2%) stated that they are. Thirty-two of the respondents (20.1%) did not feel this way. Fifty-two of the participants (32.7%) were not sure whether mentally ill individuals are or are not more likely to be dangerous. When the respondents were asked which of the mental illnesses they associated with the most violent behavior schizophrenia was the top response. Table 1 summarizes the descending order at which respondents answered this question about violent behavior.

It should be noted that antisocial personality is a personality disorder so some respondents may have been thinking about this particular personality disorder when they answered this question. It is not clear which specific personality disorder they were referring to. Also, psychopathy/sociopathy are not actual diagnoses according to the current Diagnostic and Statistical Manual of Mental Disorder (DSM-5). In clinical practice both of these commonly labeled pathologies would be included under antisocial personality disorder, which would significantly raise the number of respondents that would have stated that this was the most violent mental illness. Only 6 of the respondents (3.8%) were not sure which mental illness they felt was associated with the most violent behavior.

The largest majority of respondents believe that people with drug addictions are dangerous, followed by schizophrenia, veterans with post-traumatic stress disorder, and conduct disorder. Table 2 summarizes what the respondents feel about each mental illness and views on dangerousness. In regard to suicide and mental illness, the clear majority of respondents believe that when people take their own lives they are most likely suffering from a severe mental illness (75.4%). Only 15 respondents do not believe that suicide is closely associated to mental illness (9.4%). When asked if respondents would be concerned about being in a relationship with a person that has a mental illness 106 stated that this would be a real concern to them (66.6%).

Table 1. Beliefs about mental illnesses and associations to violent behavior.

The most violent behavior is associated with:	Frequency	%
Schizophrenia	79	49.7
Bipolar Disorder	21	13.2
Drug Addiction	11	6.9
PTSD	10	6.3
Personality Disorder	9	5.7
Psychopathy/Sociopathy	8	5.0
Unsure/Unknown	6	3.8
Antisocial Personality	5	3.1
Conduct Disorder	5	3.1
Depression	3	1.9
Dissociative Identity Disorder	1	0.6
Obsessive-Compulsive Disorder	1	0.6

Table 2. Beliefs about people with mental illnesses and dangerousness: selected disorders.

Mental Illness	Are Dangerous	Mean	Standard Deviation
Drug Addiction	74.20%	3.93	0.94
Schizophrenia	54.70%	3.59	0.92
Veterans with PTSD	47.20%	3.33	1.05
Personality Disorder	40.90%	3.25	1.07
Conduct Disorder	39.60%	3.26	0.98
Bipolar Disorder	39.00%	3.21	0.99
Depression	20.10%	1.86	1.08

4.2 Inferential Tests

In regard to how men and women feel about mental illnesses and dangerousness, bipolar disorder was the condition that stood out the most when it came to group differences. The Mann-Whitney U test produced significant results ($\text{sig.} = 0.015$) suggesting that men ($M = 3.46$, $SD = 0.88$), when compared to women (M

= 3.06, SD = 1.03), believe that those with bipolar disorder are generally more dangerous. An independent samples t-test also produced significant result regarding bipolar disorder and how men and women feel about dangerousness $t(157) = 2.48, p = 0.014$. In regard to ethnicity there were several group differences found concerning conduct disorder, personality disorder, and depression. Both the median test (sig. = 0.042) and the Kruskal-Wallis test (sig. = 0.029) produced significant result concerning how the respondents felt about conduct disorder and dangerousness. It appears that Black ($M = 4.00, SD = 1.55$) and Asian ($M = 4.00, SD = 0.92$) respondents are more concerned about conduct disorder and the sense of dangerousness than the other groups in the study. The same two ethnic groups stood out in regard to personality disorders and dangerousness. The median test also produced a significant result (sig. = 0.045) indicating that both Blacks ($M = 4.00, SD = 1.55$) and Asians ($M = 3.75, SD = 0.87$) have stronger feelings when it comes to those with personality disorders and their propensities to act in dangerous ways. The median test also produced significant result in regard to depression and dangerousness (sig. = 0.049). As a group, Black respondents felt that individuals with depression were more prone to act in dangerous ways. Other tests did not produce significant group results whereas most groups appeared to have had relatively similar feelings regarding most mental illnesses and levels of dangerousness.

4.3. Measures of Association

A number of association tests produced significant and illuminating results. Some of the most important to note seem to revolve around drug addiction. Respondents seem to feel that there was an association between schizophrenia and drug addiction, bipolar disorder and drug addiction, and personality disorder and drug addiction. Respondents also seem to be concerned about being in a relationship with those that have schizophrenia, bipolar disorder, and a personality disorder. Table 3 breaks down some of the ordinal by ordinal measures regarding these particular mental illnesses. These findings would seem to make sense and correlate well with what respondents stated about each of these respective mental illness and beliefs about dangerousness. Schizophrenia, bipolar disorder, drug addiction, and personality disorders (particularly antisocial personality disorder—which includes psychopathy and sociopathy) were among the top ranked when it came to respondents believing that they were generally more prone to acting dangerously and them also being concerned about being in a relationship with these particular types of individuals.

5. General Discussion

The findings of this study support what has been found in numerous other studies looking at people's views

and perceptions about mental illness and dangerousness⁷³⁷⁴⁷⁵⁷⁶. This study has produced further evidence that those in the general population do tend to have concerns about those with mental illnesses when it comes to their own safety and well-being. When asked if mental illnesses are connected to dangerous behaviors the most common response given by the respondents was that they are. The clear majority of respondents would also be concerned about being in any kind of relationship with a person that was dealing with a mental illness. The respondents did have different views on which mental illnesses would be the most concerning to them and which ones they associate with the most dangerous, and violent, behaviors. Most of the respondents did not see depression, as one example, as being as concerning as bipolar disorder. This meshes with prior studies looking at what people think about mental illnesses and which ones they think are linked to the most dangerous behavior. In these prior studies, depression was generally not viewed as being as threatening or violent as other mental illness.⁷⁷⁷⁸ Anxiety disorders are also generally not seen as being as dangerous as many of the other mental illnesses looked at in the current study.⁷⁹⁸⁰

-
73. Mannarini, S. and Boffo, M. (2015) Anxiety, Bulimia, Drug and Alcohol Addiction, Depression, and Schizophrenia: What Do You Think about Their Aetiology, Dangerousness, Social Distance, and Treatment? A Latent class Analysis Approach. *Social Psychiatry and Psychiatric Epidemiology*, 50, 27-37. <https://doi.org/10.1007/s00127-014-0925-x>
 74. Reavley, N.J., Jorm, A.F. and Morgan, A.J. (2016) Beliefs about Dangerousness of People with Mental Health Problems: The Role of Media Reports and Personal Exposure to Threat or Harm. *Social Psychiatry and Psychiatric Epidemiology*, 51, 1257-1264. <https://doi.org/10.1007/s00127-016-1215-6>
 75. Guimon, J. (2010) Prejudice and Realities in Stigma. *International Journal of Mental Health*, 39, 20-43. <https://doi.org/10.2753/IMH0020-7411390302>
 76. Thachuk, A.J. (2011) Stigma and the Politics of Biomedical Models of Mental Illness. *International Journal of Feminist Approaches to Bioethics*, 4, 140-163. <https://doi.org/10.3138/ijfab.4.1.140>
 77. Mannarini, S. and Boffo, M. (2015) Anxiety, Bulimia, Drug and Alcohol Addiction, Depression, and Schizophrenia: What Do You Think about Their Aetiology, Dangerousness, Social Distance, and Treatment? A Latent class Analysis Approach. *Social Psychiatry and Psychiatric Epidemiology*, 50, 27-37. <https://doi.org/10.1007/s00127-014-0925-x>
 78. Stuber, J.P., Rocha, A., Christian, A. and Link, B.G. (2014) Conceptions of Mental Illness: Attitudes of Mental Health Professionals and the General Public. *Psychiatric Services*, 65, 490-497. <https://doi.org/10.1176/appi.ps.201300136>
 79. Mannarini, S. and Boffo, M. (2015) Anxiety, Bulimia, Drug and Alcohol Addiction, Depression, and Schizophrenia: What Do You Think about Their Aetiology, Dangerousness, Social Distance, and Treatment? A Latent class Analysis Approach. *Social Psychiatry and Psychiatric Epidemiology*, 50, 27-37. <https://doi.org/10.1007/s00127-014-0925-x>
 80. Marie, D. and Miles, B. (2008) Social Distance and Perceived Dangerousness across Four Diagnostic Categories of Mental Disorder. *Australian and New Zealand Journal of Psychiatry*, 42, 126-133. <https://doi.org/10.1080/00048670701787545>

Table 3. Directional and symmetric measures of association.

Pairings	Somer's d	Sig.	Gamma	Sig.
Schizophrenia × Drug Addiction	0.257	0.000	0.361	0.000
Schizophrenia × Relationship	0.254	0.000	0.350	0.000
Bipolar Disorder × Drug Addiction	0.343	0.000	0.474	0.000
Bipolar Disorder × Relationship	0.134	0.038	0.184	0.038
Conduct Disorder × Drug Addiction	0.231	0.002	0.323	0.002
Personality Disorder × Drug Addiction	0.236	0.002	0.323	0.002
Personality Disorder × Relationship	0.159	0.014	0.217	0.014

Outside of obsessive-compulsive disorder being mentioned by a single respondent that believes this disorder is closely associated with violent behavior, none of the general anxiety-related disorders were spotlighted at all by the respondents. The disorders that were clearly of the most concern to respondents revolved mostly around psychotic disorders, personality disorders, and substance abuse disorders. Bipolar disorder was also at the top when it came to perceptions about dangerousness and even violent behavior. These findings seem to coalesce with what other researchers have found in their related studies.⁸¹⁸²⁸³ It was clear that schizophrenia was the top disorder when it comes to how the respondents felt about their own safety and the propensity for violent behavior. Half of the respondents in this study said that schizophrenia is the mental illness most closely associated to violent behavior. The second leading response was bipolar disorder, with only 13.2% of the respondents stating that this was the disorder most closely connected to violence. These findings clearly highlight what people generally feel and think about those with schizophrenia. Other studies have also produced similar results whereby the participants firmly believe that schizophrenia is closely linked to dangerous behaviors and that the participants are not comfortable being around these particular types of individuals.⁸⁴⁸⁵⁸⁶ The findings of this study in regard to attitudes and perceptions about bipolar disorder

81. Boyson, G.A. (2011) Biological Explanations and Stigmatizing Attitudes: Using Essentialism and Perceived Dangerousness to Predict Antistigma Intervention Effectiveness. *The Journal of Social Psychology*, 151, 274-291. <https://doi.org/10.1080/00224545.2010.481689>
82. Theriot, M.T. and Lodato, G.A. (2012) Attitudes about Mental Illness and Professional Danger among New Social Work Students. *Journal of Social Work Education*, 48, 403-423. <https://doi.org/10.5175/JSWE.2012.201000079>
83. Gross, N.R. and Morgan, R.D. (2013) Understanding Persons with Mental Illness who Are and Are Not Criminal Justice Involved: A Comparison of Criminal Thinking and Psychiatric Symptoms. *Law and Human Behavior*, 37, 175-186. <https://doi.org/10.1037/lhb0000013>
84. Corrigan, P.W., Powell, K.J. and Rusch, N. (2012) How Does Stigma Affect Work in People with Serious Mental Illness? *Psychiatric Rehabilitation Journal*, 35, 381-384. <https://doi.org/10.1037/h0094497>
85. Varshney, M., Mahapatra, A., Krishnan, V., Gupta, R. and Sinha Deb, K. (2016) Violence and Mental Illness: What Is the True Story? *Journal of Epidemiology and Community Health*, 70, 223-225. <https://doi.org/10.1136/jech-2015-205546>
86. Covarrubias, I. and Han, M. (2011) Mental Health Stigma in Serious Mental Illness among MSW Students: Social Contact and Attitude. *Social Work*, 56, 317-325. <https://doi.org/10.1093/sw/56.4.317>

and personality disorders (particularly antisocial personality disorder) are also in line with what has been found in other studies. This study, as well as a number of other outside studies, has widely found that these particular mental illnesses often raise suspicion and concerns about personal safety and potentially dangerous behaviors.⁸⁷⁸⁸⁸⁹

Substance use disorder has been shown to be closely connected to risky and even violent behavior among mentally ill populations.⁹⁰⁹¹ The participants in this study also seemed to feel that drug addiction was at the top when it comes to dangerous and violent behavior. In fact, the respondents in this study ranked drug addiction as the most dangerous of all of the mental illnesses. They were even more inclined to feel this way if there was a co-occurrence taking place with schizophrenia, bipolar disorder, conduct disorder, or a personality disorder. These findings also seem to support the wider literature where it has been found that those with mental illnesses that are simultaneously using drugs (or that have a substance use disorder) are significantly more likely to engage in criminal, dangerous, and even violent behaviors.⁹²⁹³⁹⁴⁹⁵ Based on all of the evidence to date it would appear that substance use is the most highly correlated to dangerous and criminal behaviors. This has been widely shown in research looking at rates of recidivism, acts of violence, and use of substances.⁹⁶⁹⁷⁹⁸ It

-
87. Osborg Ose, S., Lilleeng, S., Pettersen, I., Ruud, T. and van Weeghel, J. (2017) Risk of Violence among Patients in Psychiatric Treatment: Results from a National Census. *Nordic Journal of Psychiatry*, 71, 551-560. <https://doi.org/10.1080/08039488.2017.1352024>
 88. Gross, N.R. and Morgan, R.D. (2013) Understanding Persons with Mental Illness who Are and Are Not Criminal Justice Involved: A Comparison of Criminal Thinking and Psychiatric Symptoms. *Law and Human Behavior*, 37, 175-186. <https://doi.org/10.1037/lhb0000013>
 89. Covarrubias, I. and Han, M. (2011) Mental Health Stigma in Serious Mental Illness among MSW Students: Social Contact and Attitude. *Social Work*, 56, 317-325. <https://doi.org/10.1093/sw/56.4.317>
 90. Barnhorst, A. (2015) California Firearms Laws and Mental Illness. *Behavioral Sciences and the Law*, 33, 246-256. <https://doi.org/10.1002/bsl.2177>
 91. Reavley, N.J., Jorm, A.F. and Morgan, A.J. (2016) Beliefs about Dangerousness of People with Mental Health Problems: The Role of Media Reports and Personal Exposure to Threat or Harm. *Social Psychiatry and Psychiatric Epidemiology*, 51, 1257-1264. <https://doi.org/10.1007/s00127-016-1215-6>
 92. Corrigan, P.W., Powell, K.J. and Rusch, N. (2012) How Does Stigma Affect Work in People with Serious Mental Illness? *Psychiatric Rehabilitation Journal*, 35, 381-384. <https://doi.org/10.1037/h0094497>
 93. Varshney, M., Mahapatra, A., Krishnan, V., Gupta, R. and Sinha Deb, K. (2016) Violence and Mental Illness: What Is the True Story? *Journal of Epidemiology and Community Health*, 70, 223-225. <https://doi.org/10.1136/jech-2015-205546>
 94. Osborg Ose, S., Lilleeng, S., Pettersen, I., Ruud, T. and van Weeghel, J. (2017) Risk of Violence among Patients in Psychiatric Treatment: Results from a National Census. *Nordic Journal of Psychiatry*, 71, 551-560. <https://doi.org/10.1080/08039488.2017.1352024>
 95. [25] Arkowitz, A. and Lilienfeld, S.O. (2011) Deranged and Dangerous? *Scientific American Mind*, 22, 64-65. <https://doi.org/10.1038/scientificamericanmind0711-64>
 96. Osborg Ose, S., Lilleeng, S., Pettersen, I., Ruud, T. and van Weeghel, J. (2017) Risk of Violence among Patients in Psychiatric Treatment: Results from a National Census. *Nordic Journal of Psychiatry*, 71, 551-560. <https://doi.org/10.1080/08039488.2017.1352024>
 97. Arkowitz, A. and Lilienfeld, S.O. (2011) Deranged and Dangerous? *Scientific American Mind*, 22, 64-65. <https://doi.org/10.1038/scientificamericanmind0711-64>
 98. Thachuk, A.J. (2011) Stigma and the Politics of Biomedical Models of Mental Illness. *International Journal of Feminist Approaches to Bioethics*, 4, 140-163. <https://doi.org/10.3138/ijfab.4.1.140>

is clear that much more attention needs to be given to this larger problem of substance use and addiction that we are currently seeing across the wider population.

It is clear that there are still impactful stigmas attached to mental illness. It is also clear that these stigmas have real effects on the lives and functioning of those that are trying to manage and cope with their psychological and behavioral issues. Being stigmatized for having a mental illness can prevent one from full acceptance and participation in society. This sense of reductionism often leads these individuals to become more socially isolated, rejected, and devalued.⁹⁹¹⁰⁰¹⁰¹ Many in the general population still believe that those with mental illnesses are more unstable, unpredictable, and prone to violent behavior.¹⁰²¹⁰³¹⁰⁴ With this being the case it would only make sense that these individuals would also face additional hardships and prejudices that would exacerbate their problems and only make things worse. This can be seen in relation to discrimination in employment, housing, medical treatment, social relations, police responses, and so forth.¹⁰⁵¹⁰⁶¹⁰⁷¹⁰⁸ These common misperceptions and stereotypes have real consequences on the lives of those dealing with a severe mental disturbance. The media is a major contributor to all of this and they do need to held more accountable in the ways in which they portray mental illness and the realities of the lives of those dealing with these various psychological disorders.¹⁰⁹¹¹⁰ This is a complicated matter that requires widespread cooperation, the

-
99. Quintero Johnson, J.M. and Riles, J. (2018) "He Acted Like a Crazy Person": Exploring the Influence of College Students' Recall of Stereotypic Media Representations of Mental Illness. *Psychology of Popular Media Culture*, 7, 146-163. <https://doi.org/10.1037/ppm0000121>
 100. Thoits, P.A. (2011) Resisting the Stigma of Mental Illness. *Social Psychology Quarterly*, 74, 6-28. <https://doi.org/10.1177/0190272511398019>
 101. [28] Thachuk, A.J. (2011) Stigma and the Politics of Biomedical Models of Mental Illness. *International Journal of Feminist Approaches to Bioethics*, 4, 140-163. <https://doi.org/10.3138/ijfab.4.1.140>
 102. Magliano, L., Read, J., Rinaldi, A., Costanzo, R., De Leo, R., Schioppa, G. and Petrillo, M. (2016) The Influence of Causal Explanations and Diagnostic Labeling on Psychology Students' Beliefs about Treatments, Prognosis, Dangerousness, and Unpredictability in Schizophrenia. *Community Mental Health Journal*, 52, 361-369. <https://doi.org/10.1007/s10597-015-9901-5>
 103. Reavley, N.J., Jorm, A.F. and Morgan, A.J. (2016) Beliefs about Dangerousness of People with Mental Health Problems: The Role of Media Reports and Personal Exposure to Threat or Harm. *Social Psychiatry and Psychiatric Epidemiology*, 51, 1257-1264. <https://doi.org/10.1007/s00127-016-1215-6>
 104. Nee, C. and Witt, C. (2013) Public Perceptions of Risk in Criminality: The Effects of Mental Illness and Social Disadvantage. *Psychiatry Research*, 209, 675-683. <https://doi.org/10.1016/j.psychres.2013.02.013>
 105. Price, J.H. and Khubchandani, J. (2016) Firearm Violence by the Mentally Ill: Mental Health Professionals' Perceptions and Practices. *Violence and Gender*, 3, 92-99. <https://doi.org/10.1089/vio.2015.0045>
 106. Magliano, J., Punzo, P., Strino, A., Acone, A., Affuso, G. and Read, J. (2017) General Practitioners' Beliefs about People with Schizophrenia and whether They Should Be Subject to Discriminatory Treatment when in Medical Hospital: The Mediating Role of Dangerousness Perception. *American Journal of Orthopsychiatry*, 87, 559-566. <https://doi.org/10.1037/ort0000217>
 107. Corrigan, P.W., Powell, K.J. and Rusch, N. (2012) How Does Stigma Affect Work in People with Serious Mental Illness? *Psychiatric Rehabilitation Journal*, 35, 381-384. <https://doi.org/10.1037/h0094497>
 108. Guimon, J. (2010) Prejudice and Realities in Stigma. *International Journal of Mental Health*, 39, 20-43. <https://doi.org/10.2753/IMH0020-7411390302>
 109. Quintero Johnson, J.M. and Riles, J. (2018) "He Acted Like a Crazy Person": Exploring the Influence of College Students' Recall of Stereotypic Media Representations of Mental Illness. *Psychology of Popular Media Culture*, 7, 146-163. <https://doi.org/10.1037/ppm0000121>
 110. Theriot, M.T. and Lodato, G.A. (2012) Attitudes about Mental Illness and Professional Danger among New Social Work Students. *Journal of Social Work Education*, 48, 403-423. <https://doi.org/10.5175/JSWE.2012.201000079>

dissemination of factual and empirically-based information, and a much broader cultural education on what mental illnesses actually are and how they really affect people's lives.

6. Conclusion

The current study has demonstrated that people still hold somewhat negative views and attitudes toward those with mental illnesses. The data from this study support the wider literature in regard to people generally believing that those with mental illness are more likely to act in dangerous ways and that they pose more of a threat than those that do not have mental illnesses. Certain mental disorders seem to come with more of a stigma than others, such as can be seen with schizophrenia, personality disorders, and bipolar disorder. People will often try and distance themselves from these particular individuals, which generally leads to further social isolation and psychological and behavioral problems. The social stigma attached to mental illness is real, and it has real effects on the lives of those that are struggling with mental health issues. We need to do better as a society. We need to stop rejecting and avoiding those with mental illnesses. Most are not dangerous, and most are not violent. Only when those trying to manage their mental health problems are given full social acceptance, and when they are also adequately provided with the mental health resources that they need to thrive, will we ever begin to really see these ongoing negative perceptions and misinformed beliefs truly dissipate.

Citation

Berger, R. (2018) Still Stigmatized? People's Beliefs and Attitudes about Mental Illness and Dangerousness. *Open Access Library Journal*, 5, 1-13. doi: 10.4236/oalib.1104768.

This work is licensed under the Creative Commons Attribution International License (CC BY 4.0).

THE ADDICTED HUMAN BRAIN: AN OVERVIEW OF IMAGING STUDIES AND THEIR TREATMENT IMPLICATIONS

The Addicted Human Brain: An Overview of Imaging Studies and Their Treatment Implications

Introduction

Addiction is characterized by a continued repetition of a behavior despite adverse consequences, and can be classified as behavioral addiction or chemical addiction. Behavioral addiction is some form of dependence not caused by the use of drugs, such as Internet addiction, gambling and obsession. In contrast, chemical addiction, also known as substance dependence, is a disease characterized by chronic exposure to drugs that causes significant molecular and cellular changes in brain circuits. While treatment for behavioral addiction is relatively easy, it's much more difficult with chemical addiction. Drugs such as nicotine and cocaine have reinforcing effects that are associated with an initial blockade of dopamine transporters, resulting in an increased in the extracellular level of dopamine.¹ Other studies using electrical brain stimulation have shown that opioids, such as heroin and morphine, and psychostimulants, such as amphetamine, can activate the brain reward system and lead to the development of addiction.² Advances in brain imaging technologies have shaped our understanding of the neurobiology of drug dependence, and have provided a new perspective on the molecular effects of addictive drugs. While the exact neurological mechanisms of addiction is not well known, it's hypothesized that addictive behaviors are the results of both genetic and environmental factors.³ Several studies have shown that a single mutation in a gene that regulates addictive behaviors can lead to an increase

-
1. Volkow, N.D., Fowler J.S. and Wang, G.J. (2004) The Addicted Human Brain Viewed in the Light of Imaging Studies: Brain Circuits and Treatment Strategies. *Neuropharmacology*, 47, 3-13. <http://dx.doi.org/10.1016/j.neuropharm.2004.07.019>
 2. Badiani, A., Belin, D., Epstein, D., Calu, D. and Shaham, Y. (2011) Opiate versus Psychostimulant Addiction: The Differences Do Matter. *Nature Reviews Neuroscience*, 12, 685-700. <http://dx.doi.org/10.1038/nrn3104>
 3. Howell, L.L. and Murnane, K.S. (2008) Nonhuman Primate Neuroimaging and the Neurobiology of Psychostimulant Addiction. *Annals of the New York Academy of Sciences*, 1141, 176-194. <http://dx.doi.org/10.1196/annals.1441.023>

in alcohol consumption.⁴ Moreover, a variety of environmental factors including stress, sexual abuse, and drug availability, contribute to a person's propensity to use drugs. Across the world, around 140 million people suffer from alcohol dependence, and there are approximately 17 million users of heroin, morphine and other synthetic drugs.⁵ Because addiction is a complex disease influenced by numerous factors, treatment remains a big challenge. However, there exist some medications such as methadone and buprenorphine that could be useful in treating drug dependence.⁶ Other approaches include rehabilitation programs and adherence to behavioral groups that prevent drug relapse and improve the health of individuals.⁷

Substance Abuse and Behavioral Addiction

Drug abuse, or substance dependence, is a chronic disorder defined as the use of a drug in excessive amount despite significant negative consequences.⁸ It is also characterized by a loss of control in limiting intake, and the emergence of a negative emotional state when access to the drug is denied. While this disease can have devastating effect on an individual's health, it is also associated with significant damage to the society in terms of monetary costs [8]. Examples of addictive drugs include alcohol, nicotine, amphetamines, benzodiazepines, cocaine, and opioids like heroin and morphine. Table 1 shows a list of the psychostimulants and opioids that can be addictive. Chronic use of these drugs can cause a variety of neurological changes in specific areas of the brains, leading to severe damage to the individual. Moreover, withdrawal of drugs of abuse is often associated with side effects, such as depression, increased anxiety, nausea, vomiting and stress.^{9,10}

In contrast, behavioral addiction, also known as non-substance-related addiction, consists of an urge to constantly follow a pattern of behavior that eventually takes an important place in someone's life and could

-
4. Tapocik, J.D. (2014) MicroRNA-206 in Rat Medial Prefrontal Cortex Regulates BDNF Expression and Alcohol Drinking. *The Journal of Neuroscience*, 34, 4581-4588. <http://dx.doi.org/10.1523/JNEUROSCI.0445-14.2014>
 5. Kamangar, F, Shakeri, R., Malekzadeh, R. and Islami, F. (2014) Opium Use: An Emerging Risk Factor for Cancer? *The Lancet Oncology*, 15, e69-e77. [http://dx.doi.org/10.1016/S1470-2045\(13\)70550-3](http://dx.doi.org/10.1016/S1470-2045(13)70550-3)
 6. Connock, M., et al. (2007) Methadone and Buprenorphine for the Management of Opioid Dependence: A Systematic Review and Economic Evaluation. *Health Technology Assessment*, 11, 1-171, iii-iv.
 7. Kiluk, B.D. and Carroll, K.M. (2013) New Developments in Behavioral Treatments for Substance Use Disorders. *Current Psychiatry Reports*, 15, 420. <http://dx.doi.org/10.1007/s11920-013-0420-1>
 8. Duncan, J.R. (2012) Current Perspectives on the Neurobiology of Drug Addiction: A Focus on Genetics and Factors Regulating Gene Expression. *ISRN Neurology*, 2012, Article ID: 972607. <http://dx.doi.org/10.5402/2012/972607>
 9. Habibi, Z., Tourani, S., Sadeghi, H. and Abolghasemi, A. (2013) Effectiveness of Stress Management Skill Training on the Depression, Anxiety and Stress Levels in Drug Addicts after Drug Withdrawal. *International Journal of High Risk Behaviors and Addiction*, 2, 82-86. <http://dx.doi.org/10.5812/ijhrba.10695>
 10. Koob, G.F. and Simon, E.J. (2009) The Neurobiology of Addiction: Where We Have Been and Where We Are Going. *Journal of Drug Issues*, 39, 115-132. <http://dx.doi.org/10.1177/002204260903900110>

lead to negative consequences.^{11,12} Examples of behavioral addiction most often include treatable forms of addiction, such as gambling, food-related addiction, as well as the use computers and Internet.¹³ Gambling, which is one of the most common forms of behavioral addiction, shares similar characteristics to drug dependence.¹⁴ It was shown that gamblers have significant lower amounts of norepinephrine in the brain compared to healthy individuals. Another very common type of non-substance-related addiction is compulsive buying, which is characterized by a habit of buying more than one can afford, most often unneeded items.¹⁵ Although there are no standard treatments for compulsive buying disorder, research is currently being pursued in order to develop novel psychopharmacological therapies.¹⁶

	Class	Drugs
Psychostimulants	Phenethylamine	Amphetamine, Pseudoephedrine
	Sympathomimetic Phenethylamine	Ephedrine, Methylphenidate Methamphetamine, Phenylpropanolamine, Pseudoephedrine
Opioids	Natural Opiates	Morphine, Codeine, Thebaine
	Semi-Synthetic Fully Synthetic	Buprenorphine, Hydrocodone, Hydromorphone, Oxycodone Fentanyl, Levorphanol, Methadone

Drug dependence and behavioral addiction share several similarities in terms of neurobiology and molecular mechanisms.¹⁷ The triggering of the addicted behavior seen in these two diseases relies on the action of dopamine. Moreover, both drug reinforcement and behavioral reward induce neurological changes in specific regions of the brain, including the amygdala and the prefrontal cortex. However, drug addiction affects more

11. Potenza, M.N. (2006) Should Addictive Disorders Include Non-Substance-Related Conditions? *Addiction*, 101, 142- 151. <http://dx.doi.org/10.1111/j.1360-0443.2006.01591.x>
12. Parashar, A. and Varma, A. (2007) Behavior and Substance Addictions: Is the World Ready for a New Category in the DSM-V? *CNS Spectrums*, 12, 257-259.
13. Grant, J.E. and Chamberlain, S.R. (2014) Impulsive Action and Impulsive Choice across Substance and Behavioral Addictions: Cause or Consequence? *Addictive Behaviors*, 39, 1632-1639.
14. Chou, K.L. and Afifi, T.O. (2011) Disordered (Pathologic or Problem) Gambling and Axis I Psychiatric Disorders: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *American Journal of Epidemiology*, 173, 1289-1297. <http://dx.doi.org/10.1093/aje/kwr017>
15. McElroy, S.L., Keck, P.E., Pope, H.G., Smith, J.M. and Strakowski, S.M. (1994) Compulsive Buying: A Report of 20 Cases. *Journal of Clinical Psychiatry*, 55, 242-248.
16. Black, D.W. (2007) A Review of Compulsive Buying Disorder. *World Psychiatry*, 6, 14-18.
17. Alavi, S.S., Ferdosi, M., Jannatifard, F., Eslami, M., Alaghemandan, H. and Setare, M. (2012) Behavioral Addiction versus Substance Addiction: Correspondence of Psychiatric and Psychological Views. *International Journal of Preventive Medicine*, 3, 290-294.

individuals and causes more devastating consequences than behavioral addiction, and will therefore be the focus of this review paper. Drug addiction is a complex disease, and more work need to be done to help us better understand its neurobiological mechanisms. Animal models of addiction play a critical role in this area of research, and will be discussed in more details in the following paragraph.

Animal Models of Addiction

Much of the recent progress in understanding the biology and pathophysiology of addiction has been derived from the study of animal models of addiction.¹⁸ Several models have been developed in order to mimic the different stages of human addiction, which are the following: intoxication, withdrawal, and drug-seeking stage.¹⁹ An animal model of drug abuse is often used for the purpose of studying a specific biological phenomenon in humans, or to test the efficiency of potential pharmacological treatments for addiction. The primary stage of addiction is characterized by a binge or intoxication due to the reinforcing effects of drugs, such as opiates, psychostimulants and alcohol. This change in reward can be measured by direct self-stimulation. Several studies in rodents have used intravenous drug self-administration to understand how addictive drugs could alter motivational behavior.²⁰ In these studies, the animal is implanted with intravenous catheters and is placed in a cage with a lever. When the animal presses the lever, this automatically delivers an intravenous infusion of drugs, like cocaine and heroin. It was shown that self-administration of cocaine in rodents produces a characteristic pattern of addictive behavior: the animal increases the number of lever presses to maintain a high rate of drug infusion.²¹ This animal model of intravenous drug self-administration will definitively help us predict the abuse potential of drugs, and their effects on motivation and behavioral actions.

When an individual stops taking a drug after continuous and excessive use, symptoms of withdrawal effects takes place, which often drives the individual to continue seeking the drug.²² Symptoms of drug withdrawal typically include a general state of anxiety, and a feeling of emotional unhappiness. The first approach in studying the symptoms of withdrawal in an animal model is the drug discrimination methodology, which can

18. Lynch, W.J., Nicholson, K.L., Dance, M.E., Morgan, R.W. and Foley, P.L. (2010) Animal Models of Substance Abuse and Addiction: Implications for Science, Animal Welfare and Society. *Comparative Medicine*, 60, 177-188.

19. Koob, G.F. and Le Moal, M. (1997) Drug Abuse: Hedonic Homeostatic Dysregulation. *Science*, 278, 52-58. <http://dx.doi.org/10.1126/science.278.5335.52>

20. Cousins, V., Rose, J.E. and Levin, E.D. (2014) IV Nicotine Self-Administration in Rats Using a Consummatory Operant Licking Response: Sensitivity to Serotonergic, Glutaminergic and Histaminergic Drugs. *Progress in Neuro-Psychopharmacology and Biological Psychiatry*, 54, 200-205.

21. Caine, S.B. and Koob, G.F. (1993) Modulation of Cocaine Self-Administration in the Rat through D-3 Dopamine Receptors. *Science*, 260, 1814-1816. <http://dx.doi.org/10.1126/science.8099761>

22. Emmett-Oglesby, M.W., Mathis, D.A., Moon, R.T.Y. and Lal, H. (1990) Animal Models of Drug Withdrawal Symptoms. *Psychopharmacology*, 101, 292-309. <http://dx.doi.org/10.1007/BF02244046>

be used to identify specific and nonspecific aspects of withdrawal.^{23,24} In this experiment, subjects are trained to distinguish administration of a particular drug from the vehicle, usually saline. Either vehicle or a dose of drug is injected prior to training, and subjects are allowed to respond while the drug is producing its effect. The animal is put in a cage with two levers and can decide which one to selectively press and activate: one lever sends a reward following drug administration, while the other lever following administration of the vehicle.²⁵ When the dose of drug is administered, the animal presses on the drug-designated lever to produce reinforcement. In this way, the presence or absence of the drug differentially controls responding, and helps characterize the anxiogenic component of the withdrawal syndrome. Another strategy lies in the studying of animal models of anxiety to understand the effects of drug withdrawal. This model is a powerful tool for studying addiction since withdrawal from many drugs generates anxiety and stress.²⁶ Several scientists have studied the behavioral measures of anxiety during drug and alcohol withdrawal in order to elucidate the mechanisms and biological manifestations that take place.^{27,28}

In summary, the animal models discussed above can efficiently validate some of the key characteristics of addiction, and will definitively help scientists target homologous genes or biological mechanisms found in humans that could render a person more susceptible to drug addiction. Other models not discussed earlier are also extensively used to study drug dependence. For instance, a genetic animal model has been developed to study alcohol related disorders,²⁹ and it has been shown that these genetically modified animals are able to drink more amount of alcohol compared to the normal strain, which enable them to attain physical dependence.³⁰ Much remains to be explored about the efficiency of animal models of addiction. A better understanding of the changes that take place in the central nervous system of these models will provide insights into the reinforcing effect of drug addiction, which might be useful for the development of novel therapeutic strategies.

-
23. Emmett-Oglesby, M.W., Mathis, D.A., Moon, R.T.Y. and Lal, H. (1990) Animal Models of Drug Withdrawal Symptoms. *Psychopharmacology*, 101, 292-309. <http://dx.doi.org/10.1007/BF02244046>
 24. Watanabe, S. (1985) Drug Discrimination: Methodology and Current Problems. *Yakubutsu Seishin Kodo*, 5, 289-302
 25. Becker, H.C. (2000) Animal Models of Alcohol Withdrawal. *Alcohol Research & Health*, 24,105-113.
 26. Emmett-Oglesby, M.W., Mathis, D.A., Moon, R.T.Y. and Lal, H. (1990) Animal Models of Drug Withdrawal Symptoms. *Psychopharmacology*, 101, 292-309. <http://dx.doi.org/10.1007/BF02244046>
 27. Emmett-Oglesby, M.W., Mathis, D.A., Moon, R.T.Y. and Lal, H. (1990) Animal Models of Drug Withdrawal Symptoms. *Psychopharmacology*, 101, 292-309. <http://dx.doi.org/10.1007/BF02244046>
 28. Becker, H.C. (2000) Animal Models of Alcohol Withdrawal. *Alcohol Research & Health*, 24,105-113.
 29. McBride, W.J. and Li, T.K. (1998) Animal Models of Alcoholism: Neurobiology of High Alcohol-Drinking Behavior in Rodents. *Critical Reviews in Neurobiology*, 12, 339-369. <http://dx.doi.org/10.1615/CritRevNeurobiol.v12.i4.40>
 30. Murphy, J.M., Gatto, G.J., Waller, M.B., McBride, W.J., Lumeng, L. and Li, T.K. (1986) Effects of Scheduled Access on Ethanol Intake by the Alcohol-Preferring (P) Line of Rats. *Alcohol*, 3, 331-336. [http://dx.doi.org/10.1016/0741-8329\(86\)90010-8](http://dx.doi.org/10.1016/0741-8329(86)90010-8)

Brain Imaging Technology

Brain imaging studies have provided enough evidence that neurological changes in specific circuits and structures of the brain occur as a result of the triggering effects of addictive drugs.^{31,32} Physicians are now able to rely on several techniques that can help them visualize the structure and activity of the brain, which is crucial for a better understanding of the causes and mechanisms of drug use and addiction. Positron emission tomography (PET) imaging is a technique used in functional human brain to detect regional changes in cerebral blood flow as well as alterations in glucose metabolism. The mapping of glucose utilization can identify which brain areas become more active following drug administration, and determine the brain structures that are interrelated. PET is also used to measure the gamma rays emitted by a radiotracer labeled with positron-emitting isotopes that bind to specific receptors.^{33,34} Radiolabeled ligands for dopamine, serotonin, and nicotinic acetylcholine receptors are available for PET imaging, and have helped scientists better visualize the neuroreceptors in the context of psychiatric disorders such as addiction and drug abuse.³⁵ PET imaging studies have shown that dopamine receptors are up-regulated in psychostimulant and nicotine users,³⁶ and that administration of cocaine inhibits the reuptake of dopamine, leading to an increase in its extracellular level.

Magnetic resonance imaging (MRI) is another imaging technique commonly used to visualize the brain of addicted individuals. By providing information about the size, shape and anatomy of brain structures, structural MRI can examine the effects that addictive drugs have on the central nervous system.³⁷ It is a noninvasive technique that allows the study of the chemical composition and biochemistry of the central nervous system, and has been proven to be efficient in the detection of neurological changes that occurs during addiction. Using MRI, it was demonstrated that alcoholic patients have diminished gray matter in the prefrontal cortex compared to healthy individuals.³⁸ Moreover, MRI studies have shown that a decreased

-
31. Volkow, N.D., Fowler J.S. and Wang, G.J. (2004) The Addicted Human Brain Viewed in the Light of Imaging Studies: Brain Circuits and Treatment Strategies. *Neuropharmacology*, 47, 3-13. <http://dx.doi.org/10.1016/j.neuropharm.2004.07.019>
 32. Fowler, J.S., Volkow, N.D., Kassed, C.A. and Chang, L. (2007) Imaging the Addicted Human Brain. *Science & Practice Perspectives*, 3, 4-16. <http://dx.doi.org/10.1151/spp07324>
 33. Volkow, N.D., Fowler J.S. and Wang, G.J. (2004) The Addicted Human Brain Viewed in the Light of Imaging Studies: Brain Circuits and Treatment Strategies. *Neuropharmacology*, 47, 3-13. <http://dx.doi.org/10.1016/j.neuropharm.2004.07.019>
 34. Volkow, N.D., Fowler, J.S. and Wang, G.J. (2003) The Addicted Human Brain: Insights from Imaging Studies. *Journal of Clinical Investigation*, 111, 1444-1451. <http://dx.doi.org/10.1172/JCI18533>
 35. Catafau, A.M., Searle, G.E., Bullich, S., et al. (2010) Imaging Cortical Dopamine D1 Receptors Using [11C]NNC112 and Ketanserin Blockade of the 5-HT_{2A} Receptors. *Journal of Cerebral Blood Flow & Metabolism*, 30, 985-993. <http://dx.doi.org/10.1038/jcbfm.2009.269>
 36. Le Foll, B., Collo, G., Rabiner, E.A., et al. (2014) Chapter 11—Dopamine D3 Receptor Ligands for Drug Addiction Treatment: Update on Recent Findings. *Progress in Brain Research*, 211, 255-275. <http://dx.doi.org/10.1016/B978-0-444-63425-2.00011-8>
 37. Volkow, N.D., Fowler, J.S. and Wang, G.J. (2003) The Addicted Human Brain: Insights from Imaging Studies. *Journal of Clinical Investigation*, 111, 1444-1451. <http://dx.doi.org/10.1172/JCI18533>
 38. Pfefferbaum, A., Sullivan, E.V., Rosenbloom, M.J., Mathalon, D.H. and Lim, K.O. (1998) A Controlled Study of Cortical Gray Matter and

in hippocampal volume, as well as serious damage to the cingulate-limbic cortex and the temporal lobe, are observed in individuals with chronic methamphetamine abuse.³⁹ While MRI is useful to visualize areas of the brain and identify pathologies that may be present, it does not detect changes in brain function. Functional magnetic resonance imaging (fMRI) is a new tool that has been developed recently that is very sensitive to alterations in brain activity. fMRI is very efficient in measuring the activity of brain circuits and their association with the reinforcing effects of drugs.⁴⁰ It has proven to be more useful than PET because of its higher spatial resolution. fMRI can determine the areas of the brain that are active by detecting changes in blood oxygenation and flow. Studies using functional magnetic resonance imaging have shown that drug intoxication significantly alter the function of the subcortical striatum, which leads to an increase in reward and gratification.⁴¹ Table 2 provides a brief summary of the imaging techniques discussed earlier, and explain how they are used in medical research.

Behavioral and Pharmacological Treatments

The primary goal of treating addiction is to allow the patient to manage their excessive use of drugs, and to enhance its ability to function normally. There exist several treatments, both behavioral and pharmacological, and the best type of treatment often depends on factors such as age, personality, drugs of choice, and the severity of physical and mental illness. Interventions consisting of as little of a single session have been shown to be effective in helping the patient control his addictive behaviors.⁴² Not only do these motivational approaches help individuals cope with drug addiction, but they also are very efficient in a wide variety of behavioral diseases such as gambling and eating disorder.⁴³ When it comes to alcohol addiction, many individuals with severe problem seek advice from a psychotherapist who can help them cope with their self-control and passive dependence. An alternative to individual psychotherapy is treatment in a clinical setting with the help of family physicians and clinical psychologists, as well as adherence to a group of alcoholics, where every member can share his personal experience. Moreover, there is strong evidence that cognitive behavioral therapy could serve

Ventricular Changes in Alcoholic Men over a 5-Year Interval. *Archives of General Psychiatry*, 55, 905-912. <http://dx.doi.org/10.1001/archpsyc.55.10.905>

39. Thompson, P.M., Hayashi, K.M., Simon, S.L., et al. (2004) Structural Abnormalities in the Brains of Human Subjects Who Use Methamphetamine. *The Journal of Neuroscience*, 24, 6028-6036. <http://dx.doi.org/10.1523/JNEUROSCI.0713-04.2004>

40. Volkow, N.D., Fowler, J.S. and Wang, G.J. (2003) The Addicted Human Brain: Insights from Imaging Studies. *Journal of Clinical Investigation*, 111, 1444-1451. <http://dx.doi.org/10.1172/JCI18533>

41. Parvaz, M.A., Alia-Klein, N., Woicik, P.A., Volkow, N.D. and Goldstein, R.Z. (2011) Neuroimaging for Drug Addiction and Related Behaviors. *Reviews in the Neurosciences*, 22, 609-624. <http://dx.doi.org/10.1515/RNS.2011.055>

42. Potenza, M.N., Sofuoglu, M., Carroll, K.M. and Rounsaville, B.J. (2011) Neuroscience of Behavioral and Pharmacological Treatments for Addictions. *Neuron*, 69, 695-712. <http://dx.doi.org/10.1016/j.neuron.2011.02.009>

43. Yip, S.W. and Potenza, M.N. (2014) Treatment of Gambling Disorders. *Current Treatment Options in Psychiatry*, 1, 189-203. <http://dx.doi.org/10.1007/s40501-014-0014-5>

as a potential approach for treating addiction.⁴⁴ It is a type of psychotherapy that encourages the patient to recognize and think about the behavioral patterns and motivations that lead him to become addicted. This approach often helps the patient learn more about his disease, which enables him to develop new strategies to change his behavior.⁴⁵⁴⁶⁴⁷

Imaging technique	Application
Positron emission tomography—PET	Used to quantify processes such as glucose metabolism, drug distribution and pharmacokinetics. Useful in for the study of the physiology, anatomy, and biochemical properties of brain structures.
Magnetic resonance imaging—MRI	A non-invasive technique used to map tissue morphology and anatomical composition. Can detect tumors in the brain and differentiate between white matter and grey matter.
Functional magnetic resonance imaging—fMRI	A technique used to observe brain structures and assess their activity during cognitive tasks. It can visualize changes in oxygenation and blood flow associated with brain activities.

An alternative to behavioral approaches for treating addiction is the use of pharmacological therapies. Methadone has proven to be very effective in treating drug abuse. It is an analgesic that is mainly used in the treatment of opioid dependence because of its ability to abolish the drug-seeking behavior and relieve the patient from narcotic craving.⁴⁸ It also acts by attenuating opioid withdrawal symptoms. Studies have found that methadone can suppress heroin use in addicted individuals, while significantly improving their social life and general productivity.⁴⁹ Although this compound is itself addictive, the withdrawal symptoms are relatively mild compared to those following withdrawal of other opiates. Another treatment for opiate

44. Potenza, M.N., Sofuoglu, M., Carroll, K.M. and Rounsaville, B.J. (2011) Neuroscience of Behavioral and Pharmacological Treatments for Addictions. *Neuron*, 69, 695-712. <http://dx.doi.org/10.1016/j.neuron.2011.02.009>

45. Potenza, M.N., Sofuoglu, M., Carroll, K.M. and Rounsaville, B.J. (2011) Neuroscience of Behavioral and Pharmacological Treatments for Addictions. *Neuron*, 69, 695-712. <http://dx.doi.org/10.1016/j.neuron.2011.02.009>

46. Dutra, L., Stathopoulou, G., Basden, S.L., Leyro, T.M., Powers, M.B. and Otto, M.W. (2008) A Meta-Analytic Review of Psychosocial Interventions for Substance Use Disorders. *American Journal of Psychiatry*, 165, 179-187. <http://dx.doi.org/10.1176/appi.ajp.2007.06111851>

47. Magill, M. and Ray, L.A. (2009) Cognitive-Behavioral Treatment with Adult Alcohol and Illicit Drug Users: A Meta-Analysis of Randomized Controlled Trials. *Journal of Studies on Alcohol and Drugs*, 70, 516-527.

48. Minozzi, S., Amato, L., Bellisario, C. and Davoli, M. (2014) Maintenance Treatments for Opiate-Dependent Adolescents. *Cochrane Database of Systematic Reviews*, 24, 6. <http://dx.doi.org/10.1002/14651858.CD007210.pub3>

49. Mattick, R.P., Breen, C., Kimber, J. and Davoli, M. (2003) Methadone Maintenance Therapy versus No Opioid Replacement Therapy for Opioid Dependence. *Cochrane Database of Systematic Reviews*, 2. <http://dx.doi.org/10.1002/14651858.CD002209>

dependence is the use of narcotic antagonists such as naloxone. By blocking the effects of opioids, naloxone can reverse the lethal respiratory depression and reduce rates of fatal drug overdose like heroin or morphine.⁵⁰ Treatment of psychostimulants, such as cocaine, nicotine, and caffeine, involves the use of dopamine agonists and various serotonin reuptake inhibitors. Bromocriptine is a potent agonist at dopamine D2 receptors that is frequently used in the treatment of cocaine addiction.⁵¹ It is hypothesized that cocaine withdrawal lead to the depletion of dopamine, and that the use of agonist such as bromocriptine could restore the level of DA and reduce drug use and mood symptoms. Fluoxetine, a medication used for the treatment of major depressive disorders, is a serotonin reuptake inhibitor that is also effective at reducing the use of cocaine in dependent individuals. Fluoxetine is also useful in reducing alcohol consumption, as demonstrated in animal models of alcohol addiction.⁵²

Conclusion

Addiction is a neurological disorder that causes profound changes in an individual's behavior, which can lead to loneliness, marginalization, stress and depression. This review primarily discussed the use of animal models to study the neurobiology of addiction, and to examine the reinforcing effects of drugs as well as the symptoms that occurs following withdrawal. Promising results from animal studies and clinical trials have helped scientists pinpoint the main neurotransmitters and brain structures involved in addiction, and have helped identify the neurocircuit of motivation and reward. The review also talked about the advances in imaging technology with a special focus on PET, MRI and fMRI. These brain imaging technologies have made possible the visualization of specific brain structures and the detection of anatomical and functional changes that follow drug intoxication. As indicated in this paper, addiction leads to significant changes in several areas of the brain, including the prefrontal cortex and the amygdala. Imaging techniques such as PET can also aid in the identification of the neuroreceptors and neurotransmitters involved in drug addiction. However, more research needs to be done to detect the anatomical and neurobiological differences among specific subgroups of addiction, which will definitively help in the design of novel pharmacological treatments. As outlined in this paper, treating addiction remains a big challenge for physicians. Although behavioral approaches have proven to be successful in treating some addicted individuals, the chances of relapse are still very high. Nowadays, most patients use prescribed medications to help attenuate their addictive symptoms. Pharmacological treatment of opiate dependence mainly relies on methadone maintenance and narcotic antagonists like naloxone, while

50. Maxwell, S., Bigg, D., Stanczykiewicz, K. and Carlberg-Racich, S. (2006) Prescribing Naloxone to Actively Injecting Heroin Users: A Program to Reduce Heroin Overdose Deaths. *Journal of Addictive Diseases*, 25, 89-96. http://dx.doi.org/10.1300/J069v25n03_11

51. Gorelick, D.A. and Wilkins, J.N. (2006) Bromocriptine Treatment for Cocaine Addiction: Association with Plasma Prolactin Levels. *Drug and Alcohol Dependence*, 81, 189-195. <http://dx.doi.org/10.1016/j.drugalcdep.2005.06.010>

52. O'Brien, E.S., Legastelois, R., Houchi, H., et al. (2011) Fluoxetine, Desipramine and the Dual Antidepressant Milnacipran Reduce Alcohol Self-Administration and/or Relapse in Dependent Rats. *Neuropsychopharmacology*, 36, 1518- 1530. <http://dx.doi.org/10.1038/npp.2011.37>

alcohol and psychostimulant addiction can be treated with dopamine agonists and serotonin reuptake inhibitors. Nonetheless, there are still several limitations about the current treatments available. The use of combination strategies, including both behavioral and pharmacological approaches, needs to be studied in order to provide a more effective and safe treatment for the patient. Moreover, when deciding which treatment is most suitable, physicians must take into account the genetic profile of each individual. Future research in drug addiction needs to seek a better understanding of the genes implicated in the predisposition for drug abuse, which will help identify molecular targets and open up new directions for therapeutic strategies.

Citation

Fakhoury, M. (2014) The Addicted Human Brain: An Overview of Imaging Studies and Their Treatment Implications. Open Access Library Journal, 1: e1033. <http://dx.doi.org/10.4236/oalib.1101033>

This work is licensed under the Creative Commons Attribution International License (CC BY).

DRUG ADDICTIONS: A HISTORICAL AND ETHOLOGICAL OVERVIEW

1. Introduction

1.1. Preliminary considerations: Focus on cocaine and heroin

It is well established that several psychoactive substances can lead to addiction. These include legal drugs such as alcohol and nicotine which generate the major part of the addiction-related social and economical costs to modern societies, and a pleiad of illegal drugs amongst which cannabis, cocaine and heroin are the most commonly used.¹

When one wants to consider the harmful consequences of an addictive drug, both the dependence and physical harm potencies of the drug should be considered for these two aspects contribute to the deterioration of the user's life. A recent classification of the major classes of addictive drugs reveals that heroin and cocaine are clearly the most dangerous ones since both their addictive properties and physical harm potency are high.² Cocaine and heroin are followed by barbiturates and street methadone, but tobacco is shown to have addictive property of the same magnitude as cocaine, thereby demonstrating that the legal status of a substance is not a predictive factor of least addictive properties.

In the present chapter, we will consider exclusively cocaine and heroin addictions, not only because these two drugs are clearly the most dangerous ones, but mainly because cocaine and heroin use have been increasing among western countries populations in the last ten years. This focus is one limitation of the general conclusions that will be provided in the following chapters that will also address alcoholism and food addiction that will be joined by another addiction, namely pathological gambling, in the clinical definition of addictions in the upcoming DSM-V. Thus, addictions are increasingly recognized as abnormal persistent maladaptive behaviors driven by specific, initially reinforcing, stimuli in the environment that are not anymore restricted to psychoactive substances.

1. Koob G, Le Moal M. Plasticity of reward neurocircuitry and the 'dark side' of drug addiction. *Nat Neurosci*. 2005; 8: 1442-1444.

2. Nutt D, King LA, Saulsbury W, Blakemore C. Development of a rational scale to assess the harm of drugs of potential misuse. *Lancet*. 2007; 369: 1047-1053.

1.2 Drug use: A behavior as old as humankind?

Drug use seems to have entered human customs as early as the emergence of human societies. Evidences that recreational drug use has emerged early on after human sedentarisation, perhaps with the development of religious rites, can be found for several drugs and routes of administration.

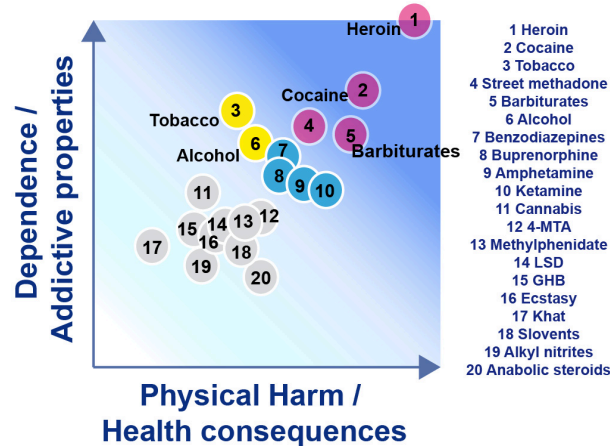


Fig. 1. Rational scale to assess the harm of drugs of potential misuse

The addictive potential of a drug varies from substance to substance, and from individual to individual. Dose, frequency, pharmacokinetics of a particular substance, route of administration, and time are critical factors for physical harm and addictive potency. Heroin and cocaine are clearly the most dangerous ones since both their addictive properties and physical harm potency are high.

Thus, 5000 B.C. the Sumerians used opium, as suggested by the fact that they had an ideogram for it which has been translated as HUL, meaning “joy” or “rejoicing.”³ A 3500 B.C. Egyptian papyrus provides the earliest historical record of the production of alcohol in the description of a brewery.⁴

Interestingly, 3000 B.C. is also the approximate date of the supposed origin of the use of tea in China. It is likely that coca leaf chewing began in the Andes at the same time since traces of coca have been found in mummies dating 3000 years back.⁵ The cocaine content of coca leaf is under 1% but after 1859, when cocaine was first isolated from coca leaf by Albert Niemann, cocaine was available legally in concentrations that were nearly 100% pure. Cocaine was first used recreationally in the 1860s, almost as soon as it was synthesized. A few years after its synthesis by Richard Willstätter in 1898, cocaine appeared in cigarettes, ointments, nasal

3. Lindesmith AR. Addiction and opiates. Chicago: Aldine Pub. Co.; 1968: vii, 295.

4. Fort J. The pleasure seekers; the drug crisis, youth, and society. Indianapolis: Bobbs-Merrill; 1969: 255.

5. Rivera MA, Aufderheide AC, Cartmell LW, Torres CM, Langsjoen O. Antiquity of coca-leaf chewing in the south central Andes: a 3,000 year archaeological record of coca-leaf chewing from northern Chile. J Psychoactive Drugs. 2005; 37: 455-458.

sprays, and tonics.⁶ The most popular cocaine-based product was Mariani Wine (Vin Mariani). It was a wine and cocaine mixture that was launched in 1863. Nearly all popular personalities of the day, including Queen Victoria, Thomas Edison and Pope Leon XIII endorsed it. Cocaine has also been popularized by Sigmund Freud who prescribed it for the treatment of digestive disorders, asthma, depression or opiate and alcohol dependence.⁷

At the same time, more precisely in 1898, heroin (diacetylmorphine) was synthesized by Felix Hoffmann, 23 years after a first academic synthesis by Alder Wright. Akin to the launch of cocaine as a medicine, heroin was then introduced by Bayer as “safe preparation free from addiction-forming properties.”

The broad availability of the pure form of cocaine and heroin has contributed to the marked development of addiction to these substances which, in their primary forms and routes of administration, were far less addictive. This phenomenon has been suggested to stem from a discrepancy between our brain and our modern environment, i.e, Nesse and Berridge wrote in 1997: “We are vulnerable to such fitness-decreasing incentives because our brains are not designed to cope with ready access to pure drugs, video games, and snack foods. Hundreds of generations of exposure would likely shape resistance to their allure and their deleterious effects.”⁸ This interesting consideration suggests that drug addiction may be a matter of mismatch between Human evolution and the recent revolution of human environment, a problem to which Evolution may be the best solution.

However, before these evolutionary, and rather fatalistic considerations, human societies have developed social and legal strategies to cope with addiction, as early as 10 years following the synthesis of heroin and cocaine. Indeed, the United States prohibited the importation of smoking opium⁹ and the manufacture of heroin in 1909 and 1924, respectively, while the Harrison Narcotics Act of 1914 prohibited the use of cocaine. Since then law enforcement has limited, but not eradicated, heroin and cocaine use; there has been a general increase in cocaine use within European countries over the past 20 years. Such a trend may induce an increase in the prevalence of drug-related health problems, and most importantly, of drug addiction.

1.3 Drug use: An evolutionary feature of animal kingdom

Drug use seems inherent to animal behavior, perhaps because of the evolutionary selection of a reward system developed to maintain species survival, bringing animals towards sources of reinforcement. Thus spontaneous drug use has been observed in several species in the wild. Elephants would intoxicate with alcohol contained in

6. Humphrey AJ, O'Hagan D. Tropane alkaloid biosynthesis. A century old problem unresolved. *Nat Prod Rep.* 2001; 18: 494-502.

7. Freud S. *Über coca.* 1884; *Centralbl Gesamte Ther.* 289-314.

8. Nesse RM, Berridge K. Psychoactive Drug Use in Evolutionary Perspective. *Science.* 1997; 278: 63-66.

9. Kolb LC. Drug addiction. *Bulletin of the New York Academy of Medicine.* 1965; 41: 306.

ripe fruits and baboons would readily eat over-ripe fruits from the marula tree until they cannot walk anymore. Birds also use alcohol in that song thrush, for instance, struggle to fly after eating ripe grapes.

An exhaustive list of examples of spontaneous drug use in animal kingdom is beyond the scope of this chapter, but a last example should be enough to emphasize how broad are sources of intoxication in mammals: in the south of the United States, sheep and horses eat astragalus and then show hyperactive behavior akin to human beings.

In experimental settings, it has been demonstrated that all drugs abused by humans are reinforcing in many species including planarians¹⁰ and flies,^{11,12} and they are readily self-administered by vertebrates such as mice^{13,14,15,16,17,18,19} or rats^{20,21,22,23,24}, dogs^{25,26}, and non human primates.^{27,28}

Thus not only is drug used common to several species of the animal kingdom but the demonstration

-
10. Kusayama T, Watanabe S. Reinforcing effects of methamphetamine in planarians. *Neuroreport*. 2000; 11: 2511-2513.
 11. Li H, Chaney S, Roberts IJ, Forte M, Hirsh J. Ectopic G-protein expression in dopamine and serotonin neurons blocks cocaine sensitization in *Drosophila melanogaster*. *Curr Biol*. 2000; 10: 211-214.
 12. Wolf F, Heberlein U. Invertebrate models of drug abuse. *J Neurobiol*. 2002; 54: 161-178.
 13. Carney JM, Landrum RW, Cheng MS, Seale TW. Establishment of chronic intravenous drug self-administration in the C57BL/6J mouse. *Neuroreport*. 1991; 2: 477-480.
 14. Grahame NJ, Phillips TJ, Burkhart-Kasch S, Cunningham CL. Intravenous cocaine self-administration in the C57BL/6J mouse. *Pharmacol Biochem Behav*. 1995; 51: 827-834.
 15. Highfield DA, Mead AN, Grimm JW, Rocha BA, Shaham Y. Reinstatement of cocaine seeking in 129X1/SvJ mice: effects of cocaine priming, cocaine cues and food deprivation. *Psychopharmacology (Berl)*. 2002; 161: 417-424.
 16. Cain ME, Denehy ED, Bardo M. Individual Differences in Amphetamine Self-Administration: The rôle of the Central Nucleus of the Amygdala. *Neuropsychopharmacology*. 2007; 33: 1149-1161.
 17. Thomsen M, Caine SB. Intravenous drug self-administration in mice: practical considerations. *Behav Genet*. 2007; 37: 101-118.
 18. van der Veen R, Piazza PV, Deroche-Gamonet V. Gene-environment interactions in vulnerability to cocaine intravenous self-administration: a brief social experience affects intake in DBA/2J but not in C57BL/6J mice. *Psychopharmacology (Berl)*. 2007; 193: 179-186.
 19. Thomsen M, Han DD, Gu HH, Caine SB. Lack of cocaine self-administration in mice expressing a cocaine-insensitive dopamine transporter. *J Pharmacol Exp Ther*. 2009
 20. Pickens R, Harris WC. Self-administration of d-amphetamine by rats. *Psychopharmacologia*. 1968; 12: 158-163.
 21. Ettenberg A, Pettit HO, Bloom FE, Koob GF. Heroin and cocaine intravenous self-administration in rats: Mediation by separate neural systems. *Psychopharmacology*. 1982; 78: 204-209.
 22. Collins RJ, Weeks JR, Cooper MM, Good PI, Russell RR. Prediction of abuse liability of drugs using IV self-administration by rats. *Psychopharmacology (Berl)*. 1984; 82: 6-13.
 23. Koob G, Le HT, Creese I. The D1 dopamine receptor antagonist SCH 23390 increases cocaine self-administration in the rat. *NeurosciLett*. 1987; 79: 315-320.
 24. Weissenborn R, Yackey M, Koob GF, Weiss F. Measures of cocaine-seeking behavior using a multiple schedule of food and drug self-administration in rats. *Drug Alcohol Depend*. 1995; 38: 237-246.
 25. Risner ME, Goldberg SR. A comparison of nicotine and cocaine self-administration in the dog: fixed-ratio and progressive-ratio schedules of intravenous drug infusion. *J Pharmacol Exp Ther*. 1983; 224: 319-326.
 26. Shannon HE, Risner ME. Comparison of behavior maintained by intravenous cocaine and d-amphetamine in dogs. *JpharmacolExpTher*. 1984; 229: 422-432.
 27. Deneau G, Yanagita T, Seevers MH. Self-administration of psychoactive substances by the monkey. *Psychopharmacologia*. 1969; 16: 30-48.
 28. Goldberg SR, Woods JH, Schuster CR. Morphine: Conditioned Increases in Self-Administration in Rhesus Monkeys. *Science*. 1969

that pure forms of psychoactive drugs have reinforcing properties in animals under experimental conditions suggests that drug taking is not a specific behavioral feature of human beings. Drug use in animals seems rather to be the evidence that the neurobiological substrates of primary motivational and reinforcement processes selected by evolution have been shaped early on and maintained from planarians to human beings, and that drugs hijack these systems.

However, it remains unclear the extent to which these findings help inform our understanding of drug addiction in humans since it is a brain disorder that is clearly far removed from primary reinforcement mechanisms.

2. Drug addiction: A human-specific disorder?

2.1 What is drug addiction?

Drug addiction is a complex brain disorder,²⁹ affecting the motivational,³⁰³¹ learning³²³³³⁴³⁵ and behavioral control systems of the brain.³⁶³⁷³⁸ Several definitions of drug addiction, ranging from the psychiatric to the social view have been presented by Koob and Le Moal³⁹ and will not be discussed any further.

Drug addiction is defined as a chronic relapsing compulsive habit characterized by loss of control over

29. Leshner AI. Addiction is a brain disease, and it matters. *Science*. 1997; 278: 45-47.

30. Robinson T, Berridge K. The psychology and neurobiology of addiction: an incentive-sensitization view. *Addiction*. 2000; 95: S91-S117.

31. Kalivas P, Volkow N. The Neural Basis of Addiction: A Pathology of Motivation and Choice. *American Journal of Psychiatry*. 2005; 162: 1403-1413.

32. Everitt B, Parkinson JA, Olmstead M, Arroyo M, Robledo P, Robbins TW. Associative processes in addiction and reward. The role of amygdala-ventral striatal subsystems. *Ann NYAcadSci*. 1999; 877: 412-438.

33. Everitt BJ, Dickinson A, Robbins TW. The neuropsychological basis of addictive behaviour. *Brain Research Reviews*. 2001; 36: 129-138.

34. Everitt BJ, Robbins TW. Neural systems of reinforcement for drug addiction: from actions to habits to compulsion. *Nat Neurosci*. 2005; 8: 1481-1489.

35. Belin D, Jonkman S, Dickinson A, Robbins TW, Everitt BJ. Parallel and interactive learning processes within the basal ganglia: Relevance for the understanding of addiction. *Behavioural Brain Research*. 2009; 199(1): 89-102.

36. Volkow N, Fowler J. Addiction, a Disease of Compulsion and Drive: Involvement of the Orbitofrontal Cortex. *Cerebral Cortex*. 2000

37. Goldstein RZ, Volkow ND. Drug addiction and its underlying neurobiological basis: neuroimaging evidence for the involvement of the frontal cortex. *Am J Psychiatry*. 2002; 159: 1642-1652.

38. Goldstein RZ, Alia-Klein N, Tomasi D et al. Anterior cingulate cortex hypoactivations to an emotionally salient task in cocaine addiction. *Proc Natl Acad Sci U S A*. 2009; 106: 9453-9458.

39. Koob G, Le Moal M. Plasticity of reward neurocircuitry and the 'dark side' of drug addiction. *Nat Neurosci*. 2005; 8: 1442-1444.

drug intake, maintained drug use despite adverse consequences⁴⁰⁴¹⁴² and the development of negative psycho-affective distress when access to the drug is prevented.⁴³⁴⁴

Because the aetiology and pathophysiology of drug addiction remain unknown, this prominent psychiatric disorder is best defined by the clinical features of the DSM-IV⁴⁵ (Figure 2). The diagnostic of drug addiction is currently based on a categorial dichotomous approach in that the patient must present at least three out of the seven clinical criteria listed in figure 5 to be said addicted to a substance.

Fig. 2. Clinical features of drug addiction according to the DSM-IV-R⁴⁶

1. Need for markedly increased amounts of a substance to achieve intoxication or desired effect, or markedly diminished effect with continued use of the same amount of the substance.
2. The presence of a characteristic withdrawal syndrome or use of a substance (or closely related substance) to relieve or avoid withdrawal symptoms.
3. Persistent desire to use drugs or one or more unsuccessful efforts to cut down or control substance.
4. Substance used in larger amounts or over a longer period of time than the person intended.
5. Important social, occupational, or recreational activities given up or reduced because of substance use.
6. A great deal of time spent in activities necessary to obtain, to use or to recover from the effects of substance used.

40. Everitt BJ., Robbins TW. Neural systems of reinforcement for drug addiction: from actions to habits to compulsion. *Nat Neurosci.* 2005; 8: 1481-1489.

41. Robbins TW, Everitt BJ. Drug addiction: bad habits add up. *Nature.* 1999; 398: 567-570.

42. Belin D, Everitt BJ. The Neural and Psychological Basis of a Compulsive Incentive Habit. In: Steiner H, tseng K, editors. *Handbook of basal ganglia structure and function*, 20. Elsevier, ACADEMIC PRESS; 2010.

43. Belin D, Everitt BJ. The Neural and Psychological Basis of a Compulsive Incentive Habit. In: Steiner H, tseng K, editors. *Handbook of basal ganglia structure and function*, 20. Elsevier, ACADEMIC PRESS; 2010.

44. Koob G, Le Moal M. Addiction and the Brain Antireward System. *Annu Rev Psychol.* 2008; 59: 29-53.

45. APA. *Diagnostic and Statistical Manual of Mental Disorders fourth edition, Text revision (DSM-IV TR)*. Washington DC: American Psychiatric Association; 2000.

46. APA. *Diagnostic and Statistical Manual of Mental Disorders fourth edition, Text revision (DSM-IV TR)*. Washington DC: American Psychiatric Association; 2000.

7. Continued substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to be caused or exacerbated by continued use.

The subject is diagnosed addicted to the substance if they show at least three out of the 7 clinical criteria over the last 12 months.

However, all addicted patients are not equally severely affected and a dimensional addiction severity scale has been developed to assess general behavioral, health and social drug-induced impairments.⁴⁷⁴⁸⁴⁹⁵⁰⁵¹

Indeed, drug addicts do not only take drugs, they spend great amounts of time foraging for their drugs, compulsively take drugs, lose control over drug intake, and persist in taking drugs despite the many adverse consequences of doing so, including compromising their health, family relationships, friendships and work. Many drug addicts resort to criminal behavior to obtain the funds necessary to sustain their compulsive drug use and the great majority eventually relapse to drug use even after prolonged periods of abstinence.

This negative behavioral picture illustrates how drug addiction is not merely a drug taking disorder. Indeed, among the individuals exposed to drugs, and there are many who occasionally drink only a glass or two of an alcoholic beverage, or smoke a cigarette or two, only 15 to 30% overall will switch from casual, 'recreational' drug use to drug abuse and drug addiction⁵²⁵³ (Figure 3).

47. McLellan A, Kushner H, Metzger D, Peters R. The Fifth Edition of the Addiction Severity Index. *J Subst Abuse Treat.* 1992

48. McLellan AT, Cacciola JC, Alterman AI, Rikoon SH, Carise D. The Addiction Severity Index at 25: origins, contributions and transitions. *Am J Addict.* 2006; 15: 113-124.

49. Rikoon S, Cacciola J, Carise D, Alterman A, McLellan A. Predicting DSM-IV dependence diagnoses from Addiction Severity Index composite scores. *Journal of Substance Abuse Treatment.* 2006; 31: 17-24.

50. Krenz S, Dieckmann S, Favrat B et al. French version of the addiction severity index (5th Edition): validity and reliability among Swiss opiate-dependent patients. French validation of the Addiction Severity Index. *Eur Addict Res.* 2004; 10: 173-179.

51. Cacciola J, Alterman A, O'Brien CP, McLellan A. The Addiction Severity Index in clinical efficacy trials of medications for cocaine dependence. *NIDA ResMonogr.* 1997; 175: 182-191.

52. Koob G, Le Moal M. Plasticity of reward neurocircuitry and the 'dark side' of drug addiction. *Nat Neurosci.* 2005; 8: 1442-1444.

53. Anthony JC, Warner LA, Kessler RC. Comparative epidemiology of dependence on tobacco, alcohol, controlled substances, and inhalants: Basic findings from the National comorbidity Survey. *Exp Clin Psychopharmacol.* 1994; 2: 244-268.

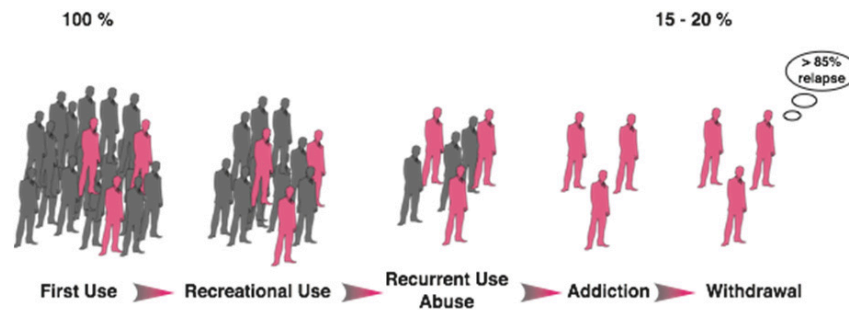


Fig. 3. We are not equally vulnerable to drug addiction.

A substantial proportion of the general population experiences drugs at least once in a lifetime. Of the recreational users who control their drug intake, some will shift to more chronic drug use. Only a subgroup of these individuals will develop drug abuse and eventually drug addiction. Epidemiological studies reveal that of the individuals who have been exposed to addictive drugs, 15 to 20 % eventually develop addiction.

Despite considerable research we still do not understand why some individuals develop a compulsive use of drugs nor do we have effective treatments⁵⁴ to reduce the substantial social and economic burden.⁵⁵ Nevertheless, there is increasing evidence suggesting that drug addiction results from gradual adaptation processes in the brain of vulnerable subjects in response to chronic drug exposure. Not only do these between-systems adaptations trigger an emotional allostatic state (hedonic allostasis)^{56,57,58,59} characterized for instance by increased anxiety, irritability and depression but they may ultimately lead to a shift in the psychological mechanisms that govern drug seeking and drug taking behaviors, including habits^{60,61,62,63,64,65} as aberrant

54. Kreek M, Laforge K, Butelman E. Pharmacotherapy of addictions. *Nat Rev Drug Discov.* 2002; 1: 710-726.

55. Uhl G, Grow RW. The burden of complex genetics in brain disorders. *Arch GenPsychiatry.* 2004; 61: 223-229.

56. Koob G, Le Moal M. Plasticity of reward neurocircuitry and the 'dark side' of drug addiction. *Nat Neurosci.* 2005; 8: 1442-1444.

57. Koob G, Moal ML. Drug Abuse: Hedonic Homeostatic Dysregulation. *Science.* 1997; 278: 52-58.

58. Koob G, Le Moal M. Drug addiction, dysregulation of reward, and allostasis. *Neuropsychopharmacology.* 2001; 24: 97-129.

59. Koob GF, Le Moal M. Review. Neurobiological mechanisms for opponent motivational processes in addiction. *Philos Trans R Soc Lond B Biol Sci.* 2008; 363: 3113-3123.

60. Everitt BJ, Robbins TW. Neural systems of reinforcement for drug addiction: from actions to habits to compulsion. *Nat Neurosci.* 2005; 8: 1481-1489.

61. Belin D, Jonkman S, Dickinson A, Robbins TW, Everitt BJ. Parallel and interactive learning processes within the basal ganglia: Relevance for the understanding of addiction. *Behavioural Brain Research.* 2009; 199(1): 89-102.

62. Robbins TW, Everitt BJ. Drug addiction: bad habits add up. *Nature.* 1999; 398: 567-570.

63. Belin D, Everitt BJ. The Neural and Psychological Basis of a Compulsive Incentive Habit. In: Steiner H, Tseng K, editors. *Handbook of basal ganglia structure and function*, 20. Elsevier, ACADEMIC PRESS; 2010.

64. Tiffany ST. A cognitive model of drug urges and drug-use behavior: rôle of automatic and nonautomatic processes. *Psychol Rev.* 1990; 97: 147-168.

65. O'Brien CP, McLellan A. Myths about the treatment of addiction. *Lancet.* 1996; 347: 237-240.

instrumental learning mechanisms controlled by Pavlovian cues, altered behavioral control,⁶⁶⁶⁷⁶⁸⁶⁹ decision-making and self-monitoring processes.⁷⁰

Similarly, Everitt and colleagues have argued that, during the development of drug addiction, drug seeking is initially goal-directed but becomes habitual, and ultimately compulsive, thereby emphasizing the potential importance of maladaptive automatic instrumental learning mechanisms and their control by Pavlovian incentive processes, so called incentive habits,⁷¹⁷² in the emergence of compulsive drug use.⁷³⁷⁴⁷⁵⁷⁶ Additionally, drug-induced adaptations may also facilitate the shift from impulsivity to compulsivity that has been suggested to occur in the development of drug addiction (Figure 6)⁷⁷ whereby only vulnerable subjects would show a transition from impulse-related recreational drug use to compulsive drug intake.⁷⁸

-
- 66. Goldstein RZ, Volkow ND. Drug addiction and its underlying neurobiological basis: neuroimaging evidence for the involvement of the frontal cortex. *Am J Psychiatry*. 2002; 159: 1642-1652.
 - 67. Jentsch JD, Taylor JR. Impulsivity resulting from frontostriatal dysfunction in drug abuse: implications for the control of behavior by reward-related stimuli. *Psychopharmacology*. 1999; 146: 373-390.
 - 68. Everitt BJ, Belin D, Economidou D, Pelloux Y, Dalley J, Robbins TW. Neural mechanisms underlying the vulnerability to develop compulsive drug-seeking habits and addiction. *Philos Trans R Soc Lond B Biol Sci*. 2008; 363: 3125-3135.
 - 69. Kalivas PW. Addiction as a pathology in prefrontal cortical regulation of corticostriatal habit circuitry. *Neurotox Res*. 2008; 14: 185-189.
 - 70. Baumeister RF, Heatherton TF, Tice DM. *Losing Control: How and Why People Fail at Self-Regulation*. 1994.
 - 71. Belin D, Jonkman S, Dickinson A, Robbins TW, Everitt BJ. Parallel and interactive learning processes within the basal ganglia: Relevance for the understanding of addiction. *Behavioural Brain Research*. 2009; 199(1): 89-102.
 - 72. Belin D, Everitt BJ. The Neural and Psychological Basis of a Compulsive Incentive Habit. In: Steiner H, Tseng K, editors. *Handbook of basal ganglia structure and function*, 20. Elsevier, ACADEMIC PRESS; 2010.
 - 73. Everitt BJ, Dickinson A, Robbins TW. The neuropsychological basis of addictive behaviour. *Brain Research Reviews*. 2001; 36: 129-138.
 - 74. Belin D, Jonkman S, Dickinson A, Robbins TW, Everitt BJ. Parallel and interactive learning processes within the basal ganglia: Relevance for the understanding of addiction. *Behavioural Brain Research*. 2009; 199(1): 89-102.
 - 75. Belin D, Everitt BJ. The Neural and Psychological Basis of a Compulsive Incentive Habit. In: Steiner H, Tseng K, editors. *Handbook of basal ganglia structure and function*, 20. Elsevier, ACADEMIC PRESS; 2010.
 - 76. Everitt BJ, Belin D, Economidou D, Pelloux Y, Dalley J, Robbins TW. Neural mechanisms underlying the vulnerability to develop compulsive drug-seeking habits and addiction. *Philos Trans R Soc Lond B Biol Sci*. 2008; 363: 3125-3135.
 - 77. Belin D, Everitt BJ. The Neural and Psychological Basis of a Compulsive Incentive Habit. In: Steiner H, Tseng K, editors. *Handbook of basal ganglia structure and function*, 20. Elsevier, Academic Press, 2010.
 - 78. Koob G, Le Moal M. Plasticity of reward neurocircuitry and the 'dark side' of drug addiction. *Nat Neurosci*. 2005; 8: 1442-1444.

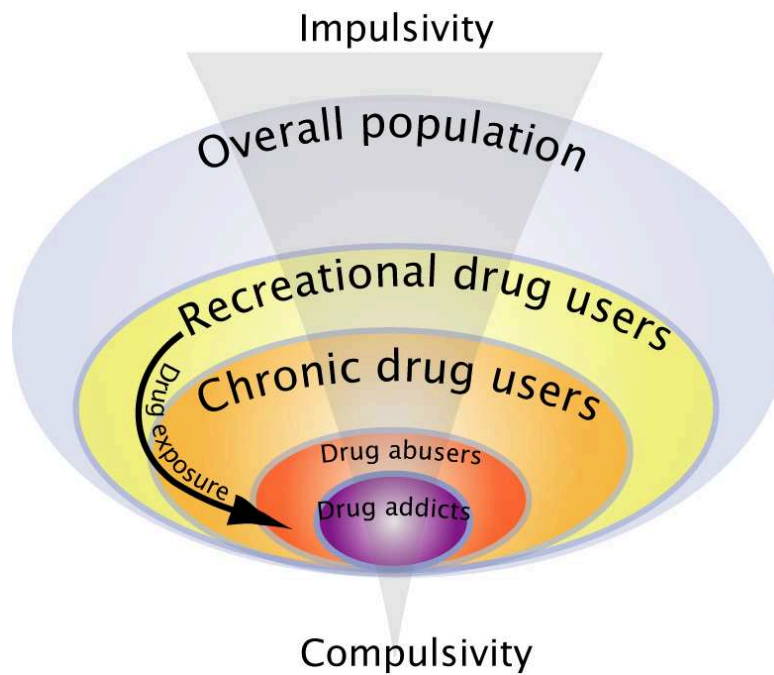


Fig. 4. A progressive shift from impulsivity to compulsivity in the development of drug addiction.

2.2 Behavioral and psychological profile of drug addicts

Besides their disinterest for alternative sources of reinforcement and their focus on the drug, drug addicts

are characterized by several behavioral and cognitive deficits including impaired inhibitory control,⁷⁹⁸⁰⁸¹⁸²⁸³⁸⁴ decision making⁸⁵⁸⁶⁸⁷⁸⁸⁸⁹⁹⁰⁹¹⁹² and insight.⁹³⁹⁴⁹⁵

However, major differences can be observed between addicts depending on their preferred drug of abuse. For instance, although opiate and stimulant addicts both display increased sensation seeking⁹⁶⁹⁷⁹⁸ and

-
79. Kirby KN, Petry NM. Heroin and cocaine abusers have higher discount rates for delayed rewards than alcoholics or non-drug-using controls. *Addiction*. 2004; 99: 461-471.
 80. Mitchell C, Flaherty C. Differential effects of removing the glucose or saccharin components of a glucose–saccharin mixture in a successive negative contrast paradigm. *Physiology & Behavior*. 2005; 84: 579-583.
 81. Baler RD, Volkow ND. Drug addiction: the neurobiology of disrupted self-control. *Trends Mol Med*. 2006; 12: 559-566.
 82. Dom G, D'haene P, Hulstijn W, Sabbe B. Impulsivity in abstinent early- and late-onset alcoholics: differences in self-report measures and a discounting task. *Addiction*. 2006; 101: 50-59.
 83. Verdejo-Garcia A, Benbrook A, Funderburk F, David P, Cadet JL, Bolla KI. The differential relationship between cocaine use and marijuana use on decision-making performance over repeat testing with the Iowa Gambling Task. *Drug Alcohol Depend*. 2007; 90: 2-11.
 84. Verdejo-Garcia A, Lawrence AJ, Clark L. Impulsivity as a vulnerability marker for substance-use disorders: review of findings from high-risk research, problem gamblers and genetic association studies. *Neuroscience and biobehavioral reviews*. 2008; 32: 777-810.
 85. Grant S, Contoreggi C, London ED. Drug abusers show impaired performance in a laboratory test of decision making. *Neuropsychologia*. 2000; 38: 1180-1187.
 86. Monterosso J, Ehrman R, Napier KL, O'Brien CP, Childress AR. Three decision-making tasks in cocaine-dependent patients: do they measure the same construct? *Addiction*. 2001; 96: 1825-1837.
 87. Bechara A, Damasio H. Decision-making and addiction (part I): impaired activation of somatic states in substance dependent individuals when pondering decisions with negative future consequences. *Neuropsychologia*. 2002; 40: 1675-1689.
 88. Bechara A, Dolan S, Hindes A. Decision-making and addiction (part II): myopia for the future or hypersensitivity to reward? *Neuropsychologia*. 2002; 40: 1690-1705.
 89. Hester R, Garavan H. Executive dysfunction in cocaine addiction: evidence for discordant frontal, cingulate, and cerebellar activity. *J Neurosci*. 2004; 24: 11017-11022.
 90. Bechara A. Decision making, impulse control and loss of willpower to resist drugs: a neurocognitive perspective. *Nat Neurosci*. 2005; 8: 1458-1463.
 91. Verdejo-Garcia A, Vilar-Lopez R, Perez-Garcia M, Podell K, Goldberg E. Altered adaptive but not veridical decision-making in substance dependent individuals. *J Int Neuropsychol Soc*. 2006; 12: 90-99.
 92. Vassileva J, Petkova P, Georgiev S et al. Impaired decision-making in psychopathic heroin addicts. *Drug Alcohol Depend*. 2007; 86: 287-289.
 93. Goldstein RZ, Craig AD, Bechara A et al. The neurocircuitry of impaired insight in drug addiction. *Trends Cogn Sci*. 2009; 13: 372-380.
 94. Naqvi NH, Bechara A. The hidden island of addiction: the insula. *Trends Neurosci*. 2009; 32: 56-67.
 95. Naqvi NH, Bechara A. The insula and drug addiction: an interoceptive view of pleasure, urges, and decision-making. *Brain Struct Funct*. 2010.
 96. Allcock CC, Grace DM. Pathological gamblers are neither impulsive nor sensation-seekers. *Aust N Z J Psychiatry*. 1988; 22: 307-311.
 97. Gerra G, Angioni L, Zaimovic A et al. Substance use among high-school students: relationships with temperament, personality traits, and parental care perception. *Subst Use Misuse*. 2004; 39: 345-367.
 98. Maremmani I, Pacini M, Popovic D et al. Affective temperaments in heroin addiction. *J Affect Disord*. 2009; 117: 186-192.

impulsivity,⁹⁹¹⁰⁰¹⁰¹¹⁰²¹⁰³¹⁰⁴ they nevertheless differ in other respects, with heroin addicts showing greater anxiety than cocaine addicts,¹⁰⁵ while the latter display higher impulsivity.¹⁰⁶¹⁰⁷¹⁰⁸

Thus not only are several personality traits, including sensation seeking, anxiety and impulsivity, associated with increased vulnerability to use drugs (91-94),¹⁰⁹¹¹⁰¹¹¹¹¹² but different personality traits are preferentially

-
99. Madden GJ, Petry NM, Badger GJ, Bickel WK. Impulsive and self-control choices in opioid-dependent patients and non-drug-using control participants: drug and monetary rewards. *Exp Clin Psychopharmacol.* 1997; 5: 256-262.
 100. Kirby KN, Petry NM, Bickel WK. Heroin addicts have higher discount rates for delayed rewards than non-drug-using controls. *J Exp Psychol Gen.* 1999; 128: 78-87.
 101. Coffey SF, Gudleski GD, Saladin ME, Brady KT. Impulsivity and rapid discounting of delayed hypothetical rewards in cocaine-dependent individuals. *Exp Clin Psychopharmacol.* 2003; 11: 18-25.
 102. Bornoalova MA, Lejuez CW, Daughters SB, Zachary Rosenthal M, Lynch TR. Impulsivity as a common process across borderline personality and substance use disorders. *Clin Psychol Rev.* 2005; 25: 790-812.
 103. Clark L, Robbins TW, Ersche KD, Sahakian BJ. Reflection impulsivity in current and former substance users. *Biol Psychiatry.* 2006; 60: 515-522.
 104. Verdejo-Garcia AJ, Perales JC, Perez-Garcia M. Cognitive impulsivity in cocaine and heroin polysubstance abusers. *Addict Behav.* 2007; 32: 950-966.
 105. Lejuez CW, Paulson A, Daughters SB, Bornoalova MA, Zvolensky MJ. The association between heroin use and anxiety sensitivity among inner-city individuals in residential drug use treatment. *Behav Res Ther.* 2006; 44: 667-677.
 106. Kirby KN, Petry NM. Heroin and cocaine abusers have higher discount rates for delayed rewards than alcoholics or non-drug-using controls. *Addiction.* 2004; 99: 461-471.
 107. Bornoalova M, Daughters S, Hernandez G, Richards J, Lejuez C. Differences in impulsivity and risk-taking propensity between primary users of crack cocaine and primary users of heroin in a residential substance-use program. *Experimental and Clinical Psychopharmacology.* 2005; 13: 311-318.
 108. Lejuez CW, Bornoalova MA, Daughters SB, Curtin JJ. Differences in impulsivity and sexual risk behavior among inner-city crack/cocaine users and heroin users. *Drug Alcohol Depend.* 2005; 77: 169-175.
 109. Zuckerman M. Sensation seeking and the endogenous deficit theory of drug abuse. *NIDA Res Monogr.* 1986; 74: 59-70.
 110. Franques P, Auriacombe M, Tignol J. [Addiction and personality]. *Encephale.* 2000; 26: 68-78.
 111. Sher KJ, Bartholow BD, Wood MD. Personality and substance use disorders: a prospective study. *J Consult Clin Psychol.* 2000; 68: 818-829.
 112. Terracciano A, Lockenhoff CE, Crum RM, Bienvu OJ, Costa PTJ. Five-Factor Model personality profiles of drug users. *BMC Psychiatry.* 2008; 8: 22.

associated with use¹¹³ and addiction to specific drugs.¹¹⁴¹¹⁵¹¹⁶¹¹⁷¹¹⁸¹¹⁹¹²⁰¹²¹¹²²¹²³¹²⁴ It is therefore possible that heroin and cocaine addicts may self-medicate different personality characteristics or affective states,¹²⁵¹²⁶¹²⁷¹²⁸ with impulsivity being preferentially self-medicated by cocaine use. However, the relative contribution of a behavioral trait to the choice of a drug does not necessarily predict its implication in the transition to compulsive drug use.

Drug addicts also show several comorbid psychiatric disorders (108-111),¹²⁹¹³⁰¹³¹¹³² as stated by O'Brien: "Psychiatric disorders commonly coexist with addictive disorders. These include anxiety disorders, psychotic disorders, and affective disorders such as depression. Although some of these so-called 'dual diagnosis' cases are simply a coincidental occurrence of common disorders, the overlap is greater than would be expected by chance on the basis of population prevalences."¹³³¹³⁴ However, it remains unknown whether comorbid

-
113. Adams JB, Heath AJ, Young SE, Hewitt JK, Corley RP, Stallings MC. Relationships between personality and preferred substance and motivations for use among adolescent substance abusers. *Am J Drug Alcohol Abuse*. 2003; 29: 691-712.
 114. Zuckerman M. Sensation seeking and the endogenous deficit theory of drug abuse. *NIDA Res Monogr*. 1986; 74: 59-70.
 115. Franques P, Auriacombe M, Tignol J. [Addiction and personality]. *Encephale*. 2000; 26: 68-78.
 116. Terracciano A, Lockenhoff CE, Crum RM, Bienvenu OJ, Costa PTJ. Five-Factor Model personality profiles of drug users. *BMC Psychiatry*. 2008; 8: 22.
 117. Gossop M. Drug dependence, crime and personality among female addicts. *Drug Alcohol Depend*. 1978; 3: 359-364.
 118. Labouvie EW, McGee CR. Relation of personality to alcohol and drug use in adolescence. *J Consult Clin Psychol*. 1986; 54: 289-293.
 119. Greene RL, Adyanthaya AE, Morse RM, Davis LJ. Personality variables in cocaine- and marijuana-dependent patients. *JpersAssess*. 1993; 61: 224-230.
 120. Clapper RL, Martin CS, Clifford PR. Personality, social environment, and past behavior as predictors of late adolescent alcohol use. *J Subst Abuse*. 1994; 6: 305-313.
 121. Schinka JA, Curtiss G, Mulloy JM. Personality variables and self-medication in substance abuse. *JpersAssess*. 1994; 63: 413-422.
 122. Ball SA, Kranzler HR, Tennen H, Poling JC, Rounsaville BJ. Personality disorder and dimension differences between type A and type B substance abusers. *J Pers Disord*. 1998; 12: 1-12.
 123. Conway K, Swendsen JD, Rounsaville BJ, Merikangas KR. Personality, drug of choice, and comorbid psychopathology among substance abusers. *Drug Alcohol Depend*. 2002; 65: 225-234.
 124. Gerra G, Bertacca S, Zaimovic A, Pirani M, Branchi B, Ferri M. Relationship of personality traits and drug of choice by cocaine addicts and heroin addicts. *Subst Use Misuse*. 2008; 43: 317-330.
 125. Khantzian EJ, Mack JE, Schatzberg AF. Heroin use as an attempt to cope: clinical observations. *AmJPsychiatry*. 1974; 131: 160-164.
 126. Khantzian EJ. Addiction: self-destruction or self-repair? *JsubstAbuse Treat*. 1989; 6: 75.
 127. Khantzian EJ. Self-regulation factors in cocaine dependence--a clinical perspective. *NIDA ResMonogr*. 1991; 110: 211-226.
 128. Khantzian EJ. The self-medication hypothesis of substance use disorders: a reconsideration and recent applications. *HarvRevPsychiatry*. 1997; 4: 231-244.
 129. Khantzian EJ. Psychiatric illness in drug abusers. *NenglJMed*. 1980; 302: 869-870.
 130. Kessler RC, Nelson CB, McGonagle KA, Edlund MJ, Frank RG, Leaf PJ. The epidemiology of co-occurring addictive and mental disorders: implications for prevention and service utilization. *Am J Orthopsychiatry*. 1996; 66: 17-31.
 131. Skinstad AH, Swain A. Comorbidity in a clinical sample of substance abusers. *Am Jdrug Alcohol Abuse*. 2001; 27: 45-64.
 132. Gum AM, Cheavens JS. Psychiatric comorbidity and depression in older adults. *Curr Psychiatry Rep*. 2008; 10: 23-29.
 133. Kessler RC, Nelson CB, McGonagle KA, Edlund MJ, Frank RG, Leaf PJ. The epidemiology of co-occurring addictive and mental disorders: implications for prevention and service utilization. *Am J Orthopsychiatry*. 1996; 66: 17-31.
 134. O'Brien CP. A Range of Research-Based Pharmacotherapies for Addiction. *Science*. 1997; 278: 66-70.

elements contribute to increased vulnerability to drug addiction¹³⁵ or whether chronic drug exposure facilitates the emergence of psychiatric comorbidity.¹³⁶ Similarly, while some personality, or behavioral, traits are triggered by chronic drug use, there is evidence that personality variables are associated with increased vulnerability to develop drug addiction.¹³⁷¹³⁸ This rather blur picture not only suggests that several sub-populations exist within drug addicts,¹³⁹ but it clearly illustrates how little is known about the factors involved in the vulnerability to develop drug addiction.

To date a triadic model of contributing factors has been established that accounts well for both clinical and preclinical literature. Thus, vulnerability to drug addiction is suggested to result from the interaction between a vulnerable phenotype, or personality (being the interaction between genes and history), the drug and the environment (Figure 5).

There is clearly a genetic vulnerability to addiction. Genetic factors may contribute up to 40% to the development of drug addiction.¹⁴⁰ This estimation gives genetic factors a limited contribution to the vulnerability to drug addiction and highlights the importance of both the drug and the environment in the development of the pathology. There is indeed compelling evidence that life experiences and environments highly influence the effects of drugs of abuse and play a critical role in the transition from controlled to compulsive drug use.¹⁴¹¹⁴² For instance, drug addiction seems to be more frequent in people living in degraded areas or in people that undergo difficult experiences during their childhood. Such specific environmental conditions at either perinatal, developmental or adulthood stages may alter one's personality construction so that they become more vulnerable to use or abuse drugs.¹⁴³ On the other hand, positive family relationships, friendships, involvement and attachment appear to somehow protect against the development of drug addiction (119, 120).¹⁴⁴¹⁴⁵

135. Khantzian EJ. The self-medication hypothesis of addictive disorders: focus on heroin and cocaine dependence. *Am J Psychiatry*. 1985; 142: 1259-1264.

136. O'Brien CP. A Range of Research-Based Pharmacotherapies for Addiction. *Science*. 1997; 278: 66-70.

137. Franques P, Auriacombe M, Tignol J. [Addiction and personality]. *Encephale*. 2000; 26: 68-78.

138. Franques P. Sensation seeking as a common factor in opioid dependent subjects and high risk sport practicing subjects. A cross sectional study. *Drug and Alcohol Dependence*. 2003; 69: 121-126.

139. Gunnarsdottir ED, Pingitore RA, Spring BJ et al. Individual differences among cocaine users. *Addict Behav*. 2000; 25: 641-652.

140. Kreek M, Laforge K, Butelman E. Pharmacotherapy of addictions. *Nat Rev Drug Discov*. 2002; 1: 710-726.

141. Swadi H. Individual risk factors for adolescent substance use. *Drug and Alcohol Dependence*. 1999; 55: 209-224.

142. Batts K, Grabill T, Galvin D, Schlenger W. Contextual and other factors related to workplace-based substance abuse prevention and early intervention for adolescents and young adults [dissertation]. 2004.

143. Khantzian EJ. A contemporary psychodynamic approach to drug abuse treatment. *Am J Drug Alcohol Abuse*. 1986; 12: 213-222.

144. Jessor R, Jessor S. A social-psychological framework for studying drug use. *NIDA Res Monogr*. 1980; 30: 102-109.

145. Jessor R, Chase JA, Donovan JE. Psychosocial correlates of marijuana use and problem drinking in a national sample of adolescents. *Am J Public Health*. 1980; 70: 604-613.

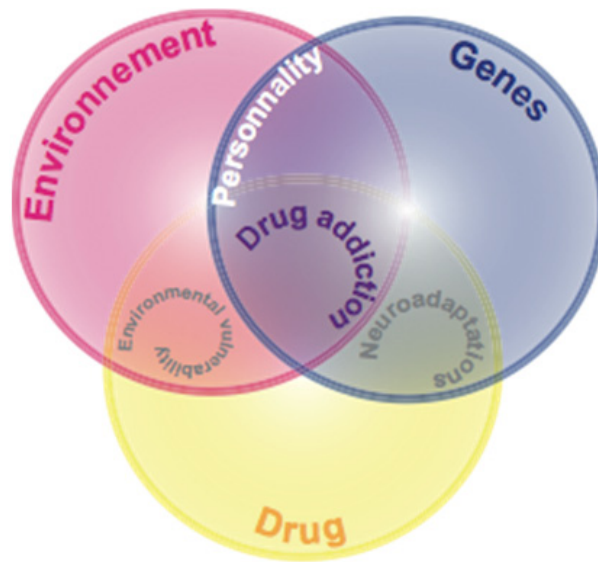


Fig. 5. Triad of influences underlying vulnerability to drug addiction.

A number of interacting factors are hypothesized to influence the pathway to addiction, including biological determinants (genes), drug exposure and the environment. Genetic influences may account for up to 40% of the vulnerability for drug addiction.

Thus, the present general strategies developed to treat addictions should perhaps be reoriented towards a more patient-based medication strategy once better insights are gained in the understanding of the etiological and neurobiological substrates of individual vulnerabilities to addictions.

2.3 Biological correlates of drug addiction in humans: Insights from imaging studies

An exhaustive synthesis of the neurobiological correlates of drug addiction is beyond the scope of this chapter. Overall, drug exposure impacts both brain structure and function. Thus at the morphological level, drug

addicts have decreased grey matter volumes in prefrontal¹⁴⁶¹⁴⁷¹⁴⁸¹⁴⁹¹⁵⁰ and cerebellar regions of the brain.¹⁵¹ Functionally, when presented with drug-related cues that induce craving, drug addicts show abnormal activation of limbic structures including the amygdala,¹⁵²¹⁵³ the insular¹⁵⁴¹⁵⁵¹⁵⁶ and orbitofrontal cortices¹⁵⁷¹⁵⁸ as well as cognitive prefrontal areas such as the cingulate¹⁵⁹¹⁶⁰¹⁶¹ and dorsolateral prefrontal cortices.¹⁶²

Moreover, drug addicts are characterized by decreased levels of striatal D2/3 dopamine receptors¹⁶³¹⁶⁴¹⁶⁵ and reduced metabolism in the orbitofrontal cortex.¹⁶⁶ These two alterations are highly correlated,¹⁶⁷ thereby

-
146. Bartzokis G, Beckson M, Lu PH et al. Increased CSF volumes are associated with diminished subjective responses to cocaine infusion. *Neuropsychopharmacology*. 2000; 23: 468-473.
 147. Bartzokis G, Beckson M, Lu PH et al. Age-related brain volume reductions in amphetamine and cocaine addicts and normal controls: implications for addiction research. *Psychiatry Res*. 2000; 98: 93-102.
 148. Bartzokis G, Beckson M, Lu PH et al. Cortical gray matter volumes are associated with subjective responses to cocaine infusion. *Am J Addict*. 2004; 13: 64-73.
 149. Liu J, Liang J, Qin W et al. Dysfunctional connectivity patterns in chronic heroin users: an fMRI study. *Neurosci Lett*. 2009; 460: 72-77.
 150. Tanabe J, Tregellas JR, Dalwani M et al. Medial orbitofrontal cortex gray matter is reduced in abstinent substance-dependent individuals. *Biol Psychiatry*. 2009; 65: 160-164.
 151. Andersen BB. Reduction of Purkinje cell volume in cerebellum of alcoholics. *Brain Res*. 2004; 1007: 10-18.
 152. Childress AR, Mozley PD, McElgin W, Fitzgerald J, Reivich M, O'Brien CP. Limbic activation during cue-induced cocaine craving. *Am J Psychiatry*. 1999; 156: 11-18.
 153. Childress AR, Ehrman R, Wang Z et al. Prelude to Passion: Limbic Activation by "Unseen" Drug and Sexual Cues. *PloS ONE*. 2008; 3: e1506.
 155. Goldstein RZ, Alia-Klein N, Tomasi D et al. Anterior cingulate cortex hypoactivations to an emotionally salient task in cocaine addiction. *Proc Natl Acad Sci U S A*. 2009; 106: 9453-9458.
 156. Gray MA, Critchley HD. Interoceptive basis to craving. *Neuron*. 2007; 54: 183-186.
 157. Goldstein RZ, Volkow ND. Drug addiction and its underlying neurobiological basis: neuroimaging evidence for the involvement of the frontal cortex. *Am J Psychiatry*. 2002; 159: 1642-1652.
 158. Goldstein RZ, Tomasi D, Rajaram S, Cottone LA, Zhang L, Maloney T, Telang F, Alia-Klein N, Volkow ND. Role of the anterior cingulate and medial orbitofrontal cortex in processing drug cues in cocaine addiction. *Neuroscience*. 2007; 144: 1153-1159.
 159. Childress AR, Mozley PD, McElgin W, Fitzgerald J, Reivich M, O'Brien CP. Limbic activation during cue-induced cocaine craving. *Am J Psychiatry*. 1999; 156: 11-18.
 160. Childress AR, Ehrman R, Wang Z et al. Prelude to Passion: Limbic Activation by "Unseen" Drug and Sexual Cues. *PloS ONE*. 2008; 3: e1506.
 161. Kaufman JN, Ross TJ, Stein EA, Garavan H. Cingulate hypoactivity in cocaine users during a GO-NOGO task as revealed by event-related functional magnetic resonance imaging. *Jneurosci*. 2003; 23: 7839-7843.
 162. Verdejo-Garcia A, Vilar-Lopez R, Perez-Garcia M, Podell K, Goldberg E. Altered adaptive but not veridical decision-making in substance dependent individuals. *J Int Neuropsychol Soc*. 2006; 12: 90-99.
 163. Volkow ND, Fowler J, Wang G, Hitzemann R. Decreased dopamine D2 receptor availability is associated with reduced frontal metabolism in cocaine abusers. *Synapse*. 1993; 14: 169-177.
 164. Volkow ND, Chang L, Wang GJ, Fowler JS, Ding YS, Sedler M, Logan J, Franceschi D, Gatler J, Hitzemann R, Gifford A, Wong C, Pappas N. Low level of brain dopamine D2 receptors in methamphetamine abusers: association with metabolism in the orbitofrontal cortex. *Am J Psychiatry*. 2001; 158: 2015-2021.
 165. Koob GF, Volkow ND. Neurocircuitry of Addiction. *Neuropsychopharmacology*. 2009.
 166. Volkow ND, Fowler J, Wang G, Hitzemann R. Decreased dopamine D2 receptor availability is associated with reduced frontal metabolism in cocaine abusers. *Synapse*. 1993; 14: 169-177.
 167. Volkow ND, Fowler J, Wang G, Hitzemann R. Decreased dopamine D2 receptor availability is associated with reduced frontal metabolism in cocaine abusers. *Synapse*. 1993; 14: 169-177.

providing the orbitofrontal-limbic striatum circuit a prominent implication in addiction (134, 135),¹⁶⁸¹⁶⁹ even though other networks, including the thalamo-cortical systems, have been identified to be impaired in drug addicts.¹⁷⁰

Interestingly, a growing body of evidence points towards an implication of non limbic striatal areas in the pathophysiology of drug addiction since dopamine transmission is specifically increased in the dorsal striatum of cocaine addicts experiencing craving in response to presentation of drug-associated cues,¹⁷¹¹⁷² providing a neurobiological evidence for a progressive involvement of dorsal striatum-dependent habits¹⁷³¹⁷⁴¹⁷⁵ in drug addiction.¹⁷⁶¹⁷⁷¹⁷⁸¹⁷⁹¹⁸⁰

A major limitation of human studies is that the data obtained, though clearly informative, are based on the comparison of current or former drug addicts and drug naive control subjects. Thereby, human studies cannot control for the effects of protracted drug exposure on the brain nor can they define whether the abnormalities observed in drug addicts are a pathological biological adaptation to drug exposure or predated drug use and hence are instead endophenotypes of vulnerability to drug addiction.

This is where the case for animal experimentation in addiction research is revealed compelling. Besides the aforementioned limitations, studies in human addicts are often prone to interpretative issues not least due to inter-subject variability in drug exposure, the frequent co-abuse of several drugs often in combination with alcohol, cannabis and nicotine, the regular occurrence of co-morbid brain disorders such as depression, conduct disorder and attention-deficit/hyperactivity disorder (ADHD) and the difficulty in controlling premorbid cognitive and intellectual abilities.

-
168. Koob GF, Volkow ND. Neurocircuitry of Addiction. *Neuropsychopharmacology*. 2009.
 169. Fowler JS, Volkow ND, Kassid CA, Chang L. Imaging the addicted human brain. *Sci Pract Perspect*. 2007; 3: 4-16.
 170. Tomasi D, Goldstein R, Telang F, Maloney T, Alia-Klein N, Caparelli EC, Volkow ND. Thalamo-cortical dysfunction in cocaine abusers: implications in attention and perception. *Psychiatry Res*. 2007; 155: 189-201.
 171. Garavan H, Pankiewicz J, Bloom A, Cho JK, Sperry L, Ross TJ, Salmeron BJ, Risinger R, Kelley D, Stein EA. Cue-Induced Cocaine Craving: Neuroanatomical Specificity for Drug Users and Drug Stimuli. *American Journal of Psychiatry*. 2000; 157: 1789-1798.
 172. Volkow ND. Stimulant medications: how to minimize their reinforcing effects? *Am J Psychiatry*. 2006; 163: 359-361.
 173. Yin H, Mulcare S, Hilário MR, Clouse E, Holloway T, Davis MI, Hansson AC, Lovinger DM, Costa RM. Dynamic reorganization of striatal circuits during the acquisition and consolidation of a skill. *Nat Neurosci*. 2009; 12: 333-341.
 174. Yin H, Knowlton B. The role of the basal ganglia in habit formation. *Nat Rev Neurosci*. 2006; 7: 464-476.
 175. Yin H, Zhuang X, Balleine B. Instrumental learning in hyperdopaminergic mice. *NeurobiolLearnMem*. 2006.
 176. Everitt BJ, Dickinson A, Robbins TW. The neuropsychological basis of addictive behaviour. *Brain Research Reviews*. 2001; 36: 129-138.
 177. Everitt BJ, Robbins TW. Neural systems of reinforcement for drug addiction: from actions to habits to compulsion. *Nat Neurosci*. 2005; 8: 1481-1489.
 178. Belin D, Jonkman S, Dickinson A, Robbins TW, Everitt BJ. Parallel and interactive learning processes within the basal ganglia: Relevance for the understanding of addiction. *Behavioural Brain Research*. 2009; 199(1): 89-102.
 179. Robbins TW, Everitt BJ. Drug addiction: bad habits add up. *Nature*. 1999; 398: 567-570.
 180. Belin D, Everitt BJ. The Neural and Psychological Basis of a Compulsive Incentive Habit. In: Steiner H, Tseng K, editors. *Handbook of basal ganglia structure and function*, 20. Elsevier, Academic Press; 2010.

Citation

Belin-Rauscent, Aude, and David Beli. “Drug Addictions: An Historical and Ethological Overview.” *Addictions – From Pathophysiology to Treatment*, InTech, 19 Oct. 2012. Crossref, doi:10.5772/52165.

This article is distributed under the terms of the Creative Commons Attribution 3.0 License (CC-BY).

PART III

UNIT 3: TREATMENT MODELS FOR MENTAL HEALTH AND SUBSTANCE ABUSE

Unit 3 looks at treatment models for Mental Health and Substance Abuse. We start this unit by watching the video “History of Psychiatry -Asylums to Community Care” to better understand how mental health was treated in the early 20th century. It helps put current treatments in perspective knowing its sordid beginnings. The next video represents the movement toward a community-based psychosocial rehabilitation model -the Clubhouse Model. This model is strength-based, rather than symptom-based, and was instrumental in fueling a mutual support system that is the antithesis of the medical model.

This unit looks at psychosocial interventions for older adults with serious mental illness. This will familiarize you with behavioral treatment modalities and outcomes. We will then move to outpatient treatment for substance abuse, first examining the underlying principles and then the most efficacious treatment approaches.

The last video is a deep dive into Recovery Oriented Systems of Care (ROSC). This recent strength-based approach acknowledges that services need to go beyond mere symptom and substance use reduction to promote a life in the community.

Unit Objectives

- Describe the beginning of mental health treatment in the 20th century
- Compare and contrast models of substance abuse and mental health treatment
- Examine Recovery Oriented Systems of Care (ROSC) and how they address social determinants of health

HISTORY OF PSYCHIATRY: ASYLUMS TO COMMUNITY CARE



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://cod.pressbooks.pub/therecoveryprocess/?p=127#oembed-1>

THE CLUBHOUSE MODEL



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://cod.pressbooks.pub/therecoveryprocess/?p=130#oembed-1>

PSYCHOSOCIAL INTERVENTIONS FOR OLDER ADULTS WITH SERIOUS MENTAL ILLNESS

What Research Tells Us

A review of the literature identified practices and programs used to provide care coordination and recovery supports for older adults experiencing serious mental illness (SMI). This chapter provides an overview of five practices, including a discussion of the typical settings, demographic groups, intensity and duration, and outcomes attributed to the intervention:

1. Assertive Community Treatment (ACT)
2. Cognitive Behavioral Social Skills Training (CBSST)
3. Skills training practices, specifically Functional Adaptation Skills Training (FAST) and Programa de Entrenamiento para el Desarrollo de Aptitudes para Latinos (PEDAL)
4. Integrated Illness Management and Recovery (I-IMR)
5. Helping Older People Experience Success (HOPES)

Each program or practice description also provides a rating, based on its evidence of various outcomes among older adults experiencing SMI.

Practice Selection

To ensure inclusion of the most useful interventions, authors required practices to meet the following criteria:

- Be clearly defined and replicable
- Developed or adapted specifically for older adults, or studied in populations aged 50 and older
- Be currently in use
- Include evidence of impact on targeted outcomes
- Have accessible implementation resources

Causal Evidence Levels

Strong Evidence

- Causal impact demonstrated by at least **two** randomized controlled trials, quasi-experimental designs, or epidemiological studies with a high or moderate rating.

Moderate Evidence

- Causal impact demonstrated by at least **one** randomized controlled trial, quasi-experimental designs, or epidemiological studies with a high or moderate rating.

Emerging Evidence

- No study received a high or moderate rating. The practice may have been evaluated with less rigorous studies (e.g., pre-post designs) that demonstrate an association between the practice and positive outcomes, but additional studies are needed to establish causal impact.

Evidence Review and Rating

The authors conducted a comprehensive review of published research for each selected intervention to determine its strength as an evidence-based practice. Eligible studies had to:

- Employ a randomized or quasi-experimental design, or
- Be a single sample pre-post design or an epidemiological study with a strong counterfactual (i.e., a study that analyzes what would have happened in the absence of the intervention)

Descriptive studies, implementation studies, and meta-analyses were not included in the review but were documented to provide context and identify implementation strengths and challenges for the practices.

Authors reviewed each individual study in this chapter for evidence of outcomes, such as improved social functioning, medication adherence, symptoms of a mental health disorder or condition, service utilization, and ability to live independently.

Causal Impact: Evidence demonstrating that an intervention causes, or is responsible for, the outcome measured in the study's sample population.

In addition, trained reviewers checked each study to ensure rigorous methodology, by asking questions such as:

- Are experimental and comparison groups demographically similar, with the only difference being that participants in the experimental group received the intervention and those in the comparison group received treatment as usual or no or minimal intervention?
- Was baseline equivalence established between the treatment and comparison groups on outcome measures?
- Were missing data addressed appropriately?
- Were outcome measures reliable, valid, and collected consistently from the participants?

Using these criteria, the authors used a two-step process to assess the strength of each study's methodology, and the causal evidence associated with each practice. Each study was given a rating of low, moderate, or high, based on the research methods. Only randomized controlled trials (RCT), quasi-experimental designs (QEDs), and epidemiological studies with a strong comparison were eligible to receive a high or moderate rating.

After authors assessed and rated all studies for a practice, they placed it into one of three categories based on its causal evidence level:

1. Strong evidence
2. Moderate evidence
3. Emerging evidence

This chapter includes a text box for each intervention that lists improved outcomes in older adults with SMI receiving that intervention. Authors also included additional findings that may be relevant for mental health professionals to consider when addressing the needs of individual clients, but these outcomes did not count towards grading either the study or the practice.

Research Opportunities

Providers face the challenge of limited evidence, particularly from RCTs, when selecting programs and practices designed specifically for older adults with SMI. The limitations in the current evidence base include:

- Some of the findings have not been replicated beyond a single RCT.
- More recent RCTs are currently in process, and results are yet to be published.
- Although many RCTs have been conducted on psychosocial interventions for people with SMI across the lifespan, most do not include enough older adults to evaluate if they are effective for the subgroup (i.e., adults aged 50 and older).
- Older Black, Indigenous, and other people of color are underrepresented in most of the current research on interventions for older adults with SMI, limiting the generalizability of findings to an ethnically diverse population.
- Research has not been conducted to identify effective approaches to implementing and sustaining evidence-based interventions addressing the needs of older adults with SMI.

Given the rapid growth of the older adult population, there is a need for more large-scale studies to better understand how to improve quality of life, functioning, and clinical outcomes for older adults with SMI, including for those with comorbid physical illness. As underscored by the 2012 Institute of Medicine Report on the mental health workforce for older adults, the growing numbers of older adults with SMI will require a workforce specifically trained to address the special needs of this high-risk group. [3] In addition, research is needed on interventions that leverage the use of technology, peer support, community-based outreach, and integrated psychiatric and medical care for older adults with SMI to extend the reach of geriatric specialty providers.

The studies discussed in this chapter confirm that psychosocial interventions are effective in older adults with SMI. Despite existing research supporting the impact of these evidence-based practices on key functional outcomes, there is a lack of uptake and implementation in usual care settings. A critical priority for future research is identifying optimal strategies that successfully implement, scale, and sustain these interventions in diverse community settings.

Assertive Community Treatment (ACT)

Overview

Assertive Community Treatment (ACT) is a team-based model that consists of a multi-disciplinary team working together to support adults with SMI. ACT aims to reduce hospitalization rates and help clients adapt to community living through intensive case management via an integrated team. The ACT team addresses the comprehensive needs of clients, including psychiatric medication, outpatient psychotherapy, employment, and

housing.¹ Teams consist of approximately 10 to 12 providers, representing various disciplines. Team members meet regularly and maintain a small caseload.²

This intervention differs from general case management programs in that the ACT team provides comprehensive services directly to clients, rather than coordinating services across multiple, disconnected providers and agencies.³ Services are flexible and delivered in the settings that the clients are comfortable with and at a frequency that they need. Treatment and support services are individualized, and the team proactively reaches out to clients, rather than expecting them to initiate engagement with services.⁴

Typical Settings

The ACT team meets with clients in the community where they already spend time, such as their homes or community institutions like libraries or parks.

Target Population

ACT is intended for adults with SMI who live in the community and experience challenges in engaging with traditional outpatient services that may not provide a cohesive team approach.

Practitioner Types

Typical ACT teams include case managers, behavioral health clinicians, psychiatric specialist prescribers, registered nurses, community health workers, and peer specialists, among others.

For example, the ACT team could consist of a substance use specialist, rehabilitation worker, social worker, psychiatric nurse, nurse specializing in care of physical health conditions, community mental health nurse, and psychiatrist.

-
1. National Alliance on Mental Illness. (2021). Psychosocial treatments. <https://www.nami.org/About-Mental-Illness/Treatments/PsychosocialTreatments>
 2. Substance Abuse and Mental Health Services Administration. (2008). Assertive community treatment (ACT) evidence-based practices (EBP) kit (DHHS Pub. No. SMA-08-4344). <https://store.samhsa.gov/product/Assertive-CommunityTreatment-ACT-Evidence-Based-Practices-EBPKIT/SMA08-4344>
 3. Phillips, S. D., Burns, B. J., Edgar, E. R., Mueser, K. T., Linkins, K. W., Rosenheck, R. A., Drake, R. E., & McDonel Herr, E. C. (2001). Moving assertive community treatment into standard practice. *Psychiatric Services*, 52(6), 771-779. <https://doi.org/10.1176/appi.ps.52.6.771>
 4. Phillips, S. D., Burns, B. J., Edgar, E. R., Mueser, K. T., Linkins, K. W., Rosenheck, R. A., Drake, R. E., & McDonel Herr, E. C. (2001). Moving assertive community treatment into standard practice. *Psychiatric Services*, 52(6), 771-779. <https://doi.org/10.1176/appi.ps.52.6.771>

Intensity and Duration of Treatment

ACT offers 24/7 support to clients for as long as they need services.

Scope of Evidence Review

This review included two studies: one RCT for adults aged 60 and older, rated high for study design,⁴ and one QED study that enrolled adults with an average age of about 50 years, rated moderate for study design.⁵ Most outcomes in the studies were long-term (18 to 24 months).

Study Intervention Design

In the RCT reviewed, only minor modifications for older adults were made to the traditional ACT model, which has demonstrated effectiveness for adults with SMI. [6-11] These modifications included the use of ACT team members, such as a psychiatrist, who specialize in treating older adults.⁵ Of note, however, another study—which did not meet inclusion criteria for review in this guide—found that older veterans receiving an ACT program not adapted specifically for the needs of older adults nonetheless benefited from it in terms of their ability to continue living in the community.⁶ Similarly, the QED did not note any modifications made to the model to adapt for older adults.

Outcomes Associated With ACT

Studies included in this evidence review demonstrated that use of ACT for older adults experiencing SMI was associated with increased:

- Treatment initiation within 3 months of contact with a mental health worker⁷

5. Stobbe, J., Wierdsma, A. I., Kok, R. M., Kroon, H., Roosenschoon, B.-J., Depla, M., & Mulder, C. L. (2014). The effectiveness of assertive community treatment for elderly patients with severe mental illness: A randomized controlled trial. *BMC Psychiatry*, 14, 42. <https://doi.org/10.1186/1471-244X-14-42>

6. Mohamed, S., Neale, M. S., & Rosenheck, R. (2009). Veterans Affairs intensive case management for older veterans. *American Journal of Geriatric Psychiatry*, 17(8), 671-681. <https://doi.org/10.1097/JGP.0b013e3181a88340>

7. Stobbe, J., Wierdsma, A. I., Kok, R. M., Kroon, H., Roosenschoon, B.-J., Depla, M., & Mulder, C. L. (2014). The effectiveness of assertive

- Treatment retention at 18 months of enrollment⁸
- Medication adherence at 24 months of enrollment⁹

Study Demographic Groups

Both studies met inclusion criteria for age and a focus on providing services to older adults with SMI. To participate in the study, the RCT required difficulty with functioning, and the QED required high hospital use in the past year. Clients with severe cognitive impairment (inability to speak, recall distant or recent events, or learn new information¹⁰) were excluded from the RCT.

Participants in the QED, which took place in a U.S. Department of Veterans Affairs setting, were predominantly male (89 percent), majority White (57 percent), and a substantial proportion had experienced homelessness in the prior year (22 percent) or had a current substance use disorder (43 percent). In analyses, ACT participants were matched to non-ACT participants on all demographic factors and a number of clinical indicators of symptom severity.

Cognitive Behavioral Social Skills Training (CBSST)

Overview

Cognitive Behavioral Social Skills Training (CBSST) is a treatment integrating cognitive behavioral therapy (CBT) and social skills training (SST) to address the needs of older adults with schizophrenia. CBSST aims

community treatment for elderly patients with severe mental illness: A randomized controlled trial. *BMC Psychiatry*, 14, 42. <https://doi.org/10.1186/1471-244X-14-42>

8. Stobbe, J., Wierdsma, A. I., Kok, R. M., Kroon, H., Roosenschoon, B.-J., Depla, M., & Mulder, C. L. (2014). The effectiveness of assertive community treatment for elderly patients with severe mental illness: A randomized controlled trial. *BMC Psychiatry*, 14, 42. <https://doi.org/10.1186/1471-244X-14-42>

9. Valenstein, M., McCarthy, J. F., Ganoczy, D., Bowersox, N. W., Dixon, L. B., Miller, R., Visnic, S., & Slade, E. P. (2013). Assertive community treatment in veterans affairs settings: Impact on adherence to antipsychotic medication. *Psychiatric Services*, 64(5), 445-451. <https://doi.org/10.1176/appi.ps.201100543>

10. Stobbe, J., Mulder, N. C. L., Roosenschoon, B.-J., Depla, M., & Kroon, H. (2010). Assertive community treatment for elderly people with severe mental illness. *BMC Psychiatry*, 10(1), 84. <https://doi.org/10.1186/1471-244X-10-84>

to equip individuals with the skills to improve functioning and challenge defeatist beliefs through three modules:¹¹¹²

1. Cognitive Skills Module—Based in CBT, individuals use thought challenging skills to examine their thinking and modify thoughts that interfere with healthy functioning behaviors. Targeted thoughts include beliefs about voices, events related to delusions, and defeatist beliefs that interfere with functioning behaviors, including self-efficacy beliefs and ageist beliefs (e.g., “I am too old to learn”).¹³ The primary skill taught is the 3C’s:
 - Catch It (identify the thought)
 - Check It (examine evidence)
 - Change It (shift the thought)
2. Social Skills Module—To improve communication skills, individuals engage in behavioral role plays focused on expressing feelings in an assertive and clear way while advocating for one’s needs with healthcare professionals; interacting with roommates, family, and friends; and engaging with service providers and support persons.
3. Problem-Solving Skills Module—Problem-solving skills are taught using the acronym SCALE:
 - Specify
 - Consider possible solutions
 - Assess the best solution
 - Lay out a plan
 - Execute and evaluate the outcome

Participants develop plans to solve real-world problems specific to older adults, such as scheduling activities, taking medication, finding a volunteer opportunity, or obtaining eyeglasses or hearing aids.

-
11. Granholm, E., McQuaid, J. R., McClure, F. S., Auslander, L. A., Perivoliotis, D., Pedrelli, P., Patterson, T., & Jeste, D. V. (2005). A randomized, controlled trial of cognitive behavioral social skills training for middle-aged and older outpatients with chronic schizophrenia. *American Journal of Psychiatry*, 162(3), 520-529. <https://doi.org/10.1176/appi.ajp.162.3.520>
 12. Granholm, E., Holden, J., Link, P. C., McQuaid, J. R., & Jeste, D. V. (2013). Randomized controlled trial of cognitive behavioral social skills training for older consumers with schizophrenia: Defeatist performance attitudes and functional outcome. *American Journal of Geriatric Psychiatry*, 21(3), 251-262. <https://doi.org/10.1016/j.jagp.2012.10.014>
 13. Granholm, E., McQuaid, J. R., McClure, F. S., Link, P. C., Perivoliotis, D., Gottlieb, J. D., Patterson, T. L., & Jeste, D. V. (2007). Randomized controlled trial of cognitive behavioral social skills training for older people with schizophrenia: 12-month followup. *Journal of Clinical Psychiatry*, 68(5), 730-737. <https://doi.org/10.4088/jcp.v68n0510>

Typical Settings

Practitioners can conduct traditional CBT in a variety of settings, including outpatient, inpatient, and partial hospitalization options.

Target Population

CBSST is designed for community-dwelling, middle-aged and older adults with an SMI diagnosis.

Practitioner Types

A wide range of practitioners trained to deliver CBSST, such as psychologists, clinical social workers, or psychiatric nurses, may lead sessions.

Intensity and Duration of Treatment

The treatment consists of 24 or 36 (see below) weekly 2-hour group therapy sessions, with a lunch or snack break (the pilot program consisted of 12 sessions, 90 minutes each).

Scope of Evidence Review

Three studies were included in this review; of which, one was rated high,^{14,15} one moderate,¹⁶ and one low for study design.¹⁷ This gave the intervention an overall rating of strong support for causal evidence. Each study incorporated age-relevant modifications to CBSST. Modifications included repeating modules multiple times to compensate for age-related and SMI-related cognitive impairment, supporting increased skill acquisition, and encouraging engagement even with missed sessions. Content also identified and challenged ageist beliefs,

-
14. Granholm, E., McQuaid, J. R., McClure, F. S., Link, P. C., Perivoliotis, D., Gottlieb, J. D., Patterson, T. L., & Jeste, D. V. (2007). Randomized controlled trial of cognitive behavioral social skills training for older people with schizophrenia: 12-month followup. *Journal of Clinical Psychiatry*, 68(5), 730-737. <https://doi.org/10.4088/jcp.v68n0510>
 15. Granholm, E., Holden, J. L., Dwyer, K., & Link, P. (2020). Mobile-assisted cognitive-behavioral social skills training in older adults with schizophrenia. *Journal of Behavioral and Cognitive Therapy*, 30(1), 13-21. <https://doi.org/10.1016/j.jbct.2020.03.006>
 16. Granholm, E., McQuaid, J. R., McClure, F. S., Auslander, L. A., Perivoliotis, D., Pedrelli, P., Patterson, T., & Jeste, D. V. (2005). A randomized, controlled trial of cognitive behavioral social skills training for middle-aged and older outpatients with chronic schizophrenia. *American Journal of Psychiatry*, 162(3), 520-529. <https://doi.org/10.1176/appi.ajp.162.3.520>
 17. Granholm, E., Holden, J. L., Dwyer, K., & Link, P. (2020). Mobile-assisted cognitive-behavioral social skills training in older adults with schizophrenia. *Journal of Behavioral and Cognitive Therapy*, 30(1), 13-21. <https://doi.org/10.1016/j.jbct.2020.03.006>

included age-relevant role-playing situations, and focused on age-specific problems (e.g., finding transportation).¹⁸

Study Settings

These studies were conducted in outpatient settings, with one study providing transportation for participants to the intervention site. However, participants were recruited from both outpatient treatment centers and residential settings.

Outcomes Associated with CBSST

Studies included in this evidence review demonstrated that use of CBSST for older adults experiencing SMI was associated with statistically significant improvements in:

- Independent functioning in the community
- CBSST skills acquisition^{19,20,21}

Study Demographic Groups

Participants ranged in age from 42 to 81, and the majority were unmarried White males with a high school

-
18. Granholm, E., McQuaid, J. R., McClure, F. S., Auslander, L. A., Perivoliotis, D., Pedrelli, P., Patterson, T., & Jeste, D. V. (2005). A randomized, controlled trial of cognitive behavioral social skills training for middle-aged and older outpatients with chronic schizophrenia. *American Journal of Psychiatry*, 162(3), 520-529. <https://doi.org/10.1176/appi.ajp.162.3.520>
 19. Granholm, E., Holden, J., Link, P. C., McQuaid, J. R., & Jeste, D. V. (2013). Randomized controlled trial of cognitive behavioral social skills training for older consumers with schizophrenia: Defeatist performance attitudes and functional outcome. *American Journal of Geriatric Psychiatry*, 21(3), 251-262. <https://doi.org/10.1016/j.jagp.2012.10.014>
 20. Granholm, E., McQuaid, J. R., McClure, F. S., Link, P. C., Perivoliotis, D., Gottlieb, J. D., Patterson, T. L., & Jeste, D. V. (2007). Randomized controlled trial of cognitive behavioral social skills training for older people with schizophrenia: 12-month followup. *Journal of Clinical Psychiatry*, 68(5), 730-737. <https://doi.org/10.4088/jcp.v68n0510>
 21. Granholm, E., Holden, J. L., Dwyer, K., & Link, P. (2020). Mobile-assisted cognitive-behavioral social skills training in older adults with schizophrenia. *Journal of Behavioral and Cognitive Therapy*, 30(1), 13-21. <https://doi.org/10.1016/j.jbct.2020.03.006>

education, living in assisted community housing (e.g., board and care homes). Participants were both veterans and non-veterans.²²²³²⁴

Participants were excluded if they had:

- Disabling medical problems that would interfere with testing
- Prior exposure to CBT
- A required level of care at baseline that would interfere with outpatient therapy (e.g., hospitalization)
- An absence of medical records to inform diagnosis
- A diagnosis of dependence on substances other than nicotine or caffeine within the past 6 months

Cognitive impairment was not an exclusion criterion, and one study demonstrated CBSST had comparable benefit to participants regardless of cognitive impairment.²⁵

Mobile Adapted CBSST (MA-CBSST)

CBSST has been adapted to use a supplemental mobile device to reduce provider contact hours. CBSST sessions were reduced from 120 minutes to 60 minutes for the 24 weeks of treatment. Handheld personal devices prompted text-based, module-specific homework adherence, and participants completed brief self-monitoring ratings on moods, voices, current activities, and medication adherence three times per day. In older adults with schizophrenia or schizoaffective disorder, skill knowledge and self-reported functioning did not differ significantly between CBSST

-
22. Granholm, E., Holden, J., Link, P. C., McQuaid, J. R., & Jeste, D. V. (2013). Randomized controlled trial of cognitive behavioral social skills training for older consumers with schizophrenia: Defeatist performance attitudes and functional outcome. *American Journal of Geriatric Psychiatry*, 21(3), 251-262. <https://doi.org/10.1016/j.jagp.2012.10.014>
 23. Granholm, E., McQuaid, J. R., McClure, F. S., Link, P. C., Perivoliotis, D., Gottlieb, J. D., Patterson, T. L., & Jeste, D. V. (2007). Randomized controlled trial of cognitive behavioral social skills training for older people with schizophrenia: 12-month followup. *Journal of Clinical Psychiatry*, 68(5), 730-737. <https://doi.org/10.4088/jcp.v68n0510>
 24. Granholm, E., McQuaid, J. R., Link, P. C., Fish, S., Patterson, T., & Jeste, D. V. (2008). Neuropsychological predictors of functional outcome in cognitive behavioral social skills training for older people with schizophrenia. *Schizophrenia Research*, 100(1-3), 133-143. <https://doi.org/10.1016/j.schres.2007.11.032>
 25. Granholm, E., McQuaid, J. R., Link, P. C., Fish, S., Patterson, T., & Jeste, D. V. (2008). Neuropsychological predictors of functional outcome in cognitive behavioral social skills training for older people with schizophrenia. *Schizophrenia Research*, 100(1-3), 133-143. <https://doi.org/10.1016/j.schres.2007.11.032>

and MA-CBSST groups, and improvements among MA-CBSST participants were significant compared to the control group.

Study Practitioner Types

In the studies included in this review, psychotherapists, including doctoral-level and master's-level practitioners with at least 2 years of CBT experience delivered sessions. Two practitioners led all group sessions. Two clinical psychologists provided training and supervision, including review of session videotapes.

Study Intensity and Duration of Treatment

Researchers taught each of the three modules weekly for four sessions. Each module was completed twice over 24 weeks. Subsequently, they increased the time for each module to 6 weekly sessions, increasing the duration of treatment to 36 weeks.²⁶ Overall, treatment adherence was high, with participants attending an average of 22 of the 24 group therapy sessions²⁷ or 30 of the 36 group therapy sessions.²⁸

Social Skills Training: Functional Adaptation Skills Training (FAST) and Programa de Entrenamiento para el Desarrollo de Aptitudes para Latinos (PEDAL)

Overview

Functional Adaptation Skills Training (FAST) is a manualized behavioral intervention for older adults with

-
26. Granholm, E., Holden, J., Link, P. C., McQuaid, J. R., & Jeste, D. V. (2013). Randomized controlled trial of cognitive behavioral social skills training for older consumers with schizophrenia: Defeatist performance attitudes and functional outcome. *American Journal of Geriatric Psychiatry*, 21(3), 251-262. <https://doi.org/10.1016/j.jagp.2012.10.014>
 27. Granholm, E., McQuaid, J. R., McClure, F. S., Auslander, L. A., Perivoliotis, D., Pedrelli, P., Patterson, T., & Jeste, D. V. (2005). A randomized, controlled trial of cognitive behavioral social skills training for middle-aged and older outpatients with chronic schizophrenia. *American Journal of Psychiatry*, 162(3), 520-529. <https://doi.org/10.1176/appi.ajp.162.3.520>
 28. Granholm, E., Holden, J., Link, P. C., McQuaid, J. R., & Jeste, D. V. (2013). Randomized controlled trial of cognitive behavioral social skills training for older consumers with schizophrenia: Defeatist performance attitudes and functional outcome. *American Journal of Geriatric Psychiatry*, 21(3), 251-262. <https://doi.org/10.1016/j.jagp.2012.10.014>

schizophrenia or schizoaffective disorder. It is based on Social Cognitive Theory and the Social and Independent Living Skills Program.²⁹ The practice aims to improve patients' independence and quality of life by targeting six areas of everyday functioning:

1. Medication management
2. Social skills
3. Communication skills
4. Organization and planning
5. Transportation
6. Financial management

Practitioners teach the 6 areas over four 120-minute long sessions, with content repeated and reviewed to maximize benefit to those with age-related cognitive impairment.^{30,31} Group sessions consist of homework assignment and review, discussion around applying exercises to real world settings, and in-session practice of skills.

Each class is structured as follows:³²

- Establish the class agenda
- Review the materials and skills learned in the previous session
- Review homework assignments (generalization)
- Hear a psychoeducational lecture teaching a new concept and/or skills
- Have group or self-practice (e.g., behavioral modeling, role-playing, hands-on practice with props)
- Develop individual homework

FAST was adapted to be culturally relevant for Latino older adults—specifically of Mexican descent—with schizophrenia or schizoaffective disorder. *Programa de Entrenamiento para el Desarrollo de Aptitudes para*

29. Patterson, T. L., McKibbin, C., Taylor, M., Goldman, S., Davila-Fraga, W., Bucardo, J., & Jeste, D. V. (2003). Functional adaptation skills training (FAST): A pilot psychosocial intervention study in middle-aged and older patients with chronic psychotic disorders. *American Journal of Geriatric Psychiatry*, 11(1), 17-23. <https://pubmed.ncbi.nlm.nih.gov/12527536/>

30. Patterson, T. L., McKibbin, C., Taylor, M., Goldman, S., Davila-Fraga, W., Bucardo, J., & Jeste, D. V. (2003). Functional adaptation skills training (FAST): A pilot psychosocial intervention study in middle-aged and older patients with chronic psychotic disorders. *American Journal of Geriatric Psychiatry*, 11(1), 17-23. <https://pubmed.ncbi.nlm.nih.gov/12527536/>

31. Patterson, T. L., Mausbach, B. T., McKibbin, C., Goldman, S., Bucardo, J., & Jeste, D. V. (2006). Functional adaptation skills training (FAST): A randomized trial of a psychosocial intervention for middle-aged and older patients with chronic psychotic disorders. *Schizophrenia Research*, 86(1-3), 291-299. <https://doi.org/10.1016/j.schres.2006.05.017>

32. Patterson, T. L., Bucardo, J., McKibbin, C. L., Mausbach, B. T., Moore, D., Barrio, C., Goldman, S. R., & Jeste, D. V. (2005). Development and pilot testing of a new psychosocial intervention for older Latinos with chronic psychosis. *Schizophrenia Bulletin*, 31(4), 922-930. <https://pubmed.ncbi.nlm.nih.gov/16037481/>

Latinos (PEDAL) is based on the structure and content of FAST and shares the same aim to improve patients' independence and quality of life.³³

PEDAL was adapted in three stages from the FAST protocol:

1. Measures, intervention materials, and manuals were directly translated into Spanish, back translated into English, and then compared by bilingual intervention group leaders. Modules were reviewed for cultural relevance and refinement by mental health professionals of Mexican descent.
2. Materials were modified to include culturally appropriate scenarios, roles, and icons. For example, they incorporated foods, songs, telenovelas/soap operas, and proverbs common in the Mexican tradition.
3. Format, content, and treatment goals were adapted to be based on Mexican values and cultural scripts. For example, materials incorporated concepts such as *simpatía* (the use of polite social relations) and *personalismo* (emphasizing warm relationships). In all modules, scenarios and examples were modified to reflect culturally normative gender roles among older adults of Mexican descent. The language of respect and hierarchical expectations in Latino culture were observed (i.e., use of formal style *usted* rather than the informal *tú*). Medication management sessions emphasized a sense of *orgullo* (i.e., pride) at contributing to the family by alleviating symptoms.

Typical Settings

Practitioners deliver FAST in board and care facilities, which house a sizable proportion of older adults with SMI. PEDAL participants live in the community with their families, and the intervention is delivered in outpatient psychiatric clinics, such as community mental health centers. Since the treatments are similar in structure, FAST and PEDAL have the potential to be delivered in both settings.

Target Population

FAST and PEDAL are designed to treat community-dwelling adults over age 40 with longstanding psychotic disorders (a diagnosis of schizophrenia, schizoaffective disorder, or psychotic mood disorder).

Practitioner Types

Trained research assistants (both FAST and PEDAL) and management or nursing para-professionals based in board-and-care facilities (FAST) lead group sessions. A wider range of mental healthcare professionals who are

33. Patterson, T. L., Bucardo, J., McKibbin, C. L., Mausbach, B. T., Moore, D., Barrio, C., Goldman, S. R., & Jeste, D. V. (2005). Development and pilot testing of a new psychosocial intervention for older Latinos with chronic psychosis. *Schizophrenia Bulletin*, 31(4), 922-930.
<https://pubmed.ncbi.nlm.nih.gov/16037481/>

trained in the delivery of FAST or PEDAL and have experience conducting interventions in a group format could also lead sessions.

Intensity and Duration of Treatment

Group sessions for both FAST and PEDAL last 120 minutes and are held once weekly for 24 weeks. The pilot study for FAST was conducted semi-weekly for 12 weeks; the results indicated a need for a longer intervention duration. Following the weekly group sessions, participants receive monthly group sessions for 6 months to review and reinforce concepts learned during the intensive intervention.

Outcomes Associated With FAST and PEDAL

Studies included in this evidence review demonstrated that use of FAST and PEDAL for older adults experiencing SMI was associated with statistically significant improvements or reductions in:

- Functional capacity in the community^{34,35}
- Psychiatric symptoms³⁶
- Social and communication skills³⁷
- Emergency service use³⁸

-
34. Patterson, T. L., McKibbin, C., Taylor, M., Goldman, S., Davila-Fraga, W., Bucardo, J., & Jeste, D. V. (2003). Functional adaptation skills training (FAST): A pilot psychosocial intervention study in middle-aged and older patients with chronic psychotic disorders. *American Journal of Geriatric Psychiatry*, 11(1), 17-23. <https://pubmed.ncbi.nlm.nih.gov/12527536/>
 35. Patterson, T. L., Bucardo, J., McKibbin, C. L., Mausbach, B. T., Moore, D., Barrio, C., Goldman, S. R., & Jeste, D. V. (2005). Development and pilot testing of a new psychosocial intervention for older Latinos with chronic psychosis. *Schizophrenia Bulletin*, 31(4), 922-930. <https://pubmed.ncbi.nlm.nih.gov/16037481/>
 36. Patterson, T. L., McKibbin, C., Taylor, M., Goldman, S., Davila-Fraga, W., Bucardo, J., & Jeste, D. V. (2003). Functional adaptation skills training (FAST): A pilot psychosocial intervention study in middle-aged and older patients with chronic psychotic disorders. *American Journal of Geriatric Psychiatry*, 11(1), 17-23. <https://pubmed.ncbi.nlm.nih.gov/12527536/>
 37. Patterson, T. L., Mausbach, B. T., McKibbin, C., Goldman, S., Bucardo, J., & Jeste, D. V. (2006). Functional adaptation skills training (FAST): A randomized trial of a psychosocial intervention for middle-aged and older patients with chronic psychotic disorders. *Schizophrenia Research*, 86(1-3), 291-299. <https://doi.org/10.1016/j.schres.2006.05.017>
 38. Mausbach, B. T., Cardenas, V., McKibbin, C. L., Jeste, D. V., & Patterson, T. L. (2008). Reducing emergency medical service use in patients with chronic psychotic disorders: Results from the FAST intervention study. *Behavior Research and Therapy: An International Multi-Disciplinary Journal*, 46(1), 145-153. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2249612/pdf/nihms39444.pdf>

- Emergency service use for psychiatric reasons³⁹
- Medication management⁴⁰

Scope of Evidence Review

This review included two FAST RCTs^{41,42,43} and one PEDAL RCT of older adults with schizophrenia, schizoaffective disorder, or psychotic mood disorder.⁴⁴ All three studies were rated high for study design.

Study Demographic Groups

The FAST participants were racially and ethnically diverse, living in board and care facilities, and mainly high school educated males.^{45,46}

-
39. Mausbach, B. T., Cardenas, V., McKibbin, C. L., Jeste, D. V., & Patterson, T. L. (2008). Reducing emergency medical service use in patients with chronic psychotic disorders: Results from the FAST intervention study. *Behavior Research and Therapy: An International Multi-Disciplinary Journal*, 46(1), 145-153. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2249612/pdf/nihms39444.pdf>
 40. Patterson, T. L., Bucardo, J., McKibbin, C. L., Mausbach, B. T., Moore, D., Barrio, C., Goldman, S. R., & Jeste, D. V. (2005). Development and pilot testing of a new psychosocial intervention for older Latinos with chronic psychosis. *Schizophrenia Bulletin*, 31(4), 922-930. <https://pubmed.ncbi.nlm.nih.gov/16037481/>
 41. Patterson, T. L., McKibbin, C., Taylor, M., Goldman, S., Davila-Fraga, W., Bucardo, J., & Jeste, D. V. (2003). Functional adaptation skills training (FAST): A pilot psychosocial intervention study in middle-aged and older patients with chronic psychotic disorders. *American Journal of Geriatric Psychiatry*, 11(1), 17-23. <https://pubmed.ncbi.nlm.nih.gov/12527536/>
 42. Patterson, T. L., Mausbach, B. T., McKibbin, C., Goldman, S., Bucardo, J., & Jeste, D. V. (2006). Functional adaptation skills training (FAST): A randomized trial of a psychosocial intervention for middle-aged and older patients with chronic psychotic disorders. *Schizophrenia Research*, 86(1-3), 291-299. <https://doi.org/10.1016/j.schres.2006.05.017>
 43. Mausbach, B. T., Cardenas, V., McKibbin, C. L., Jeste, D. V., & Patterson, T. L. (2008). Reducing emergency medical service use in patients with chronic psychotic disorders: Results from the FAST intervention study. *Behavior Research and Therapy: An International Multi-Disciplinary Journal*, 46(1), 145-153. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2249612/pdf/nihms39444.pdf>
 44. Patterson, T. L., Bucardo, J., McKibbin, C. L., Mausbach, B. T., Moore, D., Barrio, C., Goldman, S. R., & Jeste, D. V. (2005). Development and pilot testing of a new psychosocial intervention for older Latinos with chronic psychosis. *Schizophrenia Bulletin*, 31(4), 922-930. <https://pubmed.ncbi.nlm.nih.gov/16037481/>
 45. Patterson, T. L., McKibbin, C., Taylor, M., Goldman, S., Davila-Fraga, W., Bucardo, J., & Jeste, D. V. (2003). Functional adaptation skills training (FAST): A pilot psychosocial intervention study in middle-aged and older patients with chronic psychotic disorders. *American Journal of Geriatric Psychiatry*, 11(1), 17-23. <https://pubmed.ncbi.nlm.nih.gov/12527536/>
 46. Patterson, T. L., Mausbach, B. T., McKibbin, C., Goldman, S., Bucardo, J., & Jeste, D. V. (2006). Functional adaptation skills training (FAST): A randomized trial of a psychosocial intervention for middle-aged and older patients with chronic psychotic disorders. *Schizophrenia Research*, 86(1-3), 291-299. <https://doi.org/10.1016/j.schres.2006.05.017>

The PEDAL participants were Latino, specifically of Mexican descent, and community-dwelling monolingual Spanish speakers or individuals who preferred to communicate in Spanish.⁴⁷

Patients were excluded if they had a diagnosis of dementia or were a serious suicide risk, could not complete the assessment, or were participating in other psychosocial interventions or drug research at intake.

Study Practitioner Types

In the PEDAL RCT, therapists were bicultural and bilingual. The therapists in FAST were paired with a paraprofessional from the board and care facility management or nursing staff.

Integrated Illness Management and Recovery (I-IMR)

Overview

Integrated Illness Management and Recovery (I-IMR) is designed to assist older adults living with SMI and chronic medical conditions. The I-IMR program was developed by modifying the Illness Management and Recovery (IMR) program, which teaches physical illness self-management.⁴⁸ I-IMR aims to improve functioning and symptom outcomes for people with SMI and chronic medical conditions through the training of self-management for both psychiatric and general medical conditions by an I-IMR specialist, complemented by healthcare management provided by an onsite nurse or case manager.

The psychiatric focus of the intervention includes psychoeducation about illness and treatment, cognitive-behavioral approaches to increase medication adherence, training in relapse prevention, instruction about coping skills to manage persistent symptoms, and social skills training.⁴⁹

The general medical illness component consists of an individually tailored curriculum that applies the same skills and strategies used for self-management of psychiatric illness. The psychiatric and medical components are fully integrated and administered concurrently with the perspective that “whole health” consists of

-
47. Patterson, T. L., Bucardo, J., McKibbin, C. L., Mausbach, B. T., Moore, D., Barrio, C., Goldman, S. R., & Jeste, D. V. (2005). Development and pilot testing of a new psychosocial intervention for older Latinos with chronic psychosis. *Schizophrenia Bulletin*, 31(4), 922-930. <https://pubmed.ncbi.nlm.nih.gov/16037481/>
48. Mueser, K. T., Bartels, S. J., Santos, M., Pratt, S. I., & Riera, E. G. (2012). Integrated illness management and recovery: A program for integrating physical and psychiatric illness self-management in older persons with severe mental illness. *American Journal of Psychiatric Rehabilitation*, 15(2), 131-156. <https://doi.org/10.1080/15487768.2012.679558>
49. Mueser, K. T., Meyer, P. S., Penn, D. L., Clancy, R., Clancy, D. M., & Salyers, M. P. (2006). The illness management and recovery program: Rationale, development, and preliminary findings. *Schizophrenia Bulletin*, 32(Suppl 1), S32-S43. <https://doi.org/10.1093/schbul/sbl022>

common elements of mental health and physical health self-management. In addition, a nurse manager facilitates coordination and navigation of necessary preventive and ongoing health care.⁵⁰

Typical Settings

I-IMR is administered in community mental health centers.

Target Population

I-IMR is intended for community-dwelling individuals aged 50 and older with SMI and co-occurring chronic health conditions.

Practitioner Types

An I-IMR specialist provides skills training. A nurse or health outreach worker provides complementary healthcare management.

Intensity and Duration of Treatment

I-IMR is delivered individually or in groups, through weekly sessions, over a period of eight months. Twice weekly sessions may also be offered. The program requires about 40 sessions to complete.

Scope of the Evidence Review

This review included an RCT, rated high for study design,⁵¹ and a pre-post study, rated low for study design,⁵² of older adults with SMI and co-occurring chronic health conditions. Two additional RCTs of I-IMR are currently underway.

-
50. Bartels, S. J., Pratt, S. I., Mueser, K. T., Naslund, J. A., Wolfe, R. S., Santos, M., Xie, H., & Riera, E. G. (2014). Integrated IMR for psychiatric and general medical illness for adults aged 50 or older with serious mental illness. *Psychiatric Services*, 65(3), 330-337. <https://doi.org/10.1176/appi.ps.201300023>
 51. Bartels, S. J., Pratt, S. I., Mueser, K. T., Naslund, J. A., Wolfe, R. S., Santos, M., Xie, H., & Riera, E. G. (2014). Integrated IMR for psychiatric and general medical illness for adults aged 50 or older with serious mental illness. *Psychiatric Services*, 65(3), 330-337. <https://doi.org/10.1176/appi.ps.201300023>
 52. Mueser, K. T., Bartels, S. J., Santos, M., Pratt, S. I., & Riera, E. G. (2012). Integrated illness management and recovery: A program for integrating physical and psychiatric illness self-management in older persons with severe mental illness. *American Journal of Psychiatric Rehabilitation*, 15(2), 131-156. <https://doi.org/10.1080/15487768.2012.679558>

Study Demographic Groups

The studies included participants with:

- Diagnosis of schizophrenia spectrum, bipolar disorder, or major depression associated with pervasive impairment lasting at least one year across multiple areas of psychosocial functioning; and
- Diagnosis of diabetes, chronic obstructive pulmonary disease (COPD), congestive heart failure, ischemic heart disease, hypertension, hyperlipidemia, or osteoarthritis, with treatment received at a community mental health center for at least three months.

Outcomes Associated With I-IMR

Studies included in this evidence review demonstrated that use of I-IMR for older adults experiencing SMI was associated with statistically significant improvements in:

- Psychiatric illness self-management
- Diabetes self-management
- Use of hospitalization
- COPD self-management
- Community functioning⁵³

Participants were majority White (97 percent), and 55 percent were female.⁵⁴

Participants were excluded for previous participation in the IMR program, residence in a nursing home or psychiatric hospital, diagnosis of dementia, terminal illness with life expectancy of one year or less, or moderate to severe cognitive impairment.

53. Bartels, S. J., Pratt, S. I., Mueser, K. T., Naslund, J. A., Wolfe, R. S., Santos, M., Xie, H., & Riera, E. G. (2014). Integrated IMR for psychiatric and general medical illness for adults aged 50 or older with serious mental illness. *Psychiatric Services*, 65(3), 330-337. <https://doi.org/10.1176/appi.ps.201300023>

54. Bartels, S. J., Pratt, S. I., Mueser, K. T., Naslund, J. A., Wolfe, R. S., Santos, M., Xie, H., & Riera, E. G. (2014). Integrated IMR for psychiatric and general medical illness for adults aged 50 or older with serious mental illness. *Psychiatric Services*, 65(3), 330-337. <https://doi.org/10.1176/appi.ps.201300023>

Study Practitioner Type

An I-IMR specialist with a master's degree in social work conducted the intervention weekly for 8 months. The I-IMR specialist received 1.5 days of training in administering I-IMR. The training for the I-IMR specialist was based on the standardized program toolkit and manual.

Additionally, throughout the study, each specialist received a weekly call with a clinical psychologist with expertise in behavior change, motivational interviewing, and illness self-management.⁵⁵

A primary care nurse was embedded 1 day per week at each mental health center to coordinate healthcare appointments, medication adjustments, transfer of medical records, and counseling on self-management and lifestyle changes for management of chronic health conditions. Participants met with the nurse healthcare manager twice per month to discuss progress and barriers to meeting health goals.⁵⁶

Helping Older People Experience Success (HOPES)

Overview

The Helping Older People Experience Success (HOPES) program is designed to improve independent functioning of older adults with SMI living in the community and help them continue living in the community by teaching them social, community living, and healthy living skills. A nurse provides coordination of preventive care to individuals in the program.

Skills training is a main component in the HOPES curriculum, which includes the following skills modules:⁵⁷

1. Communicating effectively
2. Making and keeping friends
3. Making the most of leisure time
4. Healthy living

55. Bartels, S. J., Pratt, S. I., Mueser, K. T., Naslund, J. A., Wolfe, R. S., Santos, M., Xie, H., & Riera, E. G. (2014). Integrated IMR for psychiatric and general medical illness for adults aged 50 or older with serious mental illness. *Psychiatric Services*, 65(3), 330-337. <https://doi.org/10.1176/appi.ps.201300023>

56. Bartels, S. J., Pratt, S. I., Mueser, K. T., Naslund, J. A., Wolfe, R. S., Santos, M., Xie, H., & Riera, E. G. (2014). Integrated IMR for psychiatric and general medical illness for adults aged 50 or older with serious mental illness. *Psychiatric Services*, 65(3), 330-337. <https://doi.org/10.1176/appi.ps.201300023>

57. Mueser, K. T., Pratt, S. I., Bartels, S. J., Swain, K., Forester, B., Cather, C., & Feldman, J. (2010). Randomized trial of social rehabilitation and integrated health care for older people with severe mental illness. *Journal of Consulting and Clinical Psychology*, 78(4), 561-573. <https://doi.org/10.1037/a0019629>

5. Using medications effectively
6. Making the most of a healthcare visit
7. Living independently in the community

Each standalone module consists of six to eight component skills, with one skill taught each week. Programs offer the modules on a rotating basis, so clients can join throughout the year. Clients receive a workbook to reinforce skills and are encouraged to identify a support person, such as a family member, friend, or individual clinician, to help them practice skills learned in the training group.⁵⁸ Clients also set goals for preventive health care and managing chronic medical conditions through monthly meetings with a nurse.

Typical Settings

The skills training session can be held in a variety of settings, such as a mental health clinic, rehabilitation center, or senior center.

Target Population

HOPES was developed for community-dwelling older adults with SMI and enrolled in mental health treatment.

Practitioner Types

Rehabilitation specialists co-lead the skills training (e.g., one bachelor's-level clinician and one master's-level clinician or nurse manager). A registered nurse provides the monthly health management.

Intensity and Duration of Treatment

HOPES participants complete 2 years of skills training: the first year consists of intensive hour-long weekly sessions, and the second year consists of monthly maintenance sessions. Participants also receive individual meetings with a nurse and participate in trips into the community to practice social skills in a variety of settings.⁵⁹

58. Mueser, K. T., Pratt, S. I., Bartels, S. J., Swain, K., Forester, B., Cather, C., & Feldman, J. (2010). Randomized trial of social rehabilitation and integrated health care for older people with severe mental illness. *Journal of Consulting and Clinical Psychology*, 78(4), 561-573. <https://doi.org/10.1037/a0019629>

59. Mueser, K. T., Pratt, S. I., Bartels, S. J., Swain, K., Forester, B., Cather, C., & Feldman, J. (2010). Randomized trial of social rehabilitation and

Scope of the Evidence Review

This review included four studies, three of which were associated with the same RCT, which followed HOPES participants for three years following enrollment and was rated high for study design.^{60,61,62} The fourth study was a pre-post pilot trial of an individually tailored HOPES model, rated low for study design.⁶³ The studies focused on community-dwelling older adults with SMI enrolled in mental health treatment for at least 3 months.

Study Intervention Design

One of the goals of the HOPES program is to teach the participants effective social skills for day-to-day living and interactions with the general community. To accomplish this objective, periodic trips to the outside community were scheduled, enabling the patients to practice skills (e.g., conversational) they learned in the group sessions in real world settings. These trips, which were planned jointly by the coaches and patients, occurred biweekly during the intensive phase and monthly during the maintenance phase. During the latter phase, patients were also encouraged to plan their own group outings.

Study Demographic Groups

The participants in the four studies were aged 50 and older, experienced impairment in multiple areas of life, and had a diagnosis of major depression, bipolar disorder, schizoaffective disorder, or schizophrenia. The participants were overwhelmingly White (86 percent) and non-Latino (93 percent) and were majority female (58 percent). Men consistently benefited more from HOPES than women, for reasons that are unclear.

integrated health care for older people with severe mental illness. *Journal of Consulting and Clinical Psychology*, 78(4), 561-573. <https://doi.org/10.1037/a0019629>

60. Mueser, K. T., Pratt, S. I., Bartels, S. J., Swain, K., Forester, B., Cather, C., & Feldman, J. (2010). Randomized trial of social rehabilitation and integrated health care for older people with severe mental illness. *Journal of Consulting and Clinical Psychology*, 78(4), 561-573. <https://doi.org/10.1037/a0019629>
61. Pratt, S. I., Mueser, K. T., Bartels, S. J., & Wolfe, R. (2013). The impact of skills training on cognitive functioning in older people with serious mental illness. *American Journal of Geriatric Psychiatry*, 21(3), 242-250. <https://doi.org/10.1097/JGP.0b013e31826682dd>
62. Bartels, S. J., Pratt, S. I., Mueser, K. T., Forester, B. P., Wolfe, R., Cather, C., Xie, H., McHugo, G. J., Bird, B., Aschbrenner, K. A., Naslund, J. A., & Feldman, J. (2014). Long-term outcomes of a randomized trial of integrated skills training and preventive healthcare for older adults with serious mental illness. *American Journal of Geriatric Psychiatry*, 22(11), 1251-1261. <https://doi.org/10.1016/j.jagp.2013.04.013>
63. Pratt, S. I., Mueser, K. T., Wolfe, R., Santos, M. M., & Bartels, S. J. (2017). One size doesn't fit all: A trial of individually tailored skills training. *Psychiatric Rehabilitation Journal*, 40(4), 380-386. <https://doi.org/10.1037/prj0000261>

Outcomes Associated With HOPES

Studies included in this evidence review demonstrated that use of HOPES for older adults experiencing SMI was associated with statistically significant improvements in:

- Psychosocial functioning^{64,65,66}
- Independent living skills^{67,68}
- Quality of life⁶⁹
- Communication skills⁷⁰
- Psychiatric symptoms⁷¹
- Health self-management⁷²
- Productive use of leisure time^{73,74,75}

-
64. Mueser, K. T., Pratt, S. I., Bartels, S. J., Swain, K., Forester, B., Cather, C., & Feldman, J. (2010). Randomized trial of social rehabilitation and integrated health care for older people with severe mental illness. *Journal of Consulting and Clinical Psychology*, 78(4), 561-573. <https://doi.org/10.1037/a0019629>
65. Bartels, S. J., Pratt, S. I., Mueser, K. T., Forester, B. P., Wolfe, R., Cather, C., Xie, H., McHugo, G. J., Bird, B., Aschbrenner, K. A., Naslund, J. A., & Feldman, J. (2014). Long-term outcomes of a randomized trial of integrated skills training and preventive healthcare for older adults with serious mental illness. *American Journal of Geriatric Psychiatry*, 22(11), 1251-1261. <https://doi.org/10.1016/j.jagp.2013.04.013>
66. Pratt, S. I., Mueser, K. T., Wolfe, R., Santos, M. M., & Bartels, S. J. (2017). One size doesn't fit all: A trial of individually tailored skills training. *Psychiatric Rehabilitation Journal*, 40(4), 380-386. <https://doi.org/10.1037/prj0000261>
67. Bartels, S. J., Pratt, S. I., Mueser, K. T., Forester, B. P., Wolfe, R., Cather, C., Xie, H., McHugo, G. J., Bird, B., Aschbrenner, K. A., Naslund, J. A., & Feldman, J. (2014). Long-term outcomes of a randomized trial of integrated skills training and preventive healthcare for older adults with serious mental illness. *American Journal of Geriatric Psychiatry*, 22(11), 1251-1261. <https://doi.org/10.1016/j.jagp.2013.04.013>
68. Pratt, S. I., Mueser, K. T., Wolfe, R., Santos, M. M., & Bartels, S. J. (2017). One size doesn't fit all: A trial of individually tailored skills training. *Psychiatric Rehabilitation Journal*, 40(4), 380-386. <https://doi.org/10.1037/prj0000261>
69. Pratt, S. I., Mueser, K. T., Wolfe, R., Santos, M. M., & Bartels, S. J. (2017). One size doesn't fit all: A trial of individually tailored skills training. *Psychiatric Rehabilitation Journal*, 40(4), 380-386. <https://doi.org/10.1037/prj0000261>
70. Pratt, S. I., Mueser, K. T., Wolfe, R., Santos, M. M., & Bartels, S. J. (2017). One size doesn't fit all: A trial of individually tailored skills training. *Psychiatric Rehabilitation Journal*, 40(4), 380-386. <https://doi.org/10.1037/prj0000261>
71. Bartels, S. J., Pratt, S. I., Mueser, K. T., Forester, B. P., Wolfe, R., Cather, C., Xie, H., McHugo, G. J., Bird, B., Aschbrenner, K. A., Naslund, J. A., & Feldman, J. (2014). Long-term outcomes of a randomized trial of integrated skills training and preventive healthcare for older adults with serious mental illness. *American Journal of Geriatric Psychiatry*, 22(11), 1251-1261. <https://doi.org/10.1016/j.jagp.2013.04.013>
72. Pratt, S. I., Mueser, K. T., Wolfe, R., Santos, M. M., & Bartels, S. J. (2017). One size doesn't fit all: A trial of individually tailored skills training. *Psychiatric Rehabilitation Journal*, 40(4), 380-386. <https://doi.org/10.1037/prj0000261>
73. Mueser, K. T., Pratt, S. I., Bartels, S. J., Swain, K., Forester, B., Cather, C., & Feldman, J. (2010). Randomized trial of social rehabilitation and integrated health care for older people with severe mental illness. *Journal of Consulting and Clinical Psychology*, 78(4), 561-573. <https://doi.org/10.1037/a0019629>

Improved functioning and symptoms were maintained at 3-year follow-up. In addition, a secondary analysis of HOPES found that improved self-efficacy associated with HOPES was also associated with improved independent living skills.⁷⁶

Exclusion criteria included residence in a nursing home, diagnosis of dementia, terminal illness with life expectancy of one year or less, or moderate to severe cognitive impairment. An additional RCT of HOPES is currently underway.

Study Practitioner Type

In the RCTs reviewed, one master's-level clinician and one bachelor's-level clinician co-led skills training sessions. A registered nurse provided the monthly health management, starting with a medical history and evaluation of healthcare needs, including preventive health care. In the pre-post trial, the coaches were trained to provide the intervention. They had varied professional backgrounds and included interns, case managers, and master's-level therapists.

Citation

Substance Abuse and Mental Health Services Administration (SAMHSA). Psychosocial Interventions for Older Adults With Serious Mental Illness. SAMHSA Publication No. PEP21-06-05-001. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2021.

This work resides in the public domain, unless otherwise indicated.

10.1037/a0019629

74. Bartels, S. J., Pratt, S. I., Mueser, K. T., Forester, B. P., Wolfe, R., Cather, C., Xie, H., McHugo, G. J., Bird, B., Aschbrenner, K. A., Naslund, J. A., & Feldman, J. (2014). Long-term outcomes of a randomized trial of integrated skills training and preventive healthcare for older adults with serious mental illness. *American Journal of Geriatric Psychiatry*, 22(11), 1251-1261. <https://doi.org/10.1016/j.jagp.2013.04.013>
75. Pratt, S. I., Mueser, K. T., Wolfe, R., Santos, M. M., & Bartels, S. J. (2017). One size doesn't fit all: A trial of individually tailored skills training. *Psychiatric Rehabilitation Journal*, 40(4), 380-386. <https://doi.org/10.1037/prj0000261>
76. Muralidharan, A., Brown, C. H., Peer, J. E., Klingaman, E. A., Hack, S. M., Li, L., Walsh, M. B., & Goldberg, R. W. (2019). Living well: An intervention to improve medical illness selfmanagement among individuals with serious mental illness. *Psychiatric Services*, 70(1), 19-25. <https://doi.org/10.1176/appi.ps.201800162>

INTENSIVE OUTPATIENT TREATMENT

Principles of Intensive Outpatient Treatment

This section presents 14 principles that integrate the findings of addictions research with the opinion of the consensus panel. By synthesizing research and practice, the consensus panel will assist clinicians in applying these principles to the clinical decisions they face daily. The 14 principles are expressed throughout this TIP in the form of specific recommendations. They are summarized here to provide a concise overview of effective intensive outpatient treatment (IOT) principles.

The *Principles of Drug Addiction Treatment: A Research-Based Guide* (National Institute on Drug Abuse 1999) offers a valuable starting point for the principles that are described in this chapter. The National Institute on Drug Abuse (NIDA) principles pertain to the full spectrum of addiction treatment modalities, not only to IOT. The consensus panel chose to accentuate the principles that are critical to effective IOT.

The 14 principles described in this section are

1. Make treatment readily available.
2. Ease entry
3. Build on existing motivation.
4. Enhance therapeutic alliance.
5. Make retention a priority.
6. Assess and address individual treatment needs.
7. Provide ongoing care.
8. Monitor abstinence.
9. Use mutual-help and other community-based supports.
10. Use medications if indicated.
11. Educate about substance abuse, recovery, and relapse.
12. Engage families, employers, and significant others.
13. Incorporate evidence-based approaches.
14. Improve program administration.

Principle 1: Make Treatment Readily Available

Accommodate a Wide Spectrum of Clients Who Are Substance

Dependent

Clinical research and practice have established that IOT is an effective and viable way for individuals with a range of substance use disorders to begin their recovery. In the 1980s, it commonly was believed that only clients who were relatively high functioning, employed, and free of significant co-occurring psychiatric disorders could benefit from IOT and that IOT was not effective with clients who were compromised by significant psychosocial stressors such as homelessness or co-occurring disorders. Today substantial research and clinical experience indicate that IOT can be effective for clients with a range of biopsychosocial problems, particularly when appropriate psychiatric, medical, case management, housing, and other support services are provided.

IOT programs have adjusted successfully to the challenges of working with many special population groups that include

- Clients who are economically disadvantaged (Gruber et al. 2000; Milby et al. 1996)
- Clients who are psychiatrically compromised (Drake et al. 1998a, 1998b; Rosenheck et al. 1998)
- Pregnant women (Eisen et al. 2000; Howell et al. 1999)
- Individuals involved with the criminal justice system and other clients coerced into treatment

IOT programs have modified their treatment models to be responsive to the needs of adolescents (Jainchill 2000) and women with children (Nardi 1998; Volpicelli et al. 2000). In addition, panel members have described the benefits of IOT programs with culturally specific components for Native American and Spanish-speaking clients and IOT services for clients at various stages of treatment readiness. The unique needs of specific client populations often can be met in IOT by adding services and creating linkages with other service providers.

Comparing Inpatient Treatment With Intensive Outpatient Treatment

Several studies comparing intensive outpatient treatment with residential treatment have found no significant differences in outcomes (Guydish et al. 1998, 1999; Schneider et al. 1996). Finney and colleagues (1996), however, in a review of 14 studies, found that the available evidence tended to favor inpatient slightly over outpatient treatment. The consensus panel has concluded that clients benefit from both levels of care and that comparing inpatient with outpatient treatment is potentially counterproductive because the important question is not which level of care is better

but, rather, which level of care is more appropriate at a given time for each client. Matching clients with enhanced services also improves client outcomes. McLellan and colleagues (1998) found that compared with control subjects, clients with access to case managers who coordinated medical, housing, parenting, and employment services had less substance use, fewer physical and mental health problems, and better social function after 6 months. It is in the best interest of clients to have a broad continuum of treatment options available. Some clients entering IOT may be able to engage in treatment immediately, whereas others may need referral to a long-term residential program or a therapeutic community. Some clients can be detoxified successfully in an ambulatory setting, whereas others need residential services to complete detoxification successfully.

Principle 2: Ease Entry

Make Access to Treatment Straightforward and Welcoming

IOT programs need to examine policies and procedures to remove unnecessary hurdles in the admission process. From the moment a client or family member first contacts the program, efforts should be made to communicate that IOT exists to serve the client. Delays in the admission process contribute significantly to premature dropout from treatment (Festinger et al. 2002). IOT programs should strive to make the initial appointment available on demand.

Programs should address the following:

- Can the admission process be streamlined without hurting revenues?
- Are the program's hours convenient for clients?
- How can the program facilitate transportation for clients?
- How can the program accommodate clients with childcare responsibilities?
- Is the program individualizing treatment for each client?

The initial encounter with the IOT program should help the client feel like a welcomed participant who is responsible for his or her recovery. IOT programs need to develop a strong customer-focused orientation, making entry into treatment a positive and therapeutic experience.

Principle 3: Build on Existing Motivation

Employ Strategies That Enhance the Client's Motivation

One of the oldest, yet still surviving, misconceptions in the substance abuse treatment field is the notion that people have to “hit bottom” before they can be helped. Studies indicate that individuals who enter treatment for “the wrong reasons” (e.g., complying with external pressures) have outcomes that are comparable with outcomes of those who come into treatment for the “right reasons” (e.g., personal commitment to recovery) (Lawental et al. 1996).

Internal or external pressures drive people to enter treatment. Reasons include negative consequences related to substance use such as an arrest for driving under the influence, pressure from family or friends, fear that substance use is out of control, despair, job insecurity, or a trauma. An IOT program should accept that a client’s presence in its office indicates some desire for treatment services.

Regardless of how well or poorly motivated clients appear at treatment entry, their motivation is likely to waver repeatedly over time. Both IOT programs and clients benefit when counselors keep clients mindful of what led them to treatment. Counselors should try to understand what clients care about and connect client concerns with addressing substance use. For example, if a client talks frequently about her daughter, the counselor might ask the client to consider how substance use affects her relationship with the child.

Because of the central importance of motivation in substance abuse treatment, strategies to enhance and maintain client motivation have been a priority in substance abuse research. Two well-researched approaches offer insights into and strategies for maximizing client motivation:

- Contingency management and related behavioral interventions use incentives to increase client retention in treatment and abstinence. Contingency management in addiction treatment has been studied for more than 30 years, but recent studies have focused on how its principles can be applied in community-based settings (Budney and Higgins 1998; Higgins and Silverman 1999; Katz et al. 2001; Kirby et al. 1999a; Petry 2000). These behavioral intervention studies show that motivation is negotiable and can be increased when incentives are applied strategically and systematically. IOT programs are encouraged to find creative ways to use incentives to increase treatment adherence and enhance outcomes.
- Motivational enhancement and interviewing are techniques whereby the counselor responds to client denial and resistance by proposing thoughtful and detailed strategies that are designed to increase client readiness to change (CSAT 1999c; Miller and Rollnick 2002; Prochaska and DiClemente 1984). The approach is based on the theory that clients being treated for substance use disorders go through five stages of change: precontemplation, contemplation, action, relapse, and maintenance. Client resistance to treatment indicates that the counselor may be attempting to move the client to the next stage too quickly.

Principle 4: Enhance Therapeutic Alliance

Implement Strategies That Build Trust Between Counselor and Client

In treating mental and substance use disorders, research repeatedly has found one factor to be particularly important in influencing positive outcomes: therapeutic alliance (Martin et al. 2000). In fact, therapeutic alliance is one of the few aspects of treatment that consistently has been linked with increased retention in treatment and improvement in a variety of treatment outcomes. The achievement and maintenance of therapeutic alliance are high priorities in treatment.

Therapeutic alliance has four components (Gaston 1991):

- The client's capacity to work on his or her problem
- The client's emotional bond with the therapist
- The therapist's empathic understanding of the client
- The agreement between client and therapist on the goals and tasks of treatment

Therapeutic alliance tends to be enhanced when clinicians are active listeners, empathic, and nonjudgmental and approach treatment as an active collaboration (Mercer and Woody 1999). Clinical supervisors should consider the counselors' ability to establish and maintain a therapeutic alliance when hiring and evaluating staff. Staff training and supervision should emphasize consistently that therapeutic alliance is an important element of any clinical interaction. Performance monitoring and quality improvement activities can capture and measure data on therapeutic alliance, so staff members can improve their skills at fostering this important treatment element (see CSAT 2006f).

Principle 5: Make Retention a Priority

Place a Premium on Retaining Clients

Early termination of treatment harms the client and staff morale. When clients drop out of treatment prematurely, they are at increased risk of relapse. Completing a prescribed treatment episode is associated with better outcomes, regardless of the length of the treatment (Gottheil et al. 1998).

Given the large number of clients who drop out in the first few weeks of treatment, programs should use strategies and approaches that ensure that clients will complete treatment, such as conducting pre-admission interviews (Martino et al. 2000), delivering phone reminders and mailed reminders, using phone orientations, and decreasing the initial call-to-appointment delay (Stasiewicz and Stalker 1999).

A major strength of IOT is that clients have the opportunity to cope with their illness and make changes in their behavior while living at home. Individual differences in how quickly clients adopt new behaviors call for clinical sophistication and flexibility on the part of counselors and the program as a whole. It can be frustrating when clients do not accept immediately the clinical approach that the IOT program is using. Clients can be frustrated when they are forced into making major lifestyle changes that do not yet make sense to them. Under such circumstances, clients may drop out. Programs need counseling approaches that help clients move toward higher levels of healthy functioning.

Principle 6: Assess and Address Individual Treatment Needs

Match Treatment Services to Clients' Needs

At intake, treatment providers gather preliminary information from clients; then, shortly after admission, programs typically complete a comprehensive biopsychosocial assessment. Many programs administer standardized assessments, such as the Addiction Severity Index (McLellan et al. 1992a, 1992b) as well as other specific and multidomain assessments. After collecting detailed information about clients' histories and future goals, programs need to use this information to tailor treatment services to clients.

When clients have unmet psychiatric, medical, legal, housing, social, family, or other personal needs, their ability to focus on recovery can be compromised. When programs match the individual treatment needs of clients to treatment services that address those needs, outcomes improve (Hser et al. 1999; McCaul et al. 2001; McLellan et al. 1998, 1999). NIDA's Principles of Drug Addiction Treatment notes that "matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society" (National Institute on Drug Abuse 1999, p. 3). IOT programs need to find increasingly efficient strategies for assessing treatment needs and implementing individualized care plans.

The achievement and maintenance of therapeutic alliance are high priorities in treatment.

Principle 7: Provide Ongoing Care

Employ a Chronic Care Model, Adjusting Intensity According to Clients' Needs

A substance use disorder is a complex biopsychosocial illness that is not amenable to a quick fix. In addition to their substance use disorders, clients often have significant psychiatric disorders, criminal involvement, histories of physical and sexual trauma, serious medical illnesses, or profound economic challenges or are homeless. IOT programs contribute to society when they successfully assist clients in improving their ability to function in the community, in the workplace, and in their families. The successful initiation and maintenance of this transformation require sustained and conscientious efforts by the client, his or her support system, and a clinical team.

Substance abuse is a chronic illness similar in many respects to other chronic diseases such as asthma, diabetes, and hypertension (McLellan et al. 2000). During the early phase of treatment, intensive interventions may be required, including hospitalization. As the client's condition changes, the intensity of treatment gradually can be increased or decreased depending on the client's condition. Eventually client care may be reduced to periodic checkups that evaluate the client's status and adjust treatment accordingly. A substance use disorder often is treated as if it were an acute illness that responds to a brief, acute course of treatment. Frequently, a 6-week IOT experience is not followed by a stepped-down phase of counseling sessions. For many clients, this abrupt shift from intensive treatment to discharge is destabilizing. Because substance abuse is a chronic condition and relapse is always a possibility, IOT programs are encouraged to examine how they can provide smoother stepdown processes and continuing care services that are responsive to the chronic nature of substance use disorders.

Following their successful completion of an intensive phase of treatment, clients should be evaluated for their readiness to be transferred to less intensive levels of care. Gradually, clients should be transitioned from several therapeutic contacts per week to weekly contact to semimonthly contact and so on. The concept of graduation should be reframed to convey clearly—as it is in colleges and universities—not an ending but a commencement or a new beginning.

Principle 8: Monitor Abstinence

Recognize the Progress That Clients Make in Achieving and Maintaining Abstinence

Programs might consider requiring 30 days of abstinence before transitioning clients to a less intense level of care because extended abstinence is associated with positive longterm outcomes (McKay et al. 1999). Although

it is true that not all clients readily can achieve abstinence without relapsing a few times, it also is true that outcomes are best for those clients who have stopped using drugs and have submitted a drug-free urine sample before entering treatment (Ehrman et al. 2001). To monitor abstinence, IOT programs should use urine drug screens, Breathalyzer™ tests, or other laboratory tests to confirm self-reported abstinence. Urine drug screens can be an effective adjunct in treatment and can contribute to improved treatment outcomes (National Institute on Drug Abuse 1999). Although cost considerations may limit the frequency of urine drug screens and Breathalyzer tests, the consensus panel strongly encourages the use of these objective measures of abstinence.

Principle 9: Use Mutual-Help and Other CommunityBased Supports

Assist Clients in Successfully Integrating Into Mutual-Help and Other Community-Based Support Groups

Participation in mutual-help programs, such as 12-Step programs and treatment programs that facilitate 12-Step membership, is associated with better outcomes than participation in types of treatment that do not facilitate 12-Step membership (Humphreys et al. 1997; Moos et al. 1999; Project MATCH Research Group 1997; Vaillant 1983; see McCrady and Miller 1993, for a review of the Alcoholics Anonymous [AA] research literature). Clients who become involved in 12-Step programs after they step down from IOT tend to do significantly better than those who do not participate in such programs (Moos et al. 1999). IOT programs should facilitate clients' becoming integrated successfully into healthy, community-based mutual-help groups, such as AA (www.alcoholics-anonymous.org) and Narcotics Anonymous (NA) (www.na.org), during treatment. IOT programs should assist clients directly in locating a home group and a sponsor and in becoming oriented to the culture of 12-Step programs.

It is not sufficient simply to refer clients to AA or other 12-Step groups. Just as a physician works with patients to find the right medication and dosage, counselors need to help clients identify the right type of meeting and frequency of attendance (Forman 2002). Just as patients often have unwanted side effects from medications, particularly when they first start taking them, clients who begin attending 12-Step and other mutual-help groups often experience some minor side effects. IOT programs can help clients minimize the negative side effects by providing orientation and support as clients adjust to this important treatment element. (There are many 12-Step meetings for the family, such as Al-Anon/Alateen [www.al-anon.alateen.org] and Nar-Anon [naranon.com], as well as groups for compulsive behaviors such as sex, gambling, spending, and eating.)

Many individuals who are substance dependent find abstinence through participation in faith-based organizations, and many religious groups offer support for individuals who are seeking recovery. Other

individuals have benefited from support groups such as Rational Recovery (www.rational.org), Smart Recovery (www.smartrecovery.org), or Women for Sobriety (www.womenforsobriety.org) that offer an alternative to 12-Step meetings. Giving clients a choice of support groups is empowering because it enables them to make informed decisions.

Principle 10: Use Medications if Indicated

Use Appropriate Medications To Manage Co-Occurring Substance Use and Psychiatric Disorders

A substantial percentage of clients with substance use disorders also have co-occurring psychiatric conditions (Kessler et al. 1996; Marlowe et al. 1995). Psychiatric medications are critically important in the treatment of these co-occurring conditions (Carroll 1996a; Drake et al. 1998b; Minkoff 1997). Ideally, IOTs should provide psychiatric evaluation and medication management on site. If funding limitations make it impossible to offer this care on site, then efficient and functioning links with mental health providers need to be maintained. Resistance to the use of psychiatric medications by substance abuse treatment clinicians is gradually being replaced by an appreciation for the valuable role these medications can play when used appropriately. Likewise, both NA and AA historically had been averse to medications of any kind, but both have published statements supporting the appropriate use of medications (Alcoholics Anonymous World Services 1991; Narcotics Anonymous 1998).

Substance abuse is a chronic illness similar...to other chronic diseases such as asthma, diabetes, and hypertension.

A number of pharmacotherapies have been shown to be effective adjuncts to the treatment of substance abuse. Naltrexone has been effective with some people who are alcohol dependent (Guardia et al. 2002). However, a multisite study by Krystal and colleagues (2001) found that naltrexone was not effective in treating men with chronic, severe alcohol dependence. Under certain conditions, naltrexone has been effective in treating individuals addicted to opioids (Cornish et al. 1997). Similarly, disulfiram (Antabuse®) has been an effective adjunct in the treatment of alcoholism (O'Farrell et al. 1998). Some IOT programs have implemented treatment tracks for clients maintained on methadone. Buprenorphine (Ling et al. 1998; O'Connor et al. 1998) and buprenorphine combined with naloxone (Fudala et al. 1998; Mendelson et al. 1999) are now available for the treatment of opioid dependence and can be prescribed at IOT programs that have medical personnel on staff.

Ideally, IOTs should provide psychiatric evaluation and medication management on site.

Principle 11: Educate About Substance Use Disorders, Recovery, and Relapse

Provide Clients and Family Members With Information About Substance Use Disorders, Recovery Skills, and Relapse Prevention

An important task in IOT is educating clients about substance use disorders and the skills they need to live comfortably in recovery. A wealth of accurate, free information about substance abuse and recovery skills is available to clinicians through Web sites and other sources mentioned throughout this volume, but a good starting place is chapter 4 of TIP 33, *Treatment for Stimulant Use Disorders* (CSAT 1999e). IOT programs are encouraged to develop recovery curricula for clients (or use one already developed) and to facilitate opportunities for clients to practice recovery skills while in treatment. Substance refusal training, stress management, assertiveness training, relapse prevention, and relaxation training are important behavioral techniques that can be incorporated into IOT programs (Carroll 1998; CSAT 1999e; Daley 2001, 2003; Marlatt and Gordon 1985; Mercer and Woody 1999). Clients should be provided with up-to-date information about the biology of substance use disorders, mutual-help programs, and appropriate use of medications.

Given the significant body of information that clients might need to support their recovery, programs are encouraged to explore the use of videotapes, written materials, and Web-based resources to help clients understand addiction and recovery. Consideration should be given to multiple approaches to educating clients, including lectures, discussions, workbook assignments, behavioral rehearsals or role plays, and daily logs or journals. Evaluation processes, such as feedback sessions, that monitor the clients' comprehension of key recovery skills are needed.

Principle 12: Engage Families, Employers, and Significant Others

Include Others Throughout the Treatment Process

The therapeutic involvement of families throughout the recovery process is associated with improved treatment outcomes (Epstein and McCrady 1998; McCrady et al. 1999; O'Farrell and Fals-Stewart 2003; Szapocznik and Williams 2000; White et al. 1998; Winters et al. 2002). Families can be a vital resource

and a source of support and encouragement. Conversely, families also can influence the client adversely and undermine recovery. All clients are part of a group that functions as a “family” and as such are subject to the values, traditions, and culture of that family. IOT programs can marshal families’ powerful positive influences or counter their negative influences by educating, counseling, and providing therapeutic family services. Referrals to therapists and organizations that provide family therapy should be considered when family therapy is unavailable in the IOT program.

When an individual has been referred for treatment by an employee assistance or student assistance program, representatives of the employer and school can play a potent role in supporting adherence to the treatment plan and ongoing recovery.

Principle 13: Incorporate Evidence-Based Approaches

Seek Out Evidence-Based Training Opportunities and Materials

Over the past 30 years a number of treatment approaches have been developed, tested, and demonstrated to be effective in a variety of settings (see chapter 8 for more information). These approaches include

- Cognitive–behavioral therapy (Carroll 1998)
- Motivational enhancement therapy (CSAT 1999c; Miller and Rollnick 2002; Prochaska and DiClemente 1984)
- Individual drug counseling (Mercer and Woody 1999)
- Relapse prevention training (Carroll et al. 1998; Daley 2001, 2003; Daley and Marlatt 1997; Daley et al. 2003)
- Contingency management and incentives (Budney and Higgins 1998; Petry 2000)
- 12-Step facilitation (Nowinski et al. 1992)
- Case management (McLellan et al. 1998, 1999)

IOT programs can adopt methods from these various treatment interventions. NIDA, the National Institute on Alcohol Abuse and Alcoholism (NIAAA), and the Center for Substance Abuse Treatment (CSAT) have published manuals about these approaches, and most of these manuals are available free of charge. A number of other evidence-based manuals are listed throughout this TIP, including documents from NIAAA Project MATCH and CSAT’s Addiction Technology Transfer Centers and other CSAT publications.

Some counselors who enter the substance abuse treatment profession do not have extensive training. For them, the needed skills are learned on the job. Evidence-based manuals summarize the experience of knowledgeable clinicians and researchers, passing on effective techniques and approaches that have been refined over the years. Not all IOT programs are the same— some achieve better outcomes than others. IOT programs can improve their outcomes by successfully incorporating evidence-based approaches. The

consensus panel encourages the use of evidence-based approaches as a means of improving treatment outcomes.

Principle 14: Improve Program Administration

Focus on Financial, Information, and Human Resource Management

Clinicians frequently are promoted into the role of IOT program director without any formal training in how to function as an administrator. The tasks of management differ significantly from those of a clinician, and the transition from one role to the other is not always a smooth or natural one. IOT managers focus on the program's finances, regulatory compliance, human resource management, information management, administrative report preparation, and a host of other tasks that were not in their list of responsibilities as clinicians. TIP 46, Substance Abuse: Administrative Issues in Outpatient Treatment (CSAT 2006f), addresses the administrative issues that IOT managers need to master to manage programs effectively.

Intensive Outpatient Treatment Approaches

Intensive outpatient treatment (IOT) programs use a variety of theoretical approaches to treatment. No definitive research has established a best approach to treatment, and many factors (such as client characteristics and duration of treatment) influence research outcomes. However, studies have found positive associations between several treatment approaches and client outcomes.

Providers should be aware of the most commonly used approaches and their effectiveness so that they can make informed choices. This chapter contains descriptions of six commonly used and studied treatment approaches that form the core of treatment for many IOT programs:

- 12-Step facilitation
- Cognitive-behavioral
- Motivational
- Therapeutic community
- Matrix model
- Community reinforcement and contingency management

The section highlights each approach's distinguishing characteristics, theoretical orientation, research support, and other critical elements such as staffing requirements or funding considerations. Exhibits summarize the strengths and challenges of each approach.

These descriptions give readers only a basic overview; they are not recipes for implementing the approaches

in an IOT program. Clients often have complex psychosocial needs that demand creativity on the part of providers. These approaches are a means for shaping clinical interventions, but none should be considered complete treatment on its own. Excellent information, books, and treatment manuals are available from the Hazelden Foundation (www.hazelden.org), the National Institute on Drug Abuse (NIDA) (www.nida.nih.gov), the National Institute on Alcohol Abuse and Alcoholism (NIAAA) (www.niaaa.nih.gov), and the Substance Abuse and Mental Health Services Administration's National Clearinghouse for Alcohol and Drug Information (www.ncadi.samhsa.gov) and Center for Substance Abuse Treatment (CSAT) (www.csat.samhsa.gov).

Although this section describes these six approaches as distinct, in reality IOT counselors increasingly use multiple approaches, modifying and blending them to address clients' specific needs. This type of tailoring is a hallmark of effective treatment, but combining approaches calls for the provider to recognize and adjust for conflicts that may undermine each approach's effectiveness.

12-Step Facilitation Approach

The Basics

The treatment approach of many IOT programs evolved from the Minnesota Model of treatment, so called because it was first conceptualized at Hazelden Foundation and Willmar State Hospital in Minnesota in the late 1940s (White 1998). The Minnesota Model (also known as 12-Step facilitation) is based on the concepts of 12-Step fellowships, such as Alcoholics Anonymous (AA). These programs' efforts were guided by the philosophical belief that alcoholism was a primary, progressive disease, with biological, psychological, and spiritual features.

The Minnesota Model used treatment teams of physicians, nurses, alcoholism counselors, family counselors, vocational rehabilitation counselors, and AA members in the treatment process. Basic to the process was a thorough introduction of clients to the principles of AA fellowship and the 12 Steps, education about the disease of alcoholism, and participation in AA groups inside and outside the hospital (M.M. Miller 1998).

Over time, the 12-Step approach evolved for use with people who use drugs and those with other compulsive disorders (such as eating disorders) (M.M. Miller 1998). Counselors, originally all in recovery themselves and often with little training, became more professional as training and credentialing standards were implemented (M.M. Miller 1998). Programs also were adapted to a variety of settings, including IOT. However, the basic principles and methods of the 12-Step treatment approach programs remained intact.

IOT programs that use a 12-Step approach focus on helping clients understand AA principles, start working through the 12 Steps, achieve abstinence, and become involved in community-based 12-Step groups, such as AA, Narcotics Anonymous (NA), or Cocaine Anonymous (CA). In these programs, educational efforts present alcoholism as a disease characterized by denial and loss of control. Homework assignments entail reading 12-Step literature, keeping a journal, and undertaking recovery tasks that personalize the 12 Steps.

Much of the group work focuses on accepting the disease, assuming responsibility for the recovery process and one's own actions, renewing hope, establishing trust, changing behavior, practicing self-disclosure, developing insights into one's behavior, and making amends. Problems often are addressed in the context of step work. Clients are encouraged strongly to accept their addiction, develop or adopt spiritual values, and develop a sense of fellowship with others in recovery. IOT programs using a 12-Step approach usually invite AA, NA, CA, or other 12-Step groups to hold onsite meetings.

Clients are encouraged strongly to attend meetings in the community and to find a sponsor and home group for ongoing peer support following completion of the formal treatment program. Ideally, 12-Step-oriented IOT programs are in touch with a network of persons in recovery who can accompany ambivalent or reluctant clients to meetings in the community and help them find compatible groups.

Exhibit 8-1 summarizes the strengths and challenges of 12-Step facilitation.

Exhibit 8.1 Strengths and Challenges of a 12-Step Approach

Strengths

- 12-Step meetings are a free, widely available, ongoing source of support. Metropolitan areas in particular offer many meetings with a specialized focus (e.g., meetings for young people, women, newcomers to treatment, lesbians, gay men, Spanish-language speakers).
- The 12-Step approach emphasizes an array of recovery tasks in cognitive, spiritual, and health realms.
- The 12-Step approach is effective with clients from diverse backgrounds (Tonigan 2003).

Challenges

- It can be difficult to monitor accurately clients' compliance with assigned step tasks, including meeting attendance.
- 12-Step groups' emphasis on higher power may be unacceptable to some clients.
- Some communities may not be large enough to sustain 12-Step meetings or appropriate meetings for people with significant psychiatric disorders.

Other Important Aspects

Staff

Staff members who are not in recovery themselves should read AA, NA, and CA literature and consider regularly attending open meetings to ensure that they understand the beliefs, values, and mores of 12-Step fellowships. Likewise, staff members should familiarize themselves with local meetings and with the level of acceptance of clients with special needs (e.g., those with mental disorders). Familiarity with 12-Step culture and with local meetings help staff members orient departing clients to 12-Step recovery and to the available options.

Clients

Research has attempted to identify the individual characteristics that seem most predictive of affiliation with 12-Step programs, particularly AA, but results often have been contradictory for some variables (McCrady 1998). The 12-Step approach may not be appropriate for every client, but 12-Step groups clearly serve a widely diverse group of people.

Research Outcomes and Findings

The NIAAA-funded Project MATCH compared treatment outcomes for persons dependent on alcohol who were exposed to one of three different treatment approaches: 12-Step facilitation (a 12-Step approach that followed a manual), cognitive-behavioral coping skills therapy, and motivational enhancement therapy (MET). All three approaches resulted in positive outcomes regarding drinking behavior from baseline to 1 year following treatment. The study found little difference in outcomes by type of treatment, although 12-Step facilitation showed a slight advantage over the 3 years following treatment (Project MATCH 1998).

Brown and colleagues (2002) investigated matching client attributes to two types of aftercare: structured relapse prevention and 12-Step facilitation. Overall, the 12-Step facilitation approach provided more favorable outcomes for most people who abuse substances. In particular, the study found that clients reporting high psychological distress, women, and clients reporting multiple substance use at baseline maintained abstinence for longer periods following treatment with 12-Step facilitation than with structured relapse prevention.

Cognitive–Behavioral Approach

The Basics

Cognitive–behavioral therapy (CBT) is based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.

The CBT approach focuses on teaching clients skills that help them recognize and reduce relapse risks, maintain abstinence, and enhance self-efficacy. Clients learn to identify personal “cues” or “triggers”—the people, situations, or feelings that may lead to drinking or drug use. Such triggers may be internal (such as physiological craving or stress reactions) or external (such as seeing friends with whom the client has used drugs). Clients then are taught new coping and problem-solving skills and strategies for effectively counteracting urges to drink or use drugs.

By analyzing their triggers, deciding on recovery-oriented responses and strategies, and role playing high-risk situations and responses, clients gain confidence that they can resist triggered urges to use substances. CBT approaches also are applied to other challenges in recovery, such as interpersonal relations, depression, anxiety, and anger management.

IOT programs are ideal for implementing cognitive–behavioral interventions. Clients usually continue to live and work in their normal environments, which are filled with relapse triggers. These situations provide material for problem-solving exercises, homework, and role plays during group or individual counseling and offer clients opportunities to use new coping strategies, cognitive skills, and behaviors.

The number, duration, and focus of treatment sessions vary widely in CBT-oriented programs. The CBT and 12-Step approaches are compatible, and many CBT-oriented programs encourage participation in 12-Step meetings.

Exhibit 8-2 summarizes the strengths and challenges of CBT.

Other Important Aspects

Staff

Counselors must be familiar with the theory and practice of CBT and have basic counseling skills. It is sometimes helpful to have co-therapists lead cognitive–behavioral groups, particularly those involving role plays and other interactive exercises.

Clients

CBT has been effective with a broad range of clients. However, clients with low literacy or intellectual skills

or those for whom English is a second language may struggle with homework or group exercises that require reading or writing. Also, people with significant psychiatric disorders that have not been stabilized may be unable to participate sufficiently.

Research Outcomes and Findings

CBT models have been evaluated extensively, and randomized clinical trials found CBT-based relapse prevention treatment to be superior to minimal or no treatment (Carroll 1996*b*). When CBT was compared with other active therapeutic interventions, results were mixed. Project MATCH found CBT to be comparable with MET and 12- Step facilitation for decreasing alcohol use and alcohol-related problems. All three therapies resulted in positive improvements in participants' outcomes that persisted for up to 3 years (Project MATCH 1998). Farabee and colleagues (2002) found that clients who received CBT reported more frequent engagement in substance-use avoidance activities 1 year after treatment than did clients who received treatment with contingency management.

Exhibit 8.2 Strengths and Challenges of Cognitive-Behavioral Approaches

Strengths

- CBT actively engages clients in therapy and experiential learning.
- Numerous manuals on CBT are available.
- CBT is suitable for clients from diverse backgrounds and with varying histories of alcohol and drug use.
- CBT provides structured methods for understanding relapse triggers and preparing for relapse situations.

Challenges

- Clients with poor reading or cognitive skills may need alternatives to written assignments.
- The approach requires counselor training in CBT principles and techniques.
- Client motivation is critical because of the extent of homework assignments.
- CBT was developed as an individual, not group, counseling approach.

Motivational Approaches

The Basics

In practice, motivational approaches include both motivational interviewing (MI) and MET. These motivational approaches can be incorporated into every stage of treatment (see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT 1999c], pages 31–32, for specific suggestions).

MI techniques developed by Miller and Rollnick (2002) were derived from a variety of theoretical approaches to how people recover in progressive stages from addiction and other problem behaviors (Prochaska and DiClemente 1984, 1986). MI is a client-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem-solving or solution-focused strategies that build on clients' past successes. Motivational approaches acknowledge that drugs of abuse have rewarding properties that can disguise, at least temporarily, their hazards and negative long-term effects. Through empathic listening and skillful interviewing, the counselor encourages the client to

- Identify discrepancies between significant life goals and the consequences of substance abuse.
- Believe in his or her capabilities for change.
- Choose among available strategies and options.
- Take responsibility for initiating and sustaining healthy personal behavior.

MI requires the counselor to relate to clients in a nonjudgmental, collaborative manner. Counselors pose questions to clients in a way that solicits information while strengthening clients' motivation and commitment to positive change. The counselor acts as a coach or consultant rather than as an authority figure. Counselors using MI follow four basic principles (CSAT 1999c):

- **Express empathy.** The counselor communicates that the client always is responsible for change and respects the client's decision on this issue.
- **Identify discrepancies.** The counselor encourages the client to focus on how current behavior differs from his or her ideals and goals.
- **Roll with resistance and avoid arguing.** The counselor uses strategies to reduce resistance.
- **Support self-efficacy.** The counselor recognizes client strengths and encourages him or her to believe that change is possible.

MET uses structured instruments for assessing dimensions of substance use (e.g., consumption, biomedical and social consequences, family history, readiness for change, risk factors). (Several of these instruments are reproduced in appendix B of TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT

1999c].) Counselors provide feedback about assessment results in relation to societal norms and discuss clients' responses to this feedback.

Exhibit 8-3 summarizes the strengths and challenges of MI and MET.

Other Important Aspects

Staff

Staff members' educational levels are not critical to a motivational approach. Successful counselors may have graduate degrees and professional certification or be recovering peers. However, to become effective practitioners, counselors need special training as well as ongoing supervision to become proficient. Counselors also need to be flexible and have a high level of therapeutic empathy. Counselors are seen as collaborators or consultants rather than as experts.

Clients

MET was developed for, and has been effective with, clients exhibiting varying severities of alcohol-related problems. Court-mandated clients appear to benefit as much from MET as do self-referred clients.

Research Outcomes and Findings

A four-session version of MET was one of three 12-week approaches tested in Project MATCH. MET was found to be as effective as the other, more intensive interventions (CBT and 12-Step facilitation). Clients who rated high in anger fared better with MET, having more abstinent days (Project MATCH 1998).

Miller and Sanchez (1994) report that studies conducted in at least 14 countries indicate that relatively brief motivational interventions can have lasting, positive effects on drinking behavior that are comparable with the effects obtained with longer term treatment interventions.

Exhibit 8.3 Strengths and Challenges of Motivational Approaches

Strengths

- MI and MET are client centered and relevant to clients' personal interests.
- MI and MET focus on realistic, attainable goals.

- MI and MET encourage client self-efficacy and self-sufficiency.
- MI and MET emphasize positive, empathetic support that does not undermine or elicit anger from clients.

Challenges

- MI and MET rely heavily on clients' capabilities and level of self-awareness.
- Commonly used problem-oriented assessment instruments are incompatible with a motivational approach.
- Although MET provides some guidance about effective interpersonal strategies for treating ambivalent clients, the approach does not specify session content.
- Motivational approaches require significant staff training, reorientation, and ongoing supervision.
- Motivational approaches may be difficult to combine with disease or therapeutic community-oriented approaches that expect adherence to program-imposed goals.
- MI and MET were developed as individual approaches; their effectiveness for use with groups is unproved.

Therapeutic Community Approach

The Basics

Therapeutic communities (TCs) have provided residential substance abuse treatment since the 1960s. Some programs have developed a modified, community-based IOT component either to provide treatment on an outpatient basis or to help graduates successfully transition from residential treatment into the community. Some traditional, community-based IOT programs serve clients who participated in TCs while the clients were incarcerated. IOT providers should understand the TC process to ensure continuity for clients.

TCs use an approach known as “community as method” (De Leon 2000). This approach sees the community as a whole—its social organization, its staff and clients, and its daily activities—as the therapeutic agent.

The TC model considers a substance use disorder as a disorder of the whole person. TC program staff members assess each participant's problems along dimensions of psychological dysfunction and social deficits (e.g., problems with authority, poor impulse control, dishonesty) as well as substance use patterns. The TC approach assumes that recovery is a developmental process entailing mutual help and social learning. The beliefs and values that are essential to a client's recovery include (De Leon 2000)

- Demonstrating truth and honesty in all situations
- Remaining in the “here and now”
- Assuming personal responsibility for one’s behavior and future
- Demonstrating concern for others
- Developing a work ethic and understanding that rewards must be earned
- Understanding the distinction between external behavior and inner self
- Accepting that change is the only certainty
- Valuing the learning process
- Developing economic self-reliance
- Becoming involved in one’s community
- Developing good citizenship

Because many clients served by TCs have histories of severe substance use disorders and criminal behavior, TCs typically strive to habilitate, rather than rehabilitate, clients. TCs focus on all aspects of the client’s life, and all activities in the TC promote recovery and habilitation. TCs follow highly structured schedules, centering daily activities on group sessions and hierarchical job functions that teach participants specific behaviors and skills. In general, participants move from job to job in the community for different learning experiences. Peers confront negative behaviors and erroneous thinking in one another within a supportive milieu.

TCs include the following components (De Leon 1995):

- **A sense of community.** Community is created partly by a separation from other agency or institutional programs and, more important, from the drug-using environment. A TC facility contains communal space for promoting a sense of commonality during collective activities. Treatment or educational services (except individual counseling) must be delivered within the peer community.
- **Peers and staff members as role models.** TC members and staff members serve as positive role models by demonstrating expected behaviors and reflecting the values and teachings of the community. The strength of the community for social learning rests on the number and quality of its positive role models.
- **Work as therapy and education.** Consistent with the TC’s self-help approach, all clients are responsible for the daily management of the facility, and work roles are designed to bring about essential educational and therapeutic effects.
- **Peer encounter groups, awareness training, and emotional growth training.** The encounter session is the main therapeutic group and heightens clients’ awareness of specific attitudes or behavioral patterns that need to change. Other groups focus on helping clients identify feelings and express them appropriately and constructively.

TCs feature a structured day that includes ordered, routine activities to counter the characteristically

disordered lives of clients and distract them from negative thinking and boredom. The treatment protocol is organized into phases and stages. When a client masters the objectives in one phase, he or she moves to the next phase. The length of treatment depends on the client's needs and progress in recovery. Continuing services are part of the TC approach. Clients benefit from a peer network that assists them with ongoing community-based services to sustain recovery.

De Leon (2000) describes the basic stages of a TC program as

- Admission evaluation (a preprogram stage)
- Induction (an orientation stage)
- Primary treatment
- Reentry (into the outside community)

Exhibit 8-4 summarizes the strengths and challenges of the TC approach.

Exhibit 8.4 Strengths and Challenges of the Therapeutic Community Approach

Strengths

- The TC approach is effective for people with long histories of substance dependence and antisocial behavior.
- The TC approach is particularly effective in teaching clients how to plan, set, and achieve goals and to be accountable.
- The TC approach is effective in reducing recidivism among clients who have served time in prison.

Challenges

- The approach may be too confrontational for some clients.
- Effective TC treatment requires extensive staff training.
- Treating clients with mental disorders can pose difficulties.
- Finding an effective mix of professional clinicians and recovering staff (who may not be trained in assessment, treatment, planning, and counseling) can take time.

Other Important Aspects

Staff

TC staff members are generally a mix of trained clinicians (certified counselors, nurses, physicians, and case managers) and TC graduates who have had at least some additional training (many become certified). All staff members are part of the community and serve as role models. Staff members typically receive considerable training in TC philosophy and methods. Management staff in particular must be well trained to work effectively in a TC.

Clients

Clients appropriate for TC treatment typically have educational and employment deficits and histories of poverty, relationship problems, criminal behavior experiences or criminal associations, housing instability, psychiatric disorders, or antisocial or other dysfunctional behavior. Many have had previous treatment episodes.

TC approaches should be modified for women, adolescents, and those with co-occurring mental disorders because the confrontational nature and strict hierarchical structure of a standard TC may not be as effective with these groups.

Training Manuals

CSAT has developed the *Therapeutic Community Curriculum* (CSAT 2006g, CSAT 2006h) to help supervisors provide TC staff members with an understanding of the essential components and methods of the TC and an appreciation that they are part of a long tradition of community as a method of treatment. The curriculum provides detailed session-by-session instructions for trainers and exercises for participants.

Special considerations

For clients in an outpatient TC, it is important to arrange for drug-free housing.

Research Outcomes and Findings

NIDA has funded treatment outcome studies that have found that TC treatment is associated with positive outcomes. For example, the Drug Abuse Treatment Outcome Study, a long-term study of treatment outcomes, found that clients who completed TC treatment had lower levels of cocaine, heroin, and alcohol use; criminal behavior; unemployment; and depression than they had before treatment (National Institute on Drug Abuse 2002).

Clinical trials of TC day treatment have found that client outcomes for residential TC and for day TC treatment are not significantly different (Guydish et al. 1999).

A study of the effectiveness of extending the TC model from prisons to community-based settings showed that inmates who participated in an institutional TC followed by a TC- oriented outpatient work-release program had lower rates of drug use and recidivism than offenders who participated only in the institutional program (Inciardi 1996).

The Matrix Model

The Basics

The Matrix model was developed during the 1980s as an effective way to treat the increasing number of people dependent on stimulant drugs, particularly cocaine. Developers designed the Matrix model as a more intensive intervention than the then-standard weekly outpatient counseling or 28-day inpatient treatment. The Matrix model is a good fit for clients who require comprehensive care. The Matrix model, originally known as neurobehavioral treatment, integrated several research-based techniques (including cognitive-behavioral, 12 Step, and motivational enhancement) to target clients' behavioral, emotional, cognitive, and relationship issues. More research is needed to determine optimal combinations of treatment approaches; the Matrix model is one of many programs that combine various approaches. The Matrix model has been selected for discussion because its approach is comprehensive and manual based and assessment data are available.

The Matrix approach is predicated on

- Establishing a strong therapeutic relationship between the client and counselor
- Teaching clients how to structure time and initiate an orderly and healthy lifestyle
- Imparting accurate, comprehensible information about acute and subacute withdrawal effects and cravings for substances
- Providing opportunities to learn and practice relapse prevention and coping techniques
- Involving family and significant others in the therapeutic and educational processes to gain their support for—and prevent their sabotaging of—treatment
- Encouraging clients to participate in community-based mutual-help groups
- Conducting random urinalyses or breath tests to assess treatment effectiveness

Several variations of the Matrix model have been developed. The original 12-month version began with 6 months of intensive treatment that included 56 individual counseling sessions (including conjoint sessions with the client and family members); clients attended treatment sessions 3 or 4 times a week. The individual sessions were supplemented by several types of educational, relapse prevention, family, and social support groups (Obert et al. 2000). The original cocaine-specific treatment protocol was followed by versions for people

who used alcohol or opioids primarily. Because of cost constraints, a 16-week version of the Matrix model was developed that cut the number of individual sessions to three and emphasized group work.

In all versions of Matrix model treatment, a primary therapist coordinates the client's treatment experience. The relationship between the primary therapist and the client (and his or her family) is critical to treatment progress (Obert et al. 2000).

Individual sessions focus on treatment planning and evaluating progress and may include members of the client's family for at least part of the session. In addition to the individual sessions, the treatment protocol for the 16-week program includes specific structured groups (Obert et al. 2000):

- **Early recovery groups.** These groups are for those in the first month of treatment and are small to maximize the attention each client receives. Early recovery groups focus on teaching clients cognitive tools for managing cravings and emphasize time management. Clients create a daily schedule and monitor their activities with group input and support. Early recovery groups assist clients in connecting with community support services.
- **Family education sessions.** Family education is presented as a 12-week series and includes both clients and family members. These sessions include slide presentations, videos, panel presentations, and group discussions on topics such as the biology of addiction, medical effects of substances, conditioning and addiction, and effects of addiction on the family.
- **Relapse prevention groups.** These groups are the primary component of treatment. Group sessions are highly structured and focus on cognitive and behavioral change and on connecting clients to mutual-help programs. The group protocol includes 32 specific topics.
- **Social support groups.** These groups begin in the last month of treatment and focus on helping clients pursue drug-free activities and develop friendships with people who do not use substances. They are less structured than the other groups, and the content is determined by the needs of the group members.

Matrix programs orient clients to 12-Step programs and often schedule onsite 12-Step meetings. Clients are encouraged strongly to attend additional meetings in the community and to find a 12-Step sponsor.

Exhibit 8-5 summarizes the strengths and challenges of the Matrix model.

Other Important Aspects

Staff

Trained therapists are crucial to Matrix model treatment. They are expected to create nurturing, nonjudgmental relationships; maintain a supportive attitude in the face of a client's relapse; foster each client's self-esteem and dignity; and function as teachers or coaches without being either parental or confrontational.

Clients with established long-term abstinence sometimes co-lead groups, serving as role models who put a human face on the recovery process.

Clients

The Matrix model has been used in many different settings (including prisons, substance abuse treatment centers, and hospitals) and with a varied client population across the United States and in Mexico, Thailand, and the Middle East (Rawson 2003).

Treatment manuals

The Matrix model treatment materials contain instructions for therapists on conducting individual, group, and family education sessions (visit www.matrixinstitute.org). Handouts for clients and family members cover therapeutic session topics. Some materials have been translated into Spanish, Arabic, Thai, and other languages. CSAT has adapted the Matrix treatment manuals and made them available as a package called *Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders* (CSAT 2006c, 2006d).

Exhibit 8.5 Strengths and Challenges of Matrix Model Treatment

Strengths

- The model integrates a cognitive-behavioral approach with family involvement, psychosocial education, 12-Step support, and urine testing.
- The model follows a manual, providing therapists with specific instructions and practical exercises. A version of the Matrix materials is available free from NCADI (CSAT 2006c, 2006d).
- The model has been used extensively with people dependent on stimulants and has been shown to be effective.

Challenges

- Some materials may need to be modified for clients whose cognitive functioning is impaired.
- The program requires special staff training and supervision.
- The highly structured content may not appeal to all clients.
- The tight structure and schedule may not leave time for identification and stabilization of

other non-drug-specific problems.

Research Outcomes and Findings

Studies support the utility of Matrix model treatment. In a 1985 pilot study, individuals who selected Matrix treatment over a 28-day inpatient hospital program or participation in 12-Step groups reported significantly lower rates of cocaine use 8 months after treatment than those in either of the other groups (Rawson et al. 1986).

A controlled trial of the model found that people from lower income groups who smoke crack are more difficult to retain in Matrix treatment than those who used cocaine intra-nasally and had more social stability and resources (Obert et al. 2000).

Researchers conducting a CSAT-supported outcome study of Matrix model treatment (Rawson et al. 2002) interviewed a nonrandomized sample of clients who had used methamphetamine and received Matrix model treatment. They found that 2 to 5 years after completing treatment these clients had reduced their methamphetamine and other drug use substantially compared with their pretreatment levels. In addition, a substantial number of the former clients were employed and were not in the criminal justice system.

Shoptaw and colleagues (1998) developed a 48-session variation of Matrix treatment for gay and bisexual men who abuse methamphetamine. The model was found to be an important tool for preventing HIV infection because clients reduced their risky sexual behaviors concurrently with reductions in their stimulant use—without any specific focus on HIV/AIDS during treatment (Shoptaw et al. 1997, 1998).

Community Reinforcement and Contingency Management Approaches

The Basics

Community reinforcement (CR) and contingency management (CM) are treatment approaches based on operant conditioning theory. This theory maintains that future behavior is based on the positive or negative consequences of past behavior. For example, drug use is maintained by the positively reinforcing effects of the drug itself or by the negative reinforcement of relieving the pain of withdrawal. Abstinence, in and of itself, may not be sufficiently reinforcing to maintain a person's motivation to stop using drugs, particularly in early abstinence. Other rewards must be found that reinforce ongoing abstinence and lifestyle change.

CM is an approach in its own right, but its operant interventions are also the main treatment tool used in

CR. In CR, the positive and negative reinforcers that characterize CM are understood to be socially mediated. CR uses aspects of the client's life—relationships with family and friends, job, hobbies, social events—to provide the positive reinforcement that motivates the client to stop using substances. CR is successful when the client chooses the rewarding relationship and activities over substance use. (See Chapter 6 for a discussion of how CR can be used to motivate family members to support the client.) CR and CM approaches motivate clients' behavioral change and reinforce abstinence by systematically rewarding desirable behaviors and ignoring or punishing others. Reinforcers are typically positive, pleasurable, and rewarding events or objects, but some negative reinforcers also are effective. Removing a fine or restriction after a client has complied with a specified regimen is an example of negative reinforcement.

A challenge in this treatment model is to identify a reward for a desired behavior that is both practical and sufficiently powerful—over time—to replace or substitute for the potent, pleasurable, or pain-reducing effects of the drug. The reward must be available without too much cost or expenditure of staff energy. The rewards and punishments must be tailored carefully to clients' responses, as well as program capabilities. For example, vouchers worth \$5 may be motivators for some clients but not others or at a particular point in treatment but not later. Most of the financial or voucher-based CM interventions use an escalating series of rewards for achievement of the target behavior, such as drug-free urine specimens. The escalating rewards provide a greater incentive for sustaining the desired behavior. On the other hand, Kirby and colleagues (1998) found greater reductions in cocaine use when a larger reward was given at the beginning of treatment, coupled with increased requirements for earning vouchers as treatment progressed.

An example of this approach is described in a NIDA treatment manual, *A Community Reinforcement Plus Vouchers Approach: Treating Cocaine Addiction* (Budney and Higgins 1998). In this approach, abstinence is reinforced by awarding vouchers. Drug avoidance skills and relapse prevention techniques are taught along with social and recreational counseling, relationship counseling, and social and other skills training. Clients earn points for each urine screen that is negative for cocaine. For each consecutive negative urine screen, the number of points is increased. If a client submits a urine specimen that is positive for cocaine, the point value returns to baseline. The client can earn back the points lost by submitting five consecutive negative urine specimens. The client can “redeem” points for a variety of retail items that are purchased by program staff (clients are never given cash). Staff members have veto power over clients' requests. In general, staff members approve only items that are consistent with a client's treatment goals and encourage drug-free activities. Examples of items purchased for the program's clients include socks, toaster ovens, baby clothes, camera equipment, ski lift tickets, bicycle equipment, and continuing education materials.

Effective CR and CM programs select a targeted behavior that is attainable in a reasonable amount of time and has a direct effect on the desired outcome. For example, expecting clients who have never submitted a drug-free urine sample to achieve immediate abstinence may be optimistic. Abstinence from a specific substance might precede abstinence from all substances. Targeting small changes is an effective strategy. More frequent reinforcers, even if small, have a greater effect than larger, more remote rewards or punishments. It is also important that the desired behavior contribute to the treatment goals. A person's merely attending counseling

sessions may not affect his or her drug use. Of course, all rewards must be delivered as promised for the treatment to remain credible (Crowley 1999; Morral et al. 1999).

Specialized assessment and treatment planning instruments are not required for successful implementation of a CM intervention. However, CM interventions depend on detailed and precise measurements of the targeted behavior. Because of the short half-life of alcohol, using CM procedures to monitor alcohol abuse can be difficult. Self-reported drug use status is not adequate for awarding vouchers. Rather, drug use status must be determined by frequent testing of observed urine specimens (Crowley 1999). Similarly, if work activity is the target behavior, it is not enough to ask clients about their attendance or productivity. Objective, verifiable measures that demonstrate accomplishments must be used.

Activity schedules used in CR and CM programs can vary dramatically. As an example, the activity schedule of an intensive reinforcement-based day hospital program provided abstinence-contingent partial support of housing and food and access to recreational activities, social skills training, and job-finding groups (Gruber et al. 2000). The program required clients recently detoxified from heroin and cocaine to attend treatment for 6 hours a day on weekdays and 3 to 4 hours a day on weekends for the first 2 weeks, then 1-hour individual counseling sessions three times per week for the next 6 weeks, and then two sessions per week for another 4 weeks. Abstinence-based contingencies were in effect for the first month of the program. By contrast, the schedule for a 6-month CR-plus-vouchers treatment entailed 60-minute individual counseling sessions two times a week and urine monitoring three times a week during the first 12 weeks. This was followed by weekly counseling and twice weekly urine testing in weeks 13 to 24 (Budney and Higgins 1998).

Exhibit 8-6 summarizes the strengths and challenges of CR and CM.

Other Important Aspects

Staff

Designing CR and CM treatment programs requires specialized training and knowledge of operant learning principles. In practical terms, however, operant learning principles can be applied by staff members who have proper training and supervision. Some counselors may feel that the theories of operant conditioning or behavioral learning are inconsistent with the disease concept of substance use disorders (Bigelow and Silverman 1999) and are incompatible with their training and practice because behaviorists view addiction as a learned behavior rather than an illness with biological, psychological, and spiritual roots.

Clients

Intensive CM interventions have been used with treatment-resistant clients and with clients who have severe problems related to employment or housing or who have psychological and medical conditions and have been unsuccessful in achieving abstinence through traditional counseling methods.

Behavioral interventions have been effective with people who use cocaine (Higgins 1999), persons who are

homeless (Milby et al. 1996), pregnant women (Higgins 1999), and individuals on methadone who need to discontinue other drug abuse (Higgins 1999).

Funding

The cost-effectiveness of CR and CM is affected by the expense of incentives, additional urine screens, and the additional time demands placed on staff members. In some research projects incentives cost \$1,200 or more per client. This expense has limited application of CM techniques to research studies or small-scale project demonstrations. However, alternative low-cost incentives can be used to bolster the effect of traditional treatment interventions; donated goods and services can reduce the costs of CR and CM (Amass and Kamien 2004). Anniversary celebrations, special books, reductions in clinic fees, and letters of support to employers and protective service workers are among the incentives that can be used. Some programs have raised funds to support incentives or solicited local merchants for donations of goods or services (Kirby et al. 1999a).

Exhibit 8.5 Strengths and Challenges of Community Reinforcement and Contingency Management Approaches

Strengths

- CR and CM have been shown to reduce drug use significantly when incentives are used.
- CR and CM can be combined readily with other psychosocial interventions and pharmacotherapies.
- CR and CM can be implemented with a variety of low-cost incentives such as donated goods and services.
- CR and CM have proved effective for reducing drug use and increasing treatment compliance among clients with severe problems who are chronically substance dependent.
- CR and CM have extensive and robust scientific support in both laboratory and clinical studies.

Challenges

- Clients may return to baseline drug use rates when incentives are terminated.
- CM approaches can be labor intensive, require specialized staff or training for implementation, and entail frequent client attendance.
- For maximal effectiveness, rewards must be sufficiently large—and increase in value—to

- have continuing appeal to clients.
- Many research studies demonstrating CR and CM effectiveness have used small samples and incurred large costs for incentives.
- Resources required for implementing CR and CM (e.g., onsite urine-testing capabilities or alternatives to costly incentives) may be unavailable.
- Lack of emphasis on long-term supports is a potential drawback.

Research Outcomes and Findings

Studies show that the CM approach to treating substance use disorders has proved effective in motivating clients to achieve and sustain abstinence as well as increase their compliance with other treatment objectives (Bigelow and Silverman 1999; Higgins 1999; Morral et al. 1999). Generally, these studies have been conducted in outpatient settings in which delivery of incentives is coupled with traditional individual or group counseling and education services. More recently, the CM approach has been applied in intensive outpatient and day treatment settings.

The NIDA treatment manual on community reinforcement (Budney and Higgins 1998) has provided an impetus for using empirically established CM techniques for treating cocaine abuse. The manual presents findings from five controlled clinical trials that supported the superiority of CR plus vouchers over standard care. In one study, 75 percent of the clients participating in CR plus vouchers completed the program, compared with only 11 percent of standard care clients. Two subsequent studies showed that adding redeemable vouchers was more effective than CR as a standalone treatment (Higgins et al. 1995). A literature review of similar CR approaches found positive effects on cocaine dependence in 11 of 13 studies (Higgins 1996). Higgins and colleagues (2000) found that incentives delivered contingent on cocaine-free urinalysis results significantly increased abstinence during treatment and at 1-year followup.

Another landmark CM study examined the effectiveness of housing incentives for reducing crack cocaine use among people who are homeless (Milby et al. 1996). Incentives for drug-free housing and vouchers for social and recreational activities were more effective than 12-Step-oriented treatment alone for reducing alcohol and cocaine use as well as homelessness. At the 12-month followup, however, cocaine use in both groups had returned to baseline levels, suggesting the need for more intensive aftercare in this difficult-to-treat population.

Citation

Center for Substance Abuse Treatment. Substance Abuse: Clinical Issues in Intensive Outpatient Treatment.

Treatment Improvement Protocol (TIP) Series 47. DHHS Publication No. (SMA) 06-4182. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006.

This work resides in the public domain, unless otherwise indicated.

RECOVERY ORIENTED SYSTEM OF CARE IN ADDICTION RECOVERY



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://cod.pressbooks.pub/therecoveryprocess/?p=150#oembed-1>

PART IV

UNIT 4: ETHICAL GUIDELINES FOR PEER RECOVERY SERVICES

Unit 4 starts with examining how behavioral health equity is promoted through word use and then moves to looking at the underlying CRSS code of ethics. A code of ethics is a set of guidelines which are designed to set out acceptable behaviors for a particular group, association, or profession.

“The CRSS code of ethics serves to:

1. Protect consumers of recovery support services
2. Set a professional standard
3. Increase confidence in the profession
4. Identify core values which underlie the work performed
5. Create accountability among CRSSS professionals
6. Establish occupational identity and maturity”

(Peer Specialist Code of Ethics and Professional Standards by Colorado’s Northeast Behavioral Health Partnership, 2011)

Ethical considerations need to reflect cultural diversity and inclusion which is accomplished by understanding cultural humility. This is a good ending to a unit devoted to ethical guidelines and how best to honor different routes to recovery.

Unit Objectives:

- Describe peer recovery support services
- Examine ethical principles for working with people in recovery
- Discuss why cultural humility is important as a CRSS

GUIDE TO EQUITY TERMINOLOGY: PROMOTING BEHAVIORAL HEALTH EQUITY THROUGH THE WORDS WE USE

In the field of behavioral health, **words** are often our primary tools. We don't have hammers and saws, thermometers and stethoscopes, or brushes and palettes. Words are powerful tools and using them with intention is central to our craft.

"I'll never forget, years ago, when I was asked to give a talk about tribes and behavioral health indicators, I presented the data showing higher rates of suicide, alcohol use, earlier ages of initiating substance use, etc. I thought I had done a good job of documenting 'need'. However, a tribal leader came up to me saying I had painted such a negative view of their community, I had said nothing about the richness and the survival strengths of their tribe."

This quote from Larke Huang, Director of the Office of Behavioral Health Equity (OBHE), underscores how our words have the capacity to uplift communities or to marginalize them.

How often have you asked yourself, "Should I say BIPOC (Black, Indigenous, People of Color) or People of Color? Limited English Proficient (LEP) or Non-English Language Preference (NELP)? Minority or minoritized? At OBHE, we receive these questions routinely and struggle with them often. There are times when an answer is straightforward, but more often, the complexity of the issue leads to the response: "It depends." Facing this ambiguity, we decided to develop a Guide to Equity Terminology (GET) as a decision-support tool. And, in recognition of July as Minority Mental Health Month, we are sharing a preview of the GET.

Principles of Behavioral Health Equity Terminology

Equitable terminology refers to consciously selecting words that promote inclusivity and respect while also considering who is represented and who is absent from the conversation. It is built on the following guiding principles:

1. **Person-Centered:** Prioritizing the whole person by considering their multiple intersecting identities and qualities, rather than reducing them to a single attribute. This often involves using person-first language, which puts the person before their diagnosis, disability, or other characteristics. Person-centered language also means deferring to the terminology expressed by individuals with lived experience.

2. **Strengths-Based:** Highlighting the inherent strengths and assets in all individuals, families, and communities. It seeks to depict people in terms of their strengths and assets rather than exclusively describing their vulnerabilities and weaknesses through a deficit lens. If referencing deficits is necessary in our work, then it is important to also counterbalance with strengths and assets.
3. **Non-Stigmatizing:** Avoiding discriminatory, prejudicial, offensive, and stigmatizing words. Stigmatizing language creates negative associations and devalues individuals, families, and their communities. It also can contribute to internalization of negative attitudes and beliefs, known as self-stigma or internalized stigma, which is often harmful to an individual's mental health and well-being.
4. **Ever-Evolving:** Adapting to changes in terminology. Language is fluid and changes with social norms. It also is context-dependent, meaning that terms deemed appropriate in one situation may not be suitable in another.

The Power of Words in Behavioral Health

Shifting Attitudes to Increase Support

Equitable terminology can shape the culture around behavioral health. The words we use can influence strategies to address challenges. For example, the term “substance abuse” implies a personal failure within an individual's control, cultivating prejudicial beliefs and hindering public support for treating addiction as a health condition. In contrast, using the term “substance use disorder” identifies the issue as a behavioral health condition, requiring public health support. Words can be tools for advocacy that nudge societal attitudes and policies towards a more inclusive and supportive approach to behavioral health.

Creating a Culture of Acceptance and Empowerment

Equitable terminology not only reduces stigma surrounding mental health and substance use but can also promote a culture of acceptance, inclusion, and dignity, where individuals are not devalued based on their behavioral health status. This process can encourage the development of environments that foster empowerment in seeking behavioral health services and resources.

Acknowledging Historical and Systemic Influences

Equitable terminology acknowledges the historical and systemic factors that contribute to behavioral health disparities, including the impact of social determinants of health influenced by racism, colonization, ableism, and other forms of oppression. For instance, “minority” indicates a numerically smaller group compared to “majority,” but the term “minoritized” implies that societal power structures actively marginalize certain

groups. This nuanced shift in terminology underscores the active process of marginalization that unfairly disadvantages specific groups.

Adopting Terminology for Equity: Some Considerations

1. **Accept:** Understand that engaging in equity-related discussions may generate discomfort, as it often calls for addressing personal biases, presumptions, and areas of privilege.
2. **Be Respectful:** Acknowledge and respect how people choose to define and identify themselves.
3. **Learn and Listen:** Embrace the insights from those with different life experiences, especially people with lived experience. This might mean unlearning preexisting beliefs and attitudes that no longer match today's realities.
4. **Be Receptive:** Stay open to feedback and willing to adapt terminology with changing norms.
5. **Take Responsibility:** If you offend someone, even unintentionally, take responsibility and apologize. Mistakes are a part of being human, and normalizing apologies fosters a safe environment for difficult conversations about equity.
6. **Seek Education:** Find learning opportunities about equitable terminology, social determinants of health, and historical and systemic causes of behavioral health disparities. This information provides context and informs our word choice.
7. **Engage:** Stay in the conversation, even when unsure about the correct terms to use. Ask questions in good faith.

Resources

- SAMHSA: OBHE website
- SAMHSA: Language Access Plan
- Centers for Disease Control and Prevention (CDC): Inclusive Communication Principles
- CDC: Healthy People 2030 Social Determinants of Health
- National Institute on Drug Abuse (NIDA): Words Matter – Terms to Use and Avoid When Talking About Addiction
- Executive Order on Further Advancing Racial Equity and Support for Underserved Communities Through the Federal Government

Citation

Cafaro, Cori. "Guide to Equity Terminology: Promoting Behavioral Health Equity through the Words We Use." SAMHSA, 27 July 2023, <https://www.samhsa.gov/blog/guide-to-equity-terminology>.

CODE OF ETHICS FOR CRSS PROFESSIONALS

Introduction

A code of ethics is a set of guidelines which are designed to set out acceptable behaviors for members of a particular group, association, or profession. The CRSS code of ethics serves to:

- Protect consumers of recovery support services
- Set a professional standard
- Increase confidence in the profession
- Identify core values which underlie the work performed
- Create accountability among CRSS professionals
- Establish occupational identity and maturity

Code of Ethics for CRSS Professionals

1. CRSS professionals will, when appropriate, openly share their stories of hope and recovery and will likewise be able to identify and describe the supports that promote their recovery and resilience.
 - Science has shown that having hope is integral to an individual's ability to recover. Hearing stories of recovery helps people develop hope, particularly when those stories are relevant to others' lives and helps them to identify supports for their own recovery.
2. CRSS professionals will practice safe and healthy disclosure about their own experience through general sharing focused on providing hope and direction toward recovery.
 - The experience of recovery and what is helpful is different for each person. Sharing one's recovery story can promote hope, but must not be prescriptive.
3. CRSS professionals will maintain high standards of personal conduct and will also conduct self-care in a manner that fosters their own recovery.

- As a role model, a CRSS professional's integrity and health choices influence the practices of persons served.
4. CRSS professionals will fairly and accurately represent themselves and their capabilities to individuals they serve and to the community.
 - The goal is to get a person to the right source of support for their current need. Damage occurs when a professional misrepresents what services they are qualified to provide.
 5. CRSS professionals will keep current with emerging knowledge relevant to recovery and openly share their knowledge.
 - Persons served deserve to make choices based on the best information possible. Information and understanding regarding mental health recovery is ever evolving and expanding.
 6. CRSS professionals will not abuse substances under any circumstances.
 - As a role model, a CRSS professional's integrity and health choices influence the practices of persons served.
 7. CRSS professionals will provide services to meet the identified needs of the individuals they serve as indicated within their service plan. They will avoid providing services that are unnecessary or not capable of producing the desired effect.
 - Persons served deserve individualized services with demonstrated effectiveness.
 8. CRSS professionals shall only provide service and support within work hours and locations approved by the agency.
 - Persons must be afforded protection from abuse, misconduct and conflicts of interest which are more likely to occur outside the scope of professionally sanctioned hours and settings.
 9. CRSS professionals will be guided by the principle of consumer self-determination while also considering the needs of others and society. The primary responsibility of CRSS Professionals is to help individuals they serve achieve their goals, based upon their needs and wants.
 - While personal responsibility and individual choice are cornerstones of recovery, these are balanced by the need for support and safety not only of the individual, but of others and the greater society.

10. CRSS professionals will advocate for the full involvement of individuals they serve in communities of their choice with services in safe and least restrictive environments possible.
 - Recovery is the process by which persons with mental illnesses live, work, learn and participate fully in their communities. All individuals have the right to live in a safe and least restrictive environment.
11. CRSS professionals must not discriminate against individuals based on race, religion, age, sex, disability, ethnicity, national ancestry, sexual orientation or economic condition.
 - Individuals have the right to be treated with equality and esteem.
12. CRSS professionals will never intimidate, threaten, harass, financially exploit, use undue influence, physical force or verbal abuse, or make unwarranted promises of benefits to the individuals they serve.
 - Even when providing peer support services, the CRSS professional is at least implicitly in a position of power as a staff person and must be careful how that influence or perceived authority might place pressure upon individuals.
13. CRSS professionals will avoid relationships or commitments that conflict with the interests of individuals they serve, impair professional judgment, imply a conflict of interest, or create risk of harm to individuals they serve. When dual relationships are unavoidable, it is the responsibility of the professional to seek supervisory consultation to conduct him/herself in a way that does not jeopardize the integrity of the helping relationship.
 - Even when providing peer support services, the CRSS professional is at least implicitly in a position of power as a staff person and must be careful how that influence or perceived authority might place pressure upon individuals.
14. CRSS professionals will never engage in romantic or sexual/intimate activities with the individuals they serve. They will not provide services to individuals with whom they have had a prior romantic or sexual relationship.
 - The real and perceived power between a human service professional and the persons they serve creates an imbalance of power that is advantageous to the professional and disenfranchising to the person served. This removes the possibility for a genuine consensual relationship. Relationships of this type also cloud the professional's needed objective judgment, which reduces the quality of services the person deserves.

15. CRSS professionals will not accept gifts of significant value from individuals they serve. They do not loan, give, or receive money or payment for any services to, or from, individuals they serve.
 - Even when providing peer support services, the CRSS professional is at least implicitly in a position of power as a staff person and must be careful how that influence or perceived authority might place pressure upon individuals to give.
 - A gift of significant value from a consumer is essentially payment for a service that is already being paid for by other means. Receiving a gift from an individual may also unintentionally impact the treatment of that individual and other persons served in an unfair manner.
16. CRSS professionals will, at all times, respect the rights, dignity, privacy and confidentiality of those they support. CRSS Professionals will respect confidential information shared by colleagues in the course of their professional relationships and interactions.
 - Individuals have rights, including the right to privacy, and CRSS professionals should not only honor, but advocate for the necessity and enforcement of such rights.
17. CRSS professionals have a duty to inform appropriate persons when disclosure is necessary to prevent serious, foreseeable, and imminent harm to an individual they are serving or other identifiable person. CRSS Professionals working in the human services field are mandated reporters of abuse, neglect and exploitation.
 - The professional has a duty not only to protect persons served, but also other individuals and society at large.
18. CRSS professionals will avoid negative criticism of colleagues in communicating with individuals they serve and other professionals.
 - CRSS professionals must use their influence for constructive purposes and not engage in activities that detract from the recovery support of persons with mental health challenges. Persons served benefit from a thoughtful, team based approach where their welfare is the primary concern.

Citation

Illinois Department of Human Services, Division of Mental Health (2022). Code of Ethics for CRSS Professionals. Adapted from the Peer Specialist Code of Ethics and Professional Standards by Colorado's Northeast Behavioral Health Partnership, 2011.

CULTURAL HUMILITY PRIMER

Peer Support Specialist and Recovery Coach Guide to Serving and Supporting Diverse Individuals and Their Recovery Journeys

Multiculturalism Overview

In this primer the use of the term “Peer Support Specialist and/or Recovery Coach” refers to the individual providing services and the term “program participant” is used to identify the individual receiving services and supports. This primer was created as an entry level cultural reference for Peer Support Specialists and Recovery Coaches, working in both Substance Use Disorder and Mental Health fields. The stories and experiences are personal to the individuals who authored each section. The appendices contain definitions of words (glossary), acronyms, references, and tools.

The Cultural Humility Primer for Peer Specialists has adapted some of its components from Multicultural Counseling Competencies (MCCs) for this publication. MCC is a model in the counseling field that addresses three main domains:

- Peer *knowledge* about different cultures and cultural perspectives.
- Peer *skills* to utilize culturally appropriate approaches.
- Peer *awareness* of their own and their cultural heritage and the influence of culture on attitudes, beliefs, and experiences.

This overview explores two major areas:

1. The program participant’s perception of the Peer Support Specialist’s and/or Recovery Coach’s awareness of *cultural humility*, and,
2. The degree to which the Peer Support Specialist and/or Recovery Coach addresses culture and *cultural opportunities* in the peer support encounter and intervention.

Cultural humility refers to the ability to maintain an interpersonal stance that is “other- oriented” (or open to the other person) in relation to aspects of cultural identity that are most important to the person with whom you are engaging. Cultural humility contains both intrapersonal and interpersonal dimensions.

Intra-personally, cultural humility depends on the Peer Support Specialist’s and/or Recovery Coach’s openness to accepting that their own cultural identities and experiences will limit their perspective and awareness in understanding the cultural experiences of others.

The interpersonal dimension of cultural humility involves an “other-oriented” perspective that includes openness, respect, consideration, humility, and interest regarding the program participant’s cultural identity and experiences.

Be aware that it is usually much easier to empathize with people that are more like you than not. You must employ cultural humility and personal honesty and awareness so that you can see through your own bias.

Definitions

As a peer practitioner, you are encouraged to stay in your lane while doing all you can to educate yourself on best practices. Look for “cultural opportunities” in your work as a Peer Support Specialist and/or Recovery Coach. Cultural opportunities refer to moments in your work when you are presented with opportunities to address and focus on the program participant’s cultural identity. For example, a cultural opportunity may emerge when a program participant of a marginalized racial group discusses depression that is linked to being treated unjustly in the workplace. This presents an opportunity for you to explore potential discrimination, privilege, fragility, and micro- aggressions relative to cultural identity. Here are some definitions to help you further study culture as it relates to the work you do as a Peer Support Specialist and Recovery Coach. The definitions below are from Wikipedia.

White Privilege

White Privilege (or white skin privilege) is the **societal privilege that benefits white people over non-white people**, particularly if they are otherwise under the same social, political, or economic circumstances. “She doesn’t know she has white privilege because she has never had to worry about getting pulled over or targeted for shoplifting in a grocery store.”

White Fragility

White Fragility refers to discomfort and defensiveness on the part of a white person when confronted by information about racial inequality and injustice.

“Her indignant reaction comes off as the quintessential combination of White Fragility and White Privilege.”

Implicit Bias

Bias that results from the tendency to process information based on unconscious associations and feelings, even when these are contrary to ones conscious or declared beliefs is called Implicit Bias.

Cultural Humility

The ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the [person].[1]” Cultural Humility is different from other culturally-based training ideals because it focuses on self-humility rather than achieving a state of knowledge or awareness.

Cultural Appropriation

Cultural Appropriation, sometimes called, cultural misappropriation, is the adoption of an element or elements of one culture or identity by members of another culture or identity.

Micro-aggression

Micro-aggression is a term used for brief and commonplace, daily verbal or behavioral indignities, whether intentional or unintentional.

Peering-in, A Multicultural Lens

People with white skin have been the predominate population of mental health professionals in the counseling field in the United States (U.S.), as with most other professions during the first 200 years of the country’s existence; yet this was also a time in which peer support did not exist. Like most institutions of higher learning that did not admit women and men of color, these institutional inequalities still influence the counseling, and subsequently the peer support fields today. In 2015, the American Psychological Association reported that 86% of psychologists in the U.S. identified as White, 5% Asian, 5% Hispanic, and 4% identified as African American. This distribution of identities among professionals doesn’t reflect the country’s overall demographics which are: 60.4% White, 18.3% Hispanic/Latino, 13.4% African American, and 5.9% Asian, according to 2018 census data. These disparities in representation also correspond to the demographic information available about Peer Support Specialists. Think about where you work right now as a Peer Support Specialist. Is it diverse? Do the people in charge reflect the individuals being served? The answer is likely, no.

In a world that does not represent, hire and promote individuals equally- what is your responsibility? Why should you care about cultural humility and multiculturalism?

Peer Support Specialists are often the first people that program participants meet. Engagement is crucial in the beginning of a peer helping relationship. Having a multicultural lens means that you are open, know your own bias, are flexible, and know when you do not know something. You understand how critical it is to feel like you are not alone and that someone “gets” you, as a peer. Feeling understood and “seen” is one of the most crucial components to recovery for both mental health and substance use disorders. In each of the scenarios

we provide, we will present evidence to support the life and death impact that paying attention to a person's culture can yield. So how do you develop multicultural awareness and cultural humility as a Peer Support Specialist? By understanding how you process data.

Principles of Cultural Humility

Cultural Humility Principles

1. Lifelong commitment to learning and critical self-reflection;
2. Desire to fix power imbalances within provider-client dynamic;
3. Institutional accountability and mutual respectfully partnership based on trust.

Step 1: Assessment

- What do you need to know about other cultures?
- Why do you want to know about it?

Step 2: Awareness

- Be aware of your own bias and ignorance.

Step 3: Educate yourself

- Read about other cultures and ask questions when you have them. Make sure that you do not fall into a well-meaning trap of "Asking to teach." Sometimes when we are educating ourselves, we go to the nearest person we know from the culture we want to learn about.

Step 4: Implementation of new knowledge

- We use the word humility for a reason when it comes to other people's experiences of their culture. Everyone is an individual. Understand that just because you read about a culture in a book it does not necessarily (if ever) mean that you fully understand all aspects of a culture. There are cultures within cultures as well subcultures

"Each person's level of awareness is determined by their ability to judge a situation accurately both from their own viewpoint and the viewpoints of members in other cultures." – Dakota Steel

Cultural Encapsulation/Blindness

Gilbert Wrenn described individuals as “culturally encapsulated” when they define reality according to one set of cultural assumptions. Below is a table of cultural challenges defined by Wrenn that relate very well to Peer Support Specialists and Recovery Coaches when cultural humility and multiculturalism are ignored. Use Cultural Humility to combat Cultural Encapsulation, also known as Cultural *Blindness*.

The first step of developing multicultural competence is an assessment of your personal and professional cultural awareness needs. Becoming aware of culturally learned assumptions as they are both similar and different from members of other cultures is the foundation of peer support core competence.

Classification of Disabilities

Every person has skills, abilities, and their own uniqueness, regardless of the challenges that they may face (check out the Tools in the Appendices for more information). The following pages will describe the eight Classifications of Disability according to disabledworld.com.

Categories of disability include various physical and mental impairments that can hamper or reduce a person’s ability to reach their goals when working with a Peer Support Specialist. These impairments can be termed as a disability if the person struggles with his/her/their/zer, day to day activities. Disability can be broken down into the following eight broad sub-categories.

Mobility and Physical Impairments

This category includes people with varying types of physical disability, including:

- Upper limb(s) disability
- Lower limb(s) disability
- Manual dexterity
- Disability in co-ordination with different organs of the body
- Disability in mobility can be either an in-born or an acquired with age problem. It could also be the

effect of a disease or accident.

Spinal Cord Disability

Spinal Cord Injury (SCI) can sometimes lead to lifelong disabilities. This kind of injury is usually due to severe accidents. The injury can be either complete or incomplete. In an incomplete injury, the messages conveyed by the spinal cord are not completely lost. A complete injury results in a total dis-functioning of the sensory organs. In some cases, spinal cord disability can be a birth defect. It is not okay to ask, “What happened?” when you’re working with a program participant in a wheelchair

Head Injuries – Brain Disability

A disability in the brain occurs due to a brain injury. The magnitude of the brain injury can range from mild and moderate to severe. An Acquired Brain Injury (ABI) is an injury to the brain that is not hereditary, congenital, degenerative, or induced by birth trauma. Essentially, this type of brain injury is one that has occurred *after* birth. The injury affects the physical integrity, metabolic activity, or functional ability of nerve cells in the brain.

An acquired brain injury is the umbrella term for all brain injuries. There are two types of acquired brain injury: Traumatic and Non-Traumatic.

- Non-Traumatic Brain Injury (NTBI)
- Traumatic Brain Injury (TBI)

Vision Disability

There are hundreds of thousands of people that have various, minor to serious, vision disability or impairment. These injuries can also result in serious problems or diseases like blindness and ocular trauma. Some of the common vision impairments include scratched cornea, scratches on the sclera, diabetes related eye conditions, dry eyes, and corneal graft.

Hearing Disability

Hearing disabilities include complete or partial deafness. People who are hard of hearing can often use hearing aids to assist their hearing. Deafness can be evident at birth or occur later in life from several biological causes, for example Meningitis can damage the auditory nerve or the cochlea. People that are deaf or hard of hearing use sign language as a means of communication. Hundreds of sign languages are in use around the

world. In linguistic terms, sign languages are as rich and complex as any oral language, despite the common misconception that they are not “real languages.”

Cognitive or Learning Disabilities

Cognitive disabilities are impairments present in people who are living with dyslexia and various other learning difficulties. This category also includes speech disorders.

Psychological Disorders

These disorders of mood or feeling states can be either and both short or long in duration. Mental Health Impairment (MHI) is the term used to describe people who have experienced psychiatric challenges or illness such as:

- Personality disorders: Defined as deeply inadequate patterns of behavior and thought of sufficient severity to cause significant impairment to day-to-day activities.
- Schizophrenia: A mental disorder characterized by disturbances of thinking, mood, and behavior.

Invisible Disabilities

Invisible disabilities are those that are not immediately apparent to others. It is estimated that 10% of people in the U.S. have a medical condition considered to be an invisible disability.

Invisible Disabilities

What are Invisible Disabilities?

An invisible disability is a physical or mental, or physic-mental (co-occurring) impairment that limits one or more major life activities. These conditions and their symptoms are not outwardly apparent to others. These disabilities may be hard for a Peer Support Specialist and/or Recovery Coach to identify. This can lead to extreme frustration and hopelessness for individuals living with the disability. Invisible disability is a broad term that covers several health concerns, including the following:

- Chronic fatigue syndrome
- Diabetes
- Fibromyalgia
- Mental Health Conditions

- Substance Use Disorders
- Arthritis
- ADHD (Attention Deficit Hyperactivity Disorder)
- Autoimmune disorders

Diseases such as cancer also can be considered invisible disabling conditions. Unless a person loses hair or drops a significant amount of weight, outsiders may not realize that they are ill. If a person is walking with a cane, vomiting, wearing a cast, gaining weight or any other number of signs that suggest a health concern, the illness is clear even to strangers. However, the flip side is that when a condition is not outwardly identifiable, some may have difficulty accepting that there is a challenge. How, as a Peer Support Specialist and/or Recovery Coach, can you best support an individual with a hidden disability? The next page provides a few tips.

As a Peer Support Specialist and/or Recovery Coach, you will likely work with someone with a hidden disability. Do not assume it. Ask about it.

Tips for Working with Program Participants Who Identify as Having Hidden Disabilities

- Do not assume that because you cannot see it, that it is not real and poses a regular challenge for someone. If they say it is a challenge- it is.
- Just because you may not have heard about it, does not mean it does not exist.
- Remain open-minded and ask yourself if there is more to knowing and understanding what the program participant is going through that would assist them in reaching their identified goals. Is the disability interfering with goal accomplishment? Does the person want assistance?
- Examine your personal bias and resist making judgements about what a person can or cannot achieve based on what you see. Continually check-in with them. Ask questions politely.
- Do not diagnose a potential or hidden disability. Make appropriate referrals. You are not a counselor or a doctor. Use appropriate boundaries and remember your ethics and boundaries training.
- Always be open to special or unique needs and be supportive.
- Trust and believe what the program participant is telling you.
- Co-research the hidden disability and provide education.
- Be curious, not critical. We tend to reject what we do not know or believe. Remember the ladder of inference?
- We may not be able to relate to a situation exactly, but we are all human and we have felt pain, joy, and sadness. Relate to the feelings being expressed.

Rather than thinking “disability,” let us think, “different abilities” or “differently abled.” Bear in mind that every person has skills, abilities, and their own uniqueness regardless of the challenges they may face.

Invisible Disability Scenario

Jose, he/him, is a Peer Support Specialist and Recovery Coach. He is working with Andreas, they/them, who has gone back to school. Andreas is 38 years old and has not been in school in a very long time. Andreas has told Jose about their fear of going back to school because they have been told their whole life that they have a learning disability. They do not really know what it -is. They know they are struggling and need to ask for help. They have been clean and sober for two years and have been working with Jose the whole time they have been in recovery. Andreas has reached out to Jose to get support in telling their new school that they need extra support. Jose has never had a hidden disability and will use cultural humility to find out more information.

If you were Jose:

- How would you approach the situation?
- What questions would you ask?
- How could you use your personal story to assist Andreas?
- What would you do if you did not have personal experience with a hidden disability?

Suggested approach

Jose will approach the situation based on the trust built in this relationship. He will ask Andreas what questions are acceptable and what may make them feel uncomfortable. He will find out if they would like a referral to a specialist to further explore what is challenging them. He will refrain from diagnosing and playing the guessing game. He will use any part of his personal story he feels comfortable sharing. If he has not experienced a hidden disability, he will find a colleague or someone who has that is willing to share with Andreas, if that is something they are interested. He could ask the following questions:

- How can I best support you?
- How much support would you like?
- Would you like to set goals around this situation?

Visible Disabilities

What are Visible Disabilities?

A disability is defined as a condition or function that is judged to be *impaired* compared to the standard of an individual or group. The term is used to refer to an individual's functioning, including physical impairment, sensory impairment, cognitive impairment, intellectual impairment, mental illness, and other types of

challenges. Disability is conceptualized as being a multidimensional experience for the person involved. Often people without disabilities make assumptions about what it must be like to live without sight, legs, or the ability to hear. Their assumptions are often negative, and the opposite is often true. People who live with disabilities, have a more positive outlook on their quality of life than do the people that they reach out to for help.

There are three dimensions of disability that are nationally recognized:

- Body structure and function (and impairment thereof)
- Activity (and activity restrictions)
- Participation (and participation restrictions)

The classification also recognizes the role of physical and social environmental factors in affecting how people with disabilities can recover from behavioral health challenges. Disabilities can affect people in different ways, even when one person has the same type of disability as another person. There are many types of disabilities (differing- abilities) that affect a person's:

- Vision
- Movement
- Memory
- Hearing
- Mental Health
- Social Relationships
- Thinking
- Substance Use Disorder
- Trauma
- Learning
- Communicating
- Historical Trauma

Supporting Someone with Visible Disabilities

As a Peer Support Specialist and/or Recovery Coach, you will likely work with someone who has a disability. Do not assume it. Let them tell you in their own time about it. Do not assume that what you perceive to be a barrier is a barrier to the program participant that you are supporting.

Tips for Working with Program Participants Who Have Visible Disabilities

- Always think accessibility. Can they see, hear, and participate in all the activities that others are participating in? Are any accommodations needed? How can you find out?
- Use proper language to describe the disability and the person. If you do not know- Ask!
- Partner with the individual you are working with to identify potential personal and societal barriers they are experiencing.
- Examine your bias and resist making judgements about what a person can or cannot achieve based on what you see, feel, and think.
- Avoid assuming that the disability is the root of all unhappiness.
- Do not ask family members to be interpreters if the person is deaf or hard of hearing. English as a second language is not a disability, although you may need an interpreter for language accessibility.
- Trust and believe what the program participants say to you.
- Help only when assistance has been requested.
- Service animals are accommodations. Request permission before speaking or touching a service animal. Do not judge what a person considers to be a service or support animal.
- Be curious, not critical. We tend to reject what we do not know or believe.

Visible Disability Scenario

Belinda (she/her) is a 20-year old female. Chantelle (she/her) is Belinda's Peer Support Specialist. Eight months ago, on the way home from college for summer break, Belinda was in a multiple-car accident. As a result of the wreck, Belinda sustained a spinal cord injury, a mild traumatic brain injury, and a broken left wrist. She is in recovery and does not like to take the pain medication prescribed even though she needs it. Her wrist has healed but she still needs a walker to get around. Belinda came to see Chantelle for peer support because she noticed several personal challenges. She started feeling discouraged, angry, and overwhelmed. Her father (her primary natural support) from time-to-time, makes negative and hurtful comments about her disability. She wants Chantelle to help to set goals for independence and empowerment.

If you were Chantelle:

1. How would you approach the situation?
2. What questions would you ask?
3. How could you use your personal story to assist Belinda?
4. What would you do if you did not have personal experience with a visible disability?

Suggested approach

Chantelle could use open-ended questions, reflective listening and the S.M.A.R.T. (specific, measurable, achievable, realistic, and timed) method to set goals. Chantelle will want to know what Belinda's primary concern is, in order to prioritize goals. She will co-create a plan with Belinda to determine which areas to address first. Chantelle can use her own personal story to help Belinda deal with potential differences in expectations held by herself and those of her family members.

Chantelle can approach the situation based on a trusted relationship with Belinda. Belinda's primary concerns are 1. Healing from her injuries at her own pace; 2. Her relationship with her father and his lack of support; and 3. She is feeling discouraged and overwhelmed, which may indicate depression. Peer Support Specialists never diagnose. Chantelle can use her personal story like a seasoning. Her story is the salt and pepper while Belinda's story is the main course. Chantelle will use any part of her personal story she feels comfortable sharing. If she has not experienced a disability, she will find a colleague or someone who has, and is willing to share with the program participant she is supporting. She will consult her supervisor anytime she has a question or is unsure of how to proceed.

Black and African American Cultural Perspective

Overall mental health and substance abuse challenges occur in Black and African American people in America at about the same or less frequency than in Caucasian Americans. Historically, however, the Black and African American experience in America has, and continues to be characterized by trauma and violence more often than for their Caucasian counterparts and impacts the emotional and mental health of both youth and adults.

When you are not African American or Black and you are working with a person of color, you must be aware of power dynamics, your implicit bias, and the potential micro-aggressions in the assistance you are providing. Historical dehumanization, oppression, and violence against Black and African American people has evolved into present day racism and cultivates a uniquely mistrustful and less affluent community experience. Using cultural humility, you can create a trusting relationship by asking a person about their experience in their culture and how it relates to their recovery.

Statistics

- Historical adversity, which includes slavery, sharecropping, and race-based exclusion from health, educational, social, and economic resources translates into socioeconomic disparities experienced by Black and African American people today.
- 13.4 percent of the U.S. population, or nearly 46M people, identify themselves to be Black or African American and another 2.7 percent identify as multiracial.

- Overall, 24 percent of Black and African American people have a bachelor's degree or higher, as of 2017.
- The Black immigrant population in the U.S. increased from 816,000 in 1980 to over 4.2M by 2016. 39 percent were from Africa and nearly half were from the Caribbean.
- More than 1 in 5 Black and African American people in the U.S. lived in poverty as of 2018.
- Socioeconomic status is linked to mental health and substance use and abuse, meaning that people who are impoverished, homeless, and incarcerated are at a higher risk of not getting their recovery needs met.

Despite progress made over the years, racism continues to have a negative impact on the mental health and substance use recovery of Black and African American people. Negative stereotypes and attitudes of rejection continue to occur with measurable, adverse consequences. Historical and contemporary instances of negative treatment have led to a mistrust of authorities and people in positions of power.

Some of the recovery challenges African Americans face are in overcoming the false assumptions held by some Peer Support Specialists and Recovery Coaches. One assumption is that African Americans all respond to getting help in the same way.

"African Americans are not all the same," Licensed Professional Counselor and peer, Danny Eagleton explains. "Many come from backgrounds where counseling and involving others is taboo. Ethiopians, Nigerians, West Indies, Ghanaian, Southern, Eastern, Midwest, West Coast, Suburban, Urban, rural, and low-income, all have different experiences."

It is important for Peer Support Specialists and Recovery Coaches to understand when they are making assumptions; and to more importantly, understand that people are not all going to respond to peer support in the same way. Individualized and tailored care is the cornerstone of Cultural Humility.

It is important to understand power in relationships. Approach people of color with Cultural Humility always. If you are a person of color, it is also critical that you do not make assumptions. Do not think that because of the color of someone's skin, they will be a certain way. They will not. All people are individuals.

Think about ways you can even the playing field in your environment, words, and actions. Think about the concepts we have discussed and how they will apply to your peer support and recovery coach work. If you are working in mental health, substance use disorders, co-occurring disorders, or doing community work, there is a power dynamic. You have more power than the person you are healing. Recovery Coaching and Peer Support models are designed to create mutuality in the relationship. Mutuality means that both parties are enhanced positively by the relationship. Therefore, your work is not clinical. Your work is based on your lived experience.

Watch for Implicit Bias and Micro-aggressions. **Implicit Bias** refers to the attitudes or stereotypes that

affect our understanding, actions, and decisions in an unconscious manner. **Micro-aggressions** are brief and commonplace, daily, verbal, or behavioral indignities, whether intentional or unintentional that communicate hostile, derogatory, or negative attitudes toward stigmatized or culturally marginalized groups.

Black and African American Cultural Scenario

Recovery Coaches and Peer Support Specialists help individuals feel safe and understood by being transparent and using their lived experience. This helps to create trust and instill hope. After you have educated yourself, please do not assume that every African American and Black person feels oppressed or limited. This is not the case. Treat each person you support as an individual.

Jackson, he/him, is a 6ft tall 270-pound ex-football player who identifies as Black. He has had challenges in the past with alcohol, but Jesse, he/him, his Recovery Coach, has helped him get into treatment and he has remained sober for 2 years. He has no record and has maintained a B average in college. Jesse has not seen Jackson since he was discharged from Intensive Outpatient Treatment six months ago. When Jesse asks Jackson why he made the appointment to see him, this is what Jackson said:

“Last week I was pulled over and the police officer put his hands on me. He slammed my head on the car and kidney punched me. My side still hurts. He did not give me a ticket or tell me why he pulled me over. I am in shock and I do not know what to do. I feel scared and angry. I do not want to make a complaint, but I... I just do not know what to do. I know a drink won’t make this better but right now it sounds really good.”

If you were Jesse:

- How would you approach the situation?
- What questions would you ask?
- How could you use your personal story to assist Jackson?
- What would you do if you did not have personal experience with his culture?

Suggested approach

Jesse will approach the situation with cultural humility, knowing that they have a trusting relationship. He could ask Jackson if he has gone to the hospital or would like to go. His job is to make sure Jackson is physically safe as well as mentally safe. If he wants to go to the hospital, Jesse will talk to his supervisor to see if he can support him and how. He will use open-ended questions to talk about how Jackson feels about what happened.

Jesse will let Jackson lead with vulnerability. Jesse understands that a Recovery Coach empowers individuals to share their own story in their own time. He is like a recovery Sherpa, who guides and plans but does not walk

the walk for the people they are supporting. If Jackson does not feel he wants to go to the hospital, and Jesse believes he is safe, he will ask the following questions:

1. How can I best support you?
2. How much support would you like?
3. Would you like to set goals around this situation?
4. Is there any advocacy that I can partner with you on?

Jesse could use parts of his personal story that he feels comfortable sharing. If he has not experienced any related racism and trauma, he will find a colleague or someone who has, and that is willing to share about it with Jackson. He would only do this at Jackson's request. It is all about voice and choice!

Asian Pacific Islander Cultural Perspective

There are many cultures that fall under the Asian Pacific Islander (API) and Asian American Pacific Islander (AAPI) umbrella. The important thing, as always, is to not assume where someone is from because of how they look.

These communities in the United States have had to struggle to reconcile their identities and challenges while recognizing the privilege that comes with something called the “model minority” myth. The “model minority” myth is a micro-aggression known as “ascription of intelligence,” where one assigns intelligence to a person of color based on their race. It is important to recognize how the “model minority” myth plays into your personal bias and stereotypes as a Peer Support Specialist and/or Recovery Coach.

Foreigner stereotypes occur when someone is assumed to be foreign-born or does not speak English because of the way they look. Stigma from the COVID-19 pandemic in 2020, resurfaced micro and macro-aggressions against Asian Pacific Islanders, especially for those perceived as of Chinese descent.

Statistics

- There are over 20M people in the United States who identify as Asian Pacific Islander (6.1 percent of the overall population).
- As of 2018, there were 5.2M people of Chinese descent, 4.5M of (Asian) Indian descent, and 4.1M of Filipino descent, followed by 2.2M of Vietnamese descent, 1.9M of Korean descent, and 1.5M of Japanese descent.
- Over 420,000 (2.5 percent) of Asian Americans and more than 76,000 (7.6 percent) Native Hawaiian and Pacific Islanders are veterans.
- Nearly 54 percent of Asian Americans and 24.4 percent of Native Hawaiian and Pacific Islanders have a

bachelor's degree or higher.

- In 2018, 10.8 percent of Asian Americans lived at or below poverty level, and 6.2 percent were without health insurance. Hawaiian Natives and Pacific Islanders fared slightly worse with 14.8 percent at or below poverty level, and 8.6 percent went without health insurance.

There have been important studies on mental health and substance use disorders for the AAPI and API communities. The National Asian Women's Health Organization (NAWHO) sponsored a study called, *Breaking the Silence: A Study of Depression Among Asian American Women*. Here are a few findings:

- Conflicting cultural values are impacting Asian-American women's sense of control over their life decisions.
- Feeling responsible, yet unable to meet biased and unrealistic standards set by families and society, contributes to low self-esteem among Asian-American women.
- Asian-American women witness depression in their families but have learned from their Asian cultures to maintain silence on the subject.
- Asian-American women fear stigma for themselves, but more so for their families.

According to SAMHSA's National Survey on Drug Use and Health, mental health issues are on the rise for Asian American/Pacific Islander/Native Hawaiian young adults:

- Serious mental illness (SMI) rose from 2.9 percent (47,000) to 5.6 percent (136,000) in AAPI people ages 18-25 between 2008 and 2018.
- Major depressive episodes increased from 10 percent-13.6 percent in AAPI youth ages 12-17, 8.9 percent to 10.1 percent in young adults 18-25, and 3.2 percent to 5 percent in the 26-49 age range between 2015 and 2018.
- Suicidal thoughts, plans, and attempts are also rising among AAPI young adults. While still lower than the overall U.S. population aged 18-25, 8.1 percent (196,000) of AAPI who were 18-25, had serious thoughts of suicide in 2018, compared to 7.7 percent (122,000) in 2008. 2.2 percent (52,000) planned suicide in 2018, compared to 1.8 percent (29,000) in 2008, and 7,000 more AAPI young adults tried suicide in 2018, compared to 2008.

Binge drinking, smoking (cigarettes and marijuana), illicit drug use, and prescription pain reliever misuse are more frequent among AAPI adults with mental illnesses which is similar to the rest of the U.S. population.

Language barriers, when present, make it difficult for Asian American Pacific Islanders to access mental health and substance use disorder services. Discussing mental health and substance use concerns are considered taboo in many Asian Pacific Islander cultures. Because of this, Asian American Pacific Islanders tend to dismiss,

deny, or neglect their symptoms. Everyone has a right to accessible treatment. Consider interpreters, phone translators, and computer translation programs, etc.

Esther Kim is a Certified Peer Counselor in Washington State. She is from South Korea and identifies as being a Korean American, first-generation immigrant. When interviewed, she had this to say to prospective Recovery Coaches and Peer Support Specialists:

"A Peer Support Specialist and/or Recovery Coach, can best help someone who identifies as being from the Korean culture by taking the first step to understand (Step 3 from this Primer on cultural humility) Korean culture. Understand the stigma that surrounds their views and attitudes against people living with mental illness and substance use disorders. South Korea is a very conservative and homogenous country. Everything out of the norm is shunned and looked down upon. People living with mental illness are considered out of the norm and taboo. You do not mention or talk about it freely in public. You should practice strict confidentiality as a Certified Peer Counselor and/or Recovery Coach when working with a person from Korea."

Many young Asian Americans tend to seek out support from personal networks such as close friends, family members, and religious community members rather than seek professional help for their mental health concerns. Keep this in mind as you read the scenario below.

Asian Pacific Islander Scenario

Jian Kim, he/him, is a new program participant and Davey Lamb, he/him, is his Peer Support Specialist. Jian goes by the name John since he moved to the United States. He is 23 years old and has never been to formal therapy. He made the appointment for peer support because he is very stressed out by school. He wants to change majors but does not think his family will approve. He cannot sleep and has started playing video games instead of doing his homework which has made him even more stressed out. He is looking for ways to tell his family that he wants to be a musician instead of a doctor.

Davey is Chinese American and understands family pressure very well. He takes John's concerns seriously.

If you were Davey:

- How would you approach the situation?
- What questions would you ask?
- How could you use your personal story to assist John?

- What would you do if you did not have personal experience with his culture?

Suggested approach

This is Davey's first meeting with John. Davey must identify what peer support is and what it is not. Confidentiality will be stressed at the earliest appropriate time in the meeting as stated earlier. He will make sure John knows what Davey's role is and what John's rights are. Davey will let him know his personal approach to peer support and give him the code of ethics that Davey co-created with his supervisor. The first meeting is by far one of the most important meetings in peer support. When there are potential cultural barriers, Davey will not be afraid to ask if John would like assistance with them. These can range from techniques to talk to his family to getting an interpreter for an important meeting or school appointment. There may be cultural and accessibility challenges, but Davey would not assume to know what they are, he would simply ask. The four questions below are good ice breakers that will let John know he is in the driver's seat – don't be afraid to make them your own by changing the words to suit your personal style.

1. How can I best support you?
2. How much support would you like?
3. Would you like to set goals around this situation?
4. Is there any advocacy that I can partner with you on?

Davey can use his personal story quite a bit with John because he has gone through a similar experience. If you have not experienced a situation like this and feel like you cannot relate after the first meet and greet, what can you do? Here are some suggestions:

- Ask John if he would like to talk with someone who has this specific lived experience, and if he says yes, assist him in connecting with a colleague or someone he can better relate to.
- Say something like this, "Hey John, I don't have this specific experience but I do know what it feels like to be stressed out about having to tell your family something they are not going to want to hear. Is there anything I can do to help you prepare for that conversation? Would you feel more comfortable talking to someone from a background and culture more like yours?"

Native American and Indigenous Cultural Perspective

In the nineteenth century Native Americans were violently taken from their lands and homes to reservations,

sometimes hundreds of miles away. Thousands died in such forced marches. Broken treaties, land frauds, and military attacks happened often.

Some tribes responded with armed resistance, like in the “Indian Wars” of the 1880s, but they were defeated.

In 1887, the General Allotment Act (or “Dawes Act”) nullified tribal land holdings, assigning each Native American 160 acres “in trust,” while the rest was sold. As “trustee,” the US government stole legal title to the parcels, established an Individual Indian Trust, and assumed full responsibility for management of the trust lands. In all, 90 million acres of land, or about 67% of Native American land was seized and the communal property system was destroyed.

Many Native/Indigenous tribes embrace a worldview that encompasses the concept of connectedness; strong family bonds, adaptability, oneness with nature, wisdom of elders, meaningful traditions, and a strong sense spirit may often serve as protective factors against mental health and substance use disorders. While many people of Native American descent find strength in these cultural practices and traditions, do not assume that all tribes and tribal activities are the same. Tribes are very different and have different cultures within a larger culture. For example, there are different languages, food, and ways of dressing among tribes. As a Peer Support Specialist and/or Recovery Coach, be prepared to know where indigenous people can go to get culturally appropriate resources, including mental health and treatment services.

If you have not had trauma-informed care training, it would be important to do so. Learn how to approach people who are experiencing historical trauma by using a trauma-informed lens.

Access to mental health services is severely limited by the rural, isolated location of many Native American/Indigenous communities. Access is limited because many clinics and hospitals are located on reservations. Many Native American /Indigenous people in America live outside of tribal areas and reservations. Do not assume that a person is from a reservation because they identify as being Native American/Indigenous. Use cultural humility and open-ended questions when you meet people from another culture. Do not wear culturally appropriated clothing or symbols. Do not co-opt a part of a culture because it is trending on Instagram. Trustworthiness is one of the most important ingredients in a peer relationship.

Krista Mahle is from Lummi Nation in Washington State. She teaches Recovery Coaching and Peer Support classes. She says:

"We are proud of who we are and will not accept being looked down on in any way. We have current and historical trauma that we deal with every day. It is important to be trauma-informed and ask, "What happened?" rather than "what is wrong?" -this is a way to move the focus from the person to the situation."

Native American and Indigenous Scenario

Hiaqua, he/him, is a part of a peer-led group that focuses on sobriety. Hiaqua has 2 years sober and wants to go on the annual Canoe Journey. The last time he went on the journey he embarrassed himself and his family by getting really drunk and high. He is afraid to tell his Recovery Coach, Jason, that he has decided to go. He does not want to answer too many questions about his culture, and he does not know if the other group members will think it is a good idea for him to go.

Hiaqua also has a Peer Support Specialist that he likes, trusts, and has worked with for about a year. His name is Tobias. Hiaqua has made an appointment with Tobias in order to get help with his decision to go on the Canoe Journey and to process with Tobias the ways to tell the group his decision. He believes that Tobias will have a more favorable view of the Canoe Journey than Jason. Hiaqua had also been on medically assisted treatment for the first year of his sobriety. He wants to talk to Tobias about the possibility of getting back on it.

If you were Tobias:

- How would you approach the situation?
- What questions would you ask?
- How could you use your personal story to assist Hiaqua?
- What would you do if you did not have personal experience with his culture?
- If, and when would you bring in Jason, Hiaqua's Recovery Coach?

Suggested approach

It is a good idea to participate in active listening, reflection, and paraphrasing. Using open-ended questions, Tobias will explore Hiaqua's concern about what the group might think about him. Tobias will ask him directly if he is afraid that he will relapse if he goes on the Canoe Journey. He never offers advice. He will ask

him what the Canoe Journey means to him. Tobias is concerned that Hiaqua wants to go back on medically assisted treatment. He believes in abstinence as he personally, works a 12-step program. Tobias has never given advice or discussed his preferred way of recovery with Hiaqua. He knows that there are many ways to recovery; and just because a 12-step program works for him it may not work for everyone. This is called recovery culture humility.

Peer Support Specialists and Recovery Coaches do not have all the answers. They only have their own lived experience to offer. Tobias will ask him if he has any natural supports, like friends or family going on the Canoe Journey that support his sobriety. He suggests having a meeting with both he and Jason to discuss the situation. Tobias and Jason will offer to make a relapse prevention plan for the trip if that is something Hiaqua wants. Here are some questions they can ask:

1. How can I best support you?
2. How much support would you like?
3. Would you like to set goals or make a plan around this situation?
4. Is there any advocacy that we can partner with you on?

Latinx and Hispanic Cultural Perspective

In the Latinx/Hispanic cultures family comes first, (usually after God). Traditional Latinx/Hispanic individuals are brought up very close to their immediate and sometimes even extended family members. Generally, elders are highly regarded, and children must respect their parents. Many families live in multigenerational households that include parents, siblings, and grandparents. Sometimes other extended family members also reside in the home at one point or another.

When working with Latinx/Hispanic individuals, it is best to remember that family may play a large role in their everyday lives. If working with someone from the Latinx or Hispanic population who has been separated from their family, it is important to start building natural supports right away. When working with the whole family, as a Peer Support Specialist or Recovery Coach, do not speak for the program participant. Do not ask a family member to translate. Do not assume that translation is necessary.

Remember peer support is voluntary and about voice and choice.

Hispanic and Latino are terms that are often used interchangeably though they mean two different things. Hispanic refers to people who speak Spanish or are descended from Spanish-speaking populations, while Latino refers to people who are from or descended from Latin America. In the United States, these terms are thought of as racial categories and are used to describe race in the same way as White, Black, and Asian Pacific Islander labels. However, the populations described by these terms are composed of various racial groups; thus, using them as racial categories is inaccurate.

A variety of cultures and subcultures are encompassed by each term. Make no assumptions about a person's

ethnicity. Ask people direct questions with respect and dignity. Use cultural humility to be open to learning new things about the people you are working with.

Latinx and Hispanic Scenario

Alex, he/him, is a 26-year-old Latino man who has been married for eight years. Pedro, he/him, is Alex's Recovery Coach. Alex has been in recovery for five years. He lives with his wife and three young children. He is meeting with Pedro because he had his first follow-up primary care visit after receiving an HIV diagnosis last month.

Alex stated that he has not shared the information about his HIV status with his family yet, because he is afraid that they will reject him. Alex is recovering from heroin abuse and has been very successful in his current career. He expressed to Pedro that he is afraid his friends and family might think he has relapsed. He wants to talk to Pedro and make a plan about how to tell his wife about his diagnosis.

If you were Pedro:

- How would you approach the situation?
- What questions would you ask?
- How could you use your personal story to assist Alex?
- What would you do if you did not have personal experience with his culture?

Suggested approach

Pedro and Alex have developed a trusting relationship and they come from similar backgrounds. Alex knows that Pedro understands how important his family is to him. Alex believes that to risk losing his family, is to risk losing everything important in life. Pedro is open and curious about what Alex is going through, and he is not critical at all. He uses open-ended questions and some of his personal recovery experience to bring hope to the interaction.

Pedro looks at pictures of Alex's family and comments on how much Alex has done for his family to support them and keep them safe. Alex agrees that safety and his love for his family is the most important thing to him. He and Pedro create a strategy to tell his wife about his diagnosis. Alex agreed to co-create a Wellness Recovery Action Plan with Pedro before he tells his wife. This is a type of relapse prevention plan that has been useful to Alex in the past. At no time would he accuse Pedro of relapsing.

Here are some questions that can be asked to guide in this situation:

1. How can I best support you?

2. How much support would you like?
3. Would you like to set goals or make a plan around this situation?
4. Can I partner with you in advocacy?

Gay, Lesbian, and Bisexual Cultural Perspective

People who are lesbian, gay, bisexual, or transgender (LGBT) are members of every community. We will speak in depth on the “T” portion of this acronym in the next module. People that identify as being a part of the LGBT community are diverse, come from all walks of life, and include people of all races and ethnicities, all ages, all socioeconomic statuses, and are from all parts of the country.

Lesbian, gay, bisexual, and transgender individuals still face extensive discrimination and prejudice in society. There has been a rise in violence perpetuated on people who are gay, lesbian, or transgender. Peer Support Specialist and Recovery Coaches can affirm a person’s ability to integrate their sexual identity in healthy ways into their personal recovery if that is what they choose to do. In order to best serve individuals that identify as (LGBT) you will need to learn some terms. These may or may not be familiar to you. Remember to be curious and not critical. Practice cultural humility, especially if you are from a religious background, as many religious organizations have had a history of discriminating against and stigmatizing gay, lesbian, bisexual, and transgender individuals.

Terms

Sexual Orientation

Sexual orientation is an enduring pattern of romantic or sexual attraction to persons of the opposite sex or gender, the same sex or gender, to both sexes or to more than one gender. These attractions are generally subsumed under heterosexuality, homosexuality, and bisexuality, while asexuality is sometimes identified as a fourth category.

Gender Identity

Gender is concept (rather than a tangible, physical feature like sex) that has been constructed by society. Gender identity is the personal sense of one’s own gender. Gender identity can correlate with a person’s assigned sex at birth or it can differ from it. Gender expression typically reflects a person’s gender identity, but this is not always the case. While a person may express behaviors, attitudes, and appearances consistent with a particular gender role, such expression may not necessarily reflect their gender identity. The term gender identity was originally coined by Robert J. Stoller in 1964.

Gender Expression

Gender expression, or gender presentation, is a person's behavior, mannerisms, interests, and appearance associated with gender in a particular cultural context, specifically with the categories of femininity or masculinity. This also includes gender roles. These categories rely on stereotypes about gender.

Gay

Gay is a term that primarily refers to a homosexual person or the trait of being homosexual. The term was originally used to mean "carefree," "cheerful," or "bright and showy." The term's use as a reference to male homosexuality may date to the late 19th century, but its use gradually increased in the mid-20th century. In modern English gay has come to be used as an adjective, and as a noun, referring to the community, practices, and cultures associated with homosexuality.

Lesbian

A lesbian is a homosexual woman. The word lesbian is also used for women in relation to their sexual identity or sexual behavior, regardless of sexual orientation. It can also be used as an adjective to characterize or associate nouns with female homosexuality or same-sex attraction.

Bisexual

Bisexuality is romantic attraction, sexual attraction, or sexual behavior toward both males and females, or to more than one sex or gender. It may also be defined as romantic or sexual attraction to people of any sex or gender identity, which is also known as pansexuality.

Transgender

Transgender people have a gender identity or gender expression that differs from their sex at birth. Some transgender people who desire medical assistance to transition from one sex to another identify as transsexual. Transgender, often shortened as trans, is also an umbrella term. In addition to including people whose gender identity is the opposite of their assigned sex, it may include people who are not exclusively masculine or feminine. Other definitions of transgender also include people who belong to a third gender or conceptualize transgender as a third gender.

Cisgender

Cisgender is a term for people whose gender identity matches their sex at birth.

Statistics

- Approximately 1 in 8 lesbian women (13%), nearly half of bisexual women (46%), and 1 in 6 heterosexual women (17%) have been raped in their lifetime. This translates to an estimated 214,000 lesbian women, 1.5M bisexual women, and 19M heterosexual women.
- 4 in 10 gay men (40%), nearly half of bisexual men (47%), and 1 in 5 heterosexual men (21%) have experienced Spousal Violence (SV) other than rape in their lifetime. This translates into nearly 1.1M gay men, 903,000 bisexual men, and 21.6M heterosexual men. The “Me Too” movement is not just for women.
- 44% of lesbian women, 61% of bisexual women, and 35% of heterosexual women experienced rape, physical violence, and/or stalking by an intimate partner in their lifetime.
- LGBT Veterans are at a disproportionate risk for suicide and other poor health outcomes, due in part to barriers in accessing services and lack of social support.
- According to the FBI data of the nearly 1,200 incidents targeting people due to their sexual orientation, the majority of the incidents targeted gay men (roughly 60%), while approximately 12% targeted lesbians, 1.5% targeted bisexuals, and 1.4% targeted heterosexuals.

As a Recovery Coach or Peer Support Specialist it is statistically likely that you will work with an individual who has been a victim of a hate crime. Cultural humility and trauma-informed care are called for in this situation. For those who survive hate crimes, the lasting physical and mental health challenges are immense and can lead to ongoing health problems. Peer support is an excellent intervention for individuals who have experienced trauma. If you are comfortable, this is a place where you can share parts of your story. This is where you can bring hope to a hopeless situation. Have plenty of culturally relevant resources and referral services available for people that have been traumatized. Suicide attempts among LGBTQ youth and adults occur at a significantly higher rate than in the general population. Understanding basic components of suicide prevention are a must. Mental Health First Aid and e-CPR are two excellent training choices that will help you and the peers with whom you work.

Take a minute to examine any personal bias you may have regarding culture. Identify where you may need more education. You can join a book club specifically based on cultural humility or ask a friend to recommend some books. As a Certified Peer Counselor and/or a Recovery Coach you need to engage in continuing education as the field of behavioral health is ever growing.

Gay, Lesbian, and Bisexual Scenario

Sheila, she/her, is a 19-year-old female. She is meeting with Rita, she/her, who is her Peer Support Specialist. Sheila has seen Rita about four times and really gets along with her and likes her. Sheila has known she was gay since she was eleven years old. She is from a strict African American, Baptist family that believes that people who are gay, lesbian, or bisexual will go to hell in the afterlife. Sheila is very worried that she will disappoint her parents if she reveals she is gay, yet she feels she must be herself. She cannot go on pretending to be someone she is not. She respects her parents' belief system but cannot believe in a God that would not accept her as she is. She asks Rita to help her write a letter to her parents. She knows what she wants to tell them: She is not going to attend church anymore and that she is gay. Sheila is scared and believes that her parents will kick her out of the house immediately, so she needs to work on finding emergency housing and on saving money so she can support herself. Rita has shared that she is a lesbian. Sheila hopes that Rita can help her make a plan and give her some resources.

If you were Rita:

- How would you approach the situation?
- What questions would you ask?
- How could you use your personal story to assist Sheila?
- What would you do if you did not have personal experience with this culture?
- Do you think this is an appropriate time to bring up any of your own personal experiences if you have them?

Suggested approach

Sheila, she/her, and Rita, she/her, have developed trust and they come from similar backgrounds. Sheila knows that Rita understands how important her family is to her. Rita will use her lived personal experience about the time she came out to her conservative and very loving family. She will not give advice or judge Sheila. Rita is Caucasian and will not pretend or (over) relate to Sheila's entire experience. She will use cultural humility, respect, and appreciative inquiry to find out what Sheila needs and how to best support her. She will tell her about Parents, Families, and Friends of Lesbians and Gays (PFLAG). PFLAG is a well-known and well-respected family resource. Rita will share statistics and health disparities with Sheila, engaging in psychosocial education from a peer perspective. Rita will discuss her own thoughts of suicide right before she came out and give Sheila the Trevor Project contact information. Rita will encourage Sheila to go at her own pace and consider all her options before she moves forward with a plan.

1. How can I best support you?

2. How much support would you like?
3. Would you like to set goals or make a plan around this situation?
4. Is there any advocacy that I can partner with you on?

Transgender Cultural Perspective

What Does It Mean to be Transgender?

According to Webster's dictionary, the term "transgender" means, "denoting or relating to a person whose sense of personal identity and gender does not correspond with their birth sex."

Dakota Steel is a member of the Cultural Coalition for Peers in Washington State. He describes being transgender as "being in the wrong package":

"It is often a dilemma of honesty and authenticity in a cold and judgmental world where people want other people to match their packaging."

Often, judgements about one's identity quickly turn into fear of the unknown and can lead to violence. Dakota has been injured by two violent attacks because of his identity, these attacks are called hate crimes. Sometimes people hate things they do not understand.

Assigning someone's sex is based on biology — chromosomes, anatomy, and hormones. But a person's gender identity — the inner sense of being male, female, or both — does not always match their biology. Transgender people say they were assigned a sex that is not true to who they are inside. Many people have assumptions about what it means to be transgender, but it isn't about surgery, or sexual orientation, or even how someone dresses. It is how they feel. The Williams Institute, says there are nearly 700,000 people living publicly as transgender in the U.S. Each one is unique, and their journeys are personal.

Peer Support Specialists and Recovery Coaches should understand some terminology before we move forward in this module. There are some terms that may confuse you or you have never heard before. None of the terms are meant to insult you or fly in the face of any values or beliefs you may have. Remember to be curious and not critical – and to approach all situations with Cultural Humility.

Terms

Binary – (noun)

The idea that there are only two genders — male/female or man/woman and that a person must be strictly gendered as either/or. Of or pertaining to someone who identifies with one of the binary genders (man or woman).

Cisgender or Cis – (adj; pronounced “siss-jendur”)

Frequently shortened to cis; a person whose gender identity and biological sex assigned at birth align (e.g., a cisman is man and male assigned at birth, a ciswoman is a woman and female assigned at birth).

Gender Expression – (noun)

The external display of one’s gender through a combination of dress, demeanor, social behavior, and other factors, generally measured on scales of masculinity and femininity. Also referred to as “gender presentation.”

Gender Identity – (noun)

The gender a person knows they are internally and how they label themselves. Common identity labels include male, female, genderqueer, non-binary, and more. Considered to be one aspect of sex. When gender identity conflicts with other sex characteristics, such as chromosomes or genitalia, a person’s internal gender identity replaces their sex assigned at birth.

Nonbinary – (noun)

Refers to any gender that is not exclusively male or female. A similar term is genderqueer.

Also is a way of thinking that sexuality, gender, and gender expression exist on a continuous spectrum as opposed to an either/or dichotomy.

Transgender or Trans – (adj)

Umbrella term covering a range of identities that transgress socially defined gender norms.

A person who lives as a member of a gender other than that assigned at birth. A trans man is a man assigned female at birth. A trans woman is a woman assigned male at birth. Trans does not indicate sexual attraction or sexual orientation.

Sex – (noun)

A vague term used to refer to a number of characteristics traditionally associated with males and females, including, but not limited to gender identity, sex chromosomes, genitalia (internal and external), endocrine system, and secondary sex characteristics. Often seen as a binary but as there are many combinations of chromosomes, hormones, and primary/secondary sex characteristics, it's more accurate to view this as a nonbinary spectrum.

Statistics

- 50% Must educate their healthcare teams,
- 65% Struggle with Substance Use Disorder,
- The average life span of a black trans woman is 35 years old,
- Depression and anxiety diagnosis 41%,
- 71% Hide their identity at work and do not feel safe to be themselves,
- Homelessness 40% (57% due to family rejection),
- 60% Do not have an ID that matches their gender identity,
- 1 in 6 Trans students leave school due to discrimination and bullying; and,
- Supported trans youth are 67% less likely to attempt suicide.

When working with a program participant who is transgender, they will likely have a few more barriers than other individuals you work with. They may not have a passport or driver's license that matches their identity. They may not have access to locker rooms or bathrooms where they feel safe. Traveling is often dangerous. They can be denied housing and lose or not get hired for jobs for which they are well-qualified. There are disproportionate rates of violence that transgender individuals may also face. When you start working with someone who is transgender, they may not have any natural supports to identify. They may have created their own family, and their biological family may have rejected them. Be aware of all these real barriers when you begin working with an individual who is transgender.

People that are marginalized or isolated from mainstream society often need more assistance than someone that isn't in a socially marginalized group. Individuals that identify with these groups are the most statistically underserved by both public and private services. Often they are chronically under or unemployed, making it less likely they can afford or obtain access to services like healthcare. These are called healthcare disparities. Healthy People 2020 defines a health disparity as, "a particular type of health difference that is closely linked with social, economic, and/or an environmental disadvantage.

What About Pronouns? Why Are They Important?

Personal pronouns are the words used in place of specific people, places, or things. Pronouns like “me, myself, and I” are how people talk about themselves, and pronouns like “you, she, he, and they” are some pronouns that people use to talk about others.

A person’s pronouns are the third-person singular pronouns that they would like others to use in place of their name. Personal pronouns are used to convey a person’s gender identity and do not necessarily align with the sex a person was assigned at birth. The most common third-person singular pronouns are “she/her/hers” and “he/him/his.” “They/them” can also be used to refer to a single person, while some people use gender-neutral or gender-inclusive pronouns like “ze/hir” (pronounced zee/here) instead. Some people might not use pronouns at all and go only by a name.

Approach individuals who want to be called what you may think is “unique” pronouns with cultural humility. Using the pronouns that a person goes by is a way of respecting that person’s gender identity — or a person’s emotional and psychological sense of their own gender and sense of self. If someone tells you that they go by the pronouns “they/them,” for example, and you continue to refer to them using “he/him/his” pronouns, it can imply that you believe that transgender, non-binary or intersex people are unimportant, or shouldn’t exist. It can create a lack of safety and trust in a helping relationship.

What is an Ally?

An ally (pronounced al-eye) is one that is associated with another as a helper: a person or group that provides assistance and support in an ongoing effort, activity, or struggle, like “a political ally.” Example: She has proven to be a valuable ally in the fight for better working conditions.

“Ally” is often used specifically for a person who is not a member of a marginalized or mistreated group but that expresses or gives support to that group.

Here are some simple ways to start being a more engaged and active ally:

- Be open. Talk about having lesbian, gay, bisexual, transgender, and queer (LGBTQ) friends, family members, colleagues, and acquaintances. However, when you talk about them please make sure you have their permission.
- Ask questions. If you hear acronyms, terminology, or references you are not familiar with- commit to getting the answers.
- Stay informed. Learn about the realities, challenges and issues affecting the lives of people who are Transgender through news stories, social media, websites, books, documentaries, and educational materials.
- Speak up. When you hear Transgender slurs, jokes, or misinformation, say something. Explain why you are an Ally, make your case for more welcoming and inclusive spaces.

- Teach equality. Be mindful of the day-to-day messages that your family, friends and colleagues are receiving about Transgender people in schools, from their friends and family, the web, social media platforms, and TV.
- Challenge those around you. Encourage the organizations you are a part of – including social groups, your workplace, or faith community – to consider inclusive policies that protect the Transgender community from discrimination and bias.
- Be an advocate. Call, write, email, or visit public policy makers and let them know that as an ally that votes, you support laws that extend equal rights and protections to ALL people.
- Above all, replace judgment with intrigue.

Transgender Scenario

Mark, they/them, is 36 years old and is directed to get peer support and counseling by their doctor after having decided, as a part of their personal transition, to undergo sex reassignment surgery from male to female. They will change their name to Sonia. Mark reports they have suffered for a long time trying to live as a man when they are, in fact, a woman. Mark is meeting with Dee, she/her, for the first time. All Mark knows is that Dee transitioned from male to female about five years ago and is someone their doctor wants them to talk to as a Peer Support Specialist.

Mark is currently experiencing feelings of sadness, anxiety, stress, and anger about the way they have been treated by their family and certain friends because of Mark's gender identity. Mark has started drinking alcohol on daily basis to numb their emotions and fall asleep at night.

If you were Dee:

- How would you approach the situation?
- What questions would you ask?
- How could you use your personal story to assist Mark?
- What would you do if you did not have personal experience with this culture?
- Do you think this is an appropriate time to bring up any of your own personal experiences if you have them?

Suggested approach

Dee, she/her, and Mark, they/them, have not met yet so they have not been able to develop trust. When they do meet, Dee will use her story and her skills as a Peer Support Specialist to break the ice with Mark. Dee tells Mark what peer support is and what it is not and orients them to the agency policies and their rights. Dee remains conscious of cultural humility even though she has had some similar experiences. She does not assume she

knows what Mark is going through. She engages in active listening and reframing to make sure she understand where Mark is coming from. Dee will take into consideration all the needs Mark identifies at this time and ask them what they want to work on first. She does this by asking, “What is happening in your life right now that is interfering with your serenity and wellbeing?” Mark will lead the conversation and discuss what priorities to work on first. The two of them will make a plan together.

Mark asks Dee to go to their first counseling session. After Dee checks with her supervisor, she agrees to go. After they meet with the doctor, they will work on co-creating goals for Mark.

Some questions Dee can ask Mark to get the ball rolling are:

1. How best can I support you?
2. How much support would you like?
3. Would you like to set goals or make a plan around this situation?
4. Is there any advocacy that I can partner with you on?

Summary

Many trainings do not touch on cultural humility or identify exactly how to discuss and incorporate culture into a peer support practice. They discuss what culture is in a very general way. They rarely identify the crucial importance that culture plays in recovery. This Primer is an introduction to a few selected cultures, co-written by people from those cultures. We made it as readable as possible and gave plenty of statistics which are referenced in the appendix. This Primer is meant for people who have not been exposed to diversity in their lives and are now employed in diverse agencies and working with diverse groups of people.

We hope this information gives you a framework on which you can put your own personal touch in your practice as a Peer Support Specialist and/or Recovery Coach. The fact that you are reading this Primer means that you are seeking more information, educating yourself in an effort to be the best helper you can be.

Remember, the first step of developing a multicultural lens, is an assessment of your personal and professional cultural awareness needs. Becoming aware of culturally learned assumptions as they are both similar and different from members of other cultures is the foundation of peer support core competence. Being open, flexible, and curious are great benchmarks or places to start in developing cultural humility. You will find areas where you are racist and hold bias. It is human nature. It is the openness to accept and awareness of these attitudes- as well as the conscious effort to continually educate yourself and grow, that will make differences in the lives of people who are marginalized and face health disparities. Every human being has an equal right to healthcare regardless of their socio-economic status or culture.

Citation

Peer Cultural Cooperative. Cultural Humility Primer: Peer Support Specialist and Recovery Coach Guide to Serving and Supporting Diverse Individuals and Their Recovery Journeys. Northwest Addiction Technology Transfer Center (ATTC): Seattle, WA, 2020.

This work resides in the public domain, unless otherwise indicated.

RECOMMENDED RESOURCE: DEVELOPING CULTURAL HUMILITY - SEEING OURSELVES IN OTHERS

Developing Cultural Humility: Seeing Ourselves in Others

Description

As the nation demographically represents a multitude of cultures, our ability to engage in thoughtful and meaningful discussions on cultural issues, remains ever present. No one where is this more salient than in our professional roles as service providers. Whether it means understanding our own insecurities when discussing these issues or when facilitating these dialogues when helping others, understanding one's own cultural background as a way to enhance our multicultural dialogues, both personally and professionally, is a necessary outcome. This free webinar addresses the current literature on color-blind racial ideology and the major themes that surfaced from 20 psychologists examining their own cultural influences and the impact this examination has had in their personal and professional lives.

Learning Objectives

- Discuss the importance of understanding the rationale and limitations of a color-blind racial ideology (CBRI);
- Identify the challenges and benefits of understanding and discussing their own and others cultural identities; and
- Provide examples of how to address and incorporate cultural conversations as service providers.

Free NAADAC Webinar

<https://www.pathlms.com/naadac/courses/45502>

Scroll to the bottom of this website and click on the title of the webinar. You'll need to create a free NAADAC account and login in order to access the webinar.

Power Point Slides

https://www.naadac.org/assets/2416/2015-08-26_developing_cultural_humility_webinarslides.pdf

PART V

UNIT 5: IMPACT OF TRAUMA ON MENTAL HEALTH AND ADDICTION

Many addiction experts consider Trauma to be the gateway drug. Research confirms that trauma can impact brain development. The early model of addiction explained it as a “choice”, which made addiction a moral failing. Then the explanation moved on to a “disease” model, i.e., that the use of alcohol and other drugs changed the brain, in much the same way a disease can change physiology. This model, does not however explain behavioral/process addictions. The changes cited as proof of this model also happens when the brain learns.

The current model, which is gaining some traction, is the developmental brain model. The first reading is a journal article that describes the shortcomings of the disease model and why the developmental model is a better explanation of addiction and the neuroplasticity of the brain, which can be a function of learning (for example).

The remainder of unit 5 covers trauma. First we look at the mechanics of stress and trauma and how it impacts our brain, body and behavior. We also look at compassion fatigue, what it is and how to process this potential by-product of working in the field. We need to understand not only how to respond to trauma as caregivers, but we also need to look within ourselves and our environment to make sure we understand how to deal with compassion fatigue.

Finally, we look at addressing Stress and Trauma in Recovery-oriented systems and communities. It is important to weave trauma informed care into our systems of care.

Unit Objectives:

- Compare and contrast models of addiction
- Describe the impact of trauma on the brain and development

ADDICTION AND THE BRAIN: DEVELOPMENT, NOT DISEASE

Addiction and the Brain: Development, Not Disease

The harm done by addicts to themselves and those around them has riveted public attention in recent years. It has become essential to discard outdated perceptions of addiction and replace them with coherent models based on scientific principles. Toward this end, doctors, psychiatrists, medical researchers and treatment providers have come to define addiction as a brain disease. Specifically, addiction is characterized by changes in brain systems that mediate the experience and anticipation of reward, systems responsible for perception and memory, and higher-order executive systems underlying cognitive control. The disease model stipulates that these changes are caused by exposure to drugs of abuse, and they are difficult if not impossible to reverse.

By looking at changes in the function and structure of the nervous system, the disease model helps explain why it is so difficult to achieve abstinence through the exercise of willpower. It makes sense of individual differences in vulnerability to addiction, based on dispositional factors and environmental stressors. The disease model provides a knowledge base and research agenda for developing pharmaceuticals that can be useful for reducing craving and easing withdrawal symptoms. And it has countered the perception that addicts are morally deficient or self-indulgent, arguably reducing the stress and isolation they and their families experience.

Given these achievements, it isn't surprising that the disease model of addiction is accepted—in fact nearly unchallenged—by the medical community, the psychiatric community, research funding bodies, and governments themselves, as reflected by a mountain of articles and posts by the National Institute on Drug Abuse (NIDA), the National Institutes of Health (NIH), the American Medical Association (AMA), and the American Society of Addiction Medicine (ASAM). Yet there are reasons to question the validity of the disease perspective. First, this perspective clashes with the experience of many former addicts, who do not feel they were ever sick or have now been cured. Second, the strongest endorsements of the disease model come from the rehab industry and Big Pharma, both of which profit from the belief that addicts need long-term medical treatment. Rather, most alcoholics and addicts recover [1], and most of those do so without treatment of any kind [2–4], a finding that is difficult to reconcile with the idea that addiction is a chronic disease. Finally, investigators who approach addiction as a disease are far more likely to get their work funded, thus minimizing the volume and impact of discrepant findings.

For these and other reasons, the disease model of addiction has been heatedly challenged, and alternative models have been proposed in its place. Addiction may be viewed as a choice rather than a pathology. While

few people imagine that addiction is a good choice, it is sometimes considered rational in the short run—as when the pleasure or relief derived from drugs temporarily outweighs the alternatives [5, 6]. Addiction may be a natural response to environmental or economic conditions beyond the addict’s control, including poverty and social alienation [6, 7]. Addiction can be viewed as a form of self-medication that works against psychological suffering. Trauma—whether physical, psychological, or sexual—is often considered the root cause of long-term anxiety and depression; and post-traumatic stress disorder (PTSD) is highly correlated with substance use [8–10]. A framework that encompasses all these approaches views addiction as a product of cognitive and emotional development, predisposed by constitutional factors but consolidated through learning over childhood and adolescence [10].

These alternatives to the disease model of addiction may be compelling, but they lack one important ingredient. They have little or nothing to say about the brain. (There are notable exceptions [11–13], which, although valuable, provide only global neural arguments, without attention to key structures or processes. Maia Szalavitz [10] is the only author I’m aware of who backs a learning account of addiction with detailed neuroscientific explanation.) In this era of scientific acceleration, brain science has become a gold standard for conclusive explanations of human phenomena. Without detailed neurobiological analysis, alternatives to the disease model may lack the scientific traction they need. My book, *The Biology of Desire* [14], was intended to fill in the neural level of analysis in a developmental-learning model of addiction, integrate that level of explanation with experiential accounts of addiction and recovery, and demonstrate that the disease model has outlived both its credibility and its usefulness. In the following sections, I summarize these arguments and connect them to the larger debate on how to understand and combat addiction. I end by showing that the ethos of the disease model makes it difficult to reconcile with a developmental-learning orientation.

The Core Tenets of the Disease Model

According to NIDA, BAddiction is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences.[^] A key observation underlying this depiction is that dopamine transmission and reception are altered over time: increasingly, it is only the user’s substance of choice that reliably impacts on dopaminergic activity. Dopamine is a crucial neurotransmitter (or Bneuromodulator[^]) for motivating, directing, and rewarding goal-directed behavior and focusing attention and memory. Because the action of dopamine enhances the formation of new synapses (and the corresponding loss of older ones), changes in dopamine metabolism bring about structural changes in synaptic networks—the basic wiring diagram of the brain. A critical locus of dopamine reception and synaptic restructuring is the striatum, the area responsible for pursuing rewards, but other targets include the amygdala, which mediates emotional salience, the hippocampus, which directs memory encoding and retrieval, and several regions of the prefrontal cortex, responsible for a variety of cognitive functions. Indeed, starting in the 1980s and 1990s, researchers began to show synaptic changes in these regions in labo-

ratory animals exposed to cocaine, amphetamine, morphine, alcohol, and other drugs, corresponding with behavioral sensitization in addicted animals and humans [15, 16]. For example, dopamine activation of the striatum was found to go up and down with drug availability—and not much else. The receptors that absorb and use dopamine were also found to change in structure or efficiency [17] increasingly over months and years of use. The message seemed clear: drug use messes up brain wiring. These brain changes were seen as direct evidence that an insidious force—namely drugs—had hijacked the brain, a phrase first uttered by Bill Moyers on a popular PBS television series, but quick to catch on in addiction debates everywhere.

Nora Volkow M.D., the firebrand scientist who currently heads NIDA, points to tissue damage in the brain as indisputable support for the disease model [18]. In her view, this damage is specifically caused by drug use, and it corresponds with reduced capacity to engage cognitive control, increased compulsivity in drug seeking, and emotional blunting in response to rewards more generally. The *nucleus accumbens* describes one of the most ventral (lower) regions of the striatum, and it is the brain part most often referred to when it comes to addiction. Berridge and Robinson [19] coined the phrase *incentive sensitization* to describe the increasing specificity with which dopamine flows from the ventral tegmental area (VTA) in the mid-brain to the accumbens in response to drug cues. In fact, even secondary and tertiary drug-related cues were found to trigger dopamine release, which then increased activation in the accumbens and induced a more driven, even frenzied quality to drug-seeking behavior [20, 21].

The ventral striatum or accumbens is associated with impulsive drug seeking and use, but the dorsal striatum becomes increasingly important for addiction with the passage of time. As the period of addiction stretches over months and years, activation shifts from the ventral to the dorsal striatum in response to drug-associated cues, while drug-seeking behavior becomes more compulsive and less impulsive in character. Trevor Robbins and his colleagues at Cambridge have been studying the shift from impulsive to compulsive drug seeking for many years [22]. They see the compulsive phase as true addiction, as do many others in the field. Now, according to Volkow, Koob, and others, the addictive urge is truly out of control. Whether the addict actually desires the addictive reward, he or she is compelled to go after it, based on a stimulus-response (S-R) association acquired and strengthened through Pavlovian conditioning. The stimulus simply elicits a response, without the need for a reinforcing outcome.

According to Volkow and other scientists, not only the brain regions underlying goal-seeking but also those responsible for self-control are physically modified by drugs. An example can be seen in the dorsolateral prefrontal cortex (dlPFC), which is critical for reasoning, remembering, planning, and self-control. The dlPFC becomes hyperactivated in the early stages of addiction, as it does in some eating disorders, perhaps when people try to control or maintain the rewardingness of this new experience. But over time, this region and other prefrontal control centers start to disengage (i.e., lose functional connectivity) from the striatum, the amygdala, and other areas comprising the motivational core of the brain [23, 24]. Volkow and colleagues have carried out two decades of research into cortical changes underlying addiction. They conclude that prefrontal regions responsible for judging options and selecting among them

lose grey matter volume (reduced synaptic density) and become partially dysfunctional over the course of addiction [23, 25]. They dub the resulting cognitive dysfunction Bimpaired response inhibition.[^]

This cluster of changes in the function and structure of the brain has led many authorities to view addiction as a disease, and because these changes seem to endure long beyond the cessation of drug-taking, it is considered a chronic disease. According to Steven Hyman, previous director of the National Institute of Mental Health, addiction is a condition that changes the way the brain works, just like diabetes changes the way the pancreas works. Then why shouldn't it be viewed as a disease?

Development and the Brain

One of the key premises of the disease model is that addiction changes the brain. Yet brains are supposed to change. They are designed to change. In fact the stages of child and adolescent development, and the learning that goes on throughout adulthood, are all underpinned by changes in the cortex and limbic regions. Given the realities of brain change in normal development and learning, neuroscientists who endorse the disease model must view the brain changes resulting from addiction as extreme or pathological. In fact, they would have to show that the *kind* (or extent or location) of brain change characteristic of addiction is nothing like what we see in normal learning and development. How then should we characterize brain changes that occur naturally?

First of all, brains grow and shape themselves, not by following prespecified guidelines, but by a process of *self-organization*. They organize themselves, changing their own structure as they go. Such changes build on themselves over time, such that the products (synaptic changes) of one learning episode set the conditions for subsequent learning episodes. Of course there are some species-specific constraints on the timing of neural development, and there are certainly constraints on the kinds of information human beings can access and manipulate. Moreover, social norms help guide neural development along pathways consistent with particular cultural environments. Yet neural development is in no way programmed. It results almost entirely from synaptic activation patterns that both result from and give rise to experience itself.

One way to conceptualize this kind of self-perpetuating growth is to see it as a feedback loop between experience and brain change. The way we experience things changes synaptic configurations, and those changes shape the way we experience things subsequently. In other words, experience-dependent changes in brain structure make a particular way of experiencing things more probable on future occasions [26]. This can take the form of a self-perpetuating perception (as in language learning), an expectancy, a budding interpretation (as in judgments of individuals or groups), a recurring wish, a familiar emotional reaction (as in anxiety regarding perceived threats), an emergent belief (as in religious ideas and corresponding *isms*), or a conscious memory. Thus the mind and the brain shape each other. And ordinary classroom learning is just one version of this more general phenomenon—a brain that changes itself (a phrase borrowed from Norman Doidge [27]). The brain would be useless if it wasn't highly changeable and highly sensitive to events in the world. But since we need stability in our percepts, concepts, and actions, brain changes

almost always settle into habits. And once formed, habits—even minor habits—remain in place, sometimes for the rest of our lives. Examples range from idiosyncratic patterns like nail-biting and suspiciousness to cultural norms like politeness and sexual stereotyping. New synaptic pathways, and corresponding patterns of thought and behavior, start off tentative and fluctuating. But after they've been activated repeatedly, fledgling pathways get more entrenched, more concretized. As Donald Hebb made famous in the 1940s, *cells that fire together wire together*. Change and stabilization—novelty and habit formation—work together in the mind and in the brain. In a word, that's Blearning^.

Another helpful concept is *neuroplasticity*. Neuroplasticity simply describes brain changeability and elevates it to a first principle. Indeed, there's nothing more fundamental to the human brain than its plasticity [27]. Yet neuroscientists who study addiction seem to have missed the point. When the brains of addicts (following years of drug taking) are compared to those of drug-naïve controls, these scientists can be heard to say BLook! Their brains have changed!^ Yet if neuroplasticity is the rule, not the exception, then they're actually not saying much at all. The brain is supposed to change with new experiences. And those changes are supposed to stabilize and consolidate the more that experience is repeated.

When our experience of the world produces strong emotions—whether of desire, threat, pleasure, or relief—brain change takes on extra momentum. Emotions focus our attention and our thinking, partly through connections between the amygdala and a variety of cortical structures and partly through the wash of neuromodulators (including dopamine) released from the brain stem (including the VTA) in response to salient inputs. When those emotions recur over and over, in response to a particular event, perception, thought, memory, or need, then attention directs memory consolidation systematically. Our recurrently-focused brains inevitably self-organize in a particular direction, entrenching particular interpretations and emotional associations. Most relevant to addiction, the feeling of *desire* for something shapes synaptic configurations that become increasingly sensitive to cues associated with whatever is desired—since those cues are processed repeatedly in our efforts to acquire it.

Importantly, it's not just attraction or desire that fuels feedback loops and promotes neural habits. Depression and anxiety also develop through feedback. The more we think sad or fearful thoughts, the more synapses get strung together to generate scenarios of loneliness or danger, and the more likely we are to practice strategies—often unconsciously—for dealing with those scenarios. Neural patterns forged by desire can complement and merge with those born of depression or anxiety. In fact, that's a lynchpin in the self-medication model of addiction. Gabor Maté persuasively shows how early emotional disturbances steer us toward an intense desire for the relief provided by drugs [11], and Maia Szalavitz vividly portrays her experience as a late adolescent trying to brighten her depression with cocaine and ease her anxiety with heroin [10]. So, when we examine the correlation between addiction and depression or anxiety, we should recognize that addiction is often a partner or even an extension of a developmental pattern already set in motion, not simply a newcomer who happened to show up one day.

Thus, repeated experiences establish patterns, forming habits, and those habits link with other habits that also evolve with repeated experiences. But here's the main point when it comes to addiction. We don't need

an external cause like *disease* to explain the growth of bad habits, or even a set of interlocking bad habits (like being a drug addict and a criminal and a liar). Bad habits self-organize like any other habits. Addiction has been described as a habit for many decades, across various cultural contexts and societal conversations. Is that all it is? Like other habits, addiction may simply grow and stabilize, in brain tissue that is designed (by evolution) to change and stabilize. Yet addiction belongs to a subset of habits: those which are most difficult to extinguish. If we conceptualize addiction as an outcome of normal learning, we still have to explain why it is such an extreme outcome, so destructive and so difficult to reverse.

My outline of the principles of brain development highlighted individual trajectories. However, brain development also incorporates normative tendencies that are crucial for understanding addiction. First, brain development always balances the formation of new synapses—synaptogenesis—with synaptic loss or pruning. Second, and perhaps counterintuitively, synaptic pruning far outweighs synaptogenesis over the years of childhood and adolescence. The infant brain has an overabundance of synapses, roughly one-third of which are pruned through competition [28] as a result of normal learning. In fact pruning is considered the primary mechanism by which learning occurs. Third, pruning in the pre-frontal cortex increases efficiency in the processing and organizing of information—the essence of cognitive development from puberty onward [29]. Fourth, emotion regulation skills, which continue to advance through childhood and adolescence, involve two-way communication between prefrontal control centers and subcortical (e.g., striatal) regions that mediate emotions and impulses [30]. It can be assumed that both synaptogenesis and pruning play significant roles in this crucial developmental achievement.

A closer look at the nature of impulsive responding will help us understand not only the development of emotion regulation but addiction as well. All mammals and certainly human children tend to overvalue immediate rewards at the expense of long-term gains. This proclivity, called delay discounting, must be tamed in order for children to advance from a preoccupation with whatever is presently available (e.g., one marshmallow in the famous marshmallow test) to a capacity to wait for long-term gains (e.g., two marshmallows, a few minutes later) [31]—a crucial step in the development of emotion regulation. Addicts are known to be excessively now-oriented [32], consistent with their tendency to favor what Heyman calls the local choice [5]. Moreover, delay discounting has been shown to correspond to activation of the ventral striatum, the villain when it comes to addictive behavior, while the capacity to delay gratification taps activation of the dlPFC [30, 33, 34]. In other words, the neural picture in both delay discounting and addiction features striatal activation that is underregulated by the dlPFC (and other regions of the PFC).

Why Addiction Is Not a Disease

In its contemporary form [18], the disease model of addiction asserts that addiction is a chronic, relapsing brain disease. This disease is evidenced by changes in the brain, especially alterations in the striatum, brought about by the repeated uptake of dopamine in response to drugs and other substances. But it is also characterized by changes in the prefrontal cortex, where regions responsible for cognitive control become

partially disconnected from the striatum and sometimes lose a portion of their synapses as the addiction progresses. These are big changes, they can't be brushed aside, and so far the disease model is the only model of addiction that actually tries to explain them. So why should we look further?

Self-Perpetuating Attractions Do Not a Disease Make

The brain changes with all learning experiences, and it changes more rapidly and more radically in response to experiences with high motivational impact. Every experience that is repeated enough times because of its motivational appeal will change synaptic networks in the striatum and related regions (e.g., the amygdala and orbitofrontal cortex) while adjusting the flow and uptake of dopamine to all these regions. Such changes lead to the formation of habits—neural and behavioral habits—habits that become self-perpetuating and self-stabilizing. Yet we wouldn't want to call the excitement we feel about summer vacation, meeting our lover, or cheering for our favorite team a disease. As we anticipate and live through these experiences, the corresponding network of synapses is strengthened and refined; so the uptake of dopamine gets more selective as rewards are identified and habits established. This is simply learning, motivated by desire.

Even if addictive habits are more deeply entrenched than other habits, there is no clear dividing line between addiction and the repeated pursuit of other attractive goals, either in experience or in brain function [35]. So how do we know which urges, attractions, and desires to label as disease and which to consider aspects of normal experience and brain change? Some authorities apply the disease label when the pursuit of a drug, drink, or activity seriously interferes with one's life. But again, where should we draw the line? The lover we can't help but desire may be abusive, may be involved in another relationship, or may be forbidden for familial or cultural reasons. And sports fans have been known to beat each other up, get arrested, and ignore their familial responsibilities when the excitement runs high. But addiction doesn't fit a unique physiological stamp. It simply describes the repeated pursuit of highly attractive goals and the brain changes that condense this cycle of thought and behavior into a well-learned habit. Brain change, even more extreme brain change, does not imply that something is wrong with the brain.

My review of the disease model highlighted the shift in activation from the ventral to the dorsal striatum as addictive behavior becomes increasingly compulsive. This change has been well documented: it consists of the growth of fibers from the VTA to the dorsal striatum as the addictive behavior becomes an automatic response to a stimulus [22]. Once a person has reached this state, the brain is no longer functioning as it did. Yet, according to Everitt and Robbins [22], the acknowledged experts on the ventral-to-dorsal shift, there is nothing aberrant or unusual about devolving behavioural control to a dorsal striatal S-R habit mechanism. These authors remind us that this neural restructuring is to be expected in many aspects of our lives, including eating and other normal activities. Do we bite down on that piece of pizza because of an anticipated reward, or because a great many trials have established an association between a particular smell (and other gustatory cues) and the act of biting? But automatization of behaviour frees up cognitive processes, these authors continue. That would explain why we can talk, eat, drive, and listen to music all

at the same time. We need habits in order to free our minds for other things. Unfortunately, in addiction, this perfectly natural developmental mechanism often leads to suffering.

Addiction without Substances

One of the greatest blows to the current notion of addiction as a disease is the fact that behavioral addictions can be just as severe as substance addictions. However, the party line of NIDA, the AMA, and ASAM remains what it has been for decades: addiction is primarily caused by substance abuse. If that were so, how would we explain addictions to porn, sex, internet games, food, and gambling? In a comprehensive review, Brewer and Potenza conclude that disorders characterized by too much of any of the above show brain activation patterns that are nearly identical to those shown in drug addiction [36]. According to these authors, even the ventral-to-dorsal shift in striatal activation, and the corresponding increase in compulsive responding, show up in behavioral addictions just as they do in substance addictions. This is exemplified in compulsive gambling and binge eating. It is interesting that, despite widespread acceptance of neural and behavioral parallels between substance and behavioral addictions, the promoters of the disease model have never retracted their claim that drugs cause the brain changes underlying addiction.

People pursue certain activities repeatedly, often with little control, because those activities start off as highly rewarding and end up as behavioral habits. That description can cover anything from spending sprees to helicopter parenting to jihadism. But there is one very normal human endeavor that most of us recognize as the epitome of blind desire and recurrent pursuit: falling in love. Lovers think obsessively about their love object, exaggerate his or her positive qualities and avoid thinking about future repercussions. Romantic love (but also parent-child love, and even perverse forms of love including fetishism, sadomasochism, etc.) can easily become compulsive, difficult to control, and overly focused on the immediate, with little regard for the long-range forecast.

A look at the neuroscience of love reveals some remarkable similarities with addiction. It is generally agreed that increased levels of central dopamine contribute to the lover's focused attention on the beloved and the lover's tendency to regard the beloved as unique [37]. In fact, several researchers have examined the love-and-addiction link directly. Burkett and Young reviewed much of this work [38]. In their words, mesolimbic dopamine is a major contributor to the formation of pair bonds in prairie voles and particularly in the nucleus accumbens region. In a comprehensive new book, Toates summarizes research showing that the dopamine system provides a common currency of wanting in the pursuit of financial gains, drugs, and sexual partners [39]. He notes that the nucleus accumbens is involved in motivating the individual to overcome obstacles in order to reach such goals [40] and that dopamine metabolism biases decision making in favor of immediate gains [41]. With regard to romantic pairing, Burkett and Young conclude that when these early interactions with the object of addiction produce rewarding outcomes, dopamine is released in the nucleus accumbens, which acts to increase the salience of incentive cues that predict the reward [38]. If addiction is a disease, then so apparently is love.

Alternative Explanations of Cortical Change

So far, I've argued that addictions are consolidated patterns of attraction and pursuit that cultivate distinct synaptic configurations in the motivational core of the brain (the striatum and related regions). But the disease model also stipulates cortical changes: most seriously the loss of functional coupling between the PFC and the striatum and, perhaps as a result, the eventual loss of synapses in the PFC, both of which contribute to a loss of self-control. Indeed, after a while, with a variety of substances and some eating disorders (including binge eating), the dorsolateral PFC becomes partially disconnected from the striatum. The reasons for this disconnection are complex and not fully understood. But suffice it to say that dopamine signaling in the cortex is partly under the control of striatal outputs, and with long-term addiction striatal habits no longer send signals to the PFC eliciting control. Functional connections are lost, which means some of the synaptic pathways get pruned and eventually disappear. Now structural connections are lost. This explains the loss of grey matter volume reported with long-term addiction. Can these changes be seen as anything but the ravages of a disease?

From a functional perspective, the interplay between prefrontally mediated control and striatal goal-pursuit is never permanently fixed in the brain. Children's ability to overcome delay discounting (and other impulsive tendencies) improves with age from middle childhood to middle adolescence, due at least in part to the maturation of the dorsolateral PFC [42]. Not surprisingly, adults also overcome delay discounting by activating the dlPFC [33], yet this avenue of control isn't carved in stone. Adults fall prey to delay discounting regularly, suggesting functional rather than structural variability in prefrontal control. And they can reverse this tendency in response to novel environmental inputs. In one set of studies, the tendency to discount future gains in favour of immediate rewards was consistently reversed by exposing participants to images of their future selves [43]. To examine such changes at the neural level, Figner applied transcranial magnetic stimulation (TMS), a procedure that can temporarily disrupt activity in the cortex, while participants were engaged in a delay discounting task [44]. Participants chose immediate rewards of lower value more frequently when the TMS machine was placed over their dorsolateral PFC, but their discounting rate went back to normal immediately afterward. There are more natural (and less expensive) ways to disrupt dlPFC activation and facilitate impulsive responding. Drug or alcohol use, especially during the sensitive developmental period of adolescence, is clearly one such way [45].

Yet the loss of cortical control is thought to be long-lasting, even permanent, in long-term addiction. This implies structural changes, which are often conflated with the notion of disease. However, as noted previously, synaptic pruning is a normal developmental process. In fact, research shows that, when the same inputs are encountered repeatedly, connections are depleted to improve overall efficiency [46], and addiction certainly exemplifies repeated inputs. In the sequel to Hebb's famous maxim, not only do cells that fire together wire together but cells that fire apart wire apart. In other words, changes in behavior and experience naturally deplete synaptic connections, not only functionally but, over time, structurally as well. As addicts pursue the same rewards every day, it appears that they no longer rely on reflective judgment to

curtail the feelings and behaviors to which they've grown accustomed. Then it should not be surprising, nor should it imply the presence of disease, if their neural configurations readjust by pruning the underused synapses.

This account of cortical decoupling and loss of cortical synapses doesn't quite close Pandora's Box. It isn't easy to determine which patterns of synaptic pruning are normal and which are not [47]. Yet, in a seminal study, Connolly and colleagues showed that the reduction of grey matter volume in specific regions of the prefrontal cortex (and the anterior cingulate, a closely related structure), induced by years of addiction, can reverse over several months of abstinence [48]. These authors reported that grey matter volume returned to a normal (population) baseline level within six months to a year of abstinence (from heroin, cocaine, and alcohol), and similar results have been found by others [e.g. 49]. Of even greater interest, Connolly and colleagues observed an increase in grey matter volume *beyond* the population baseline in participants who remained abstinent for a year or more. These findings jibe with the idea that synaptic loss and synaptic growth in these regions correspond with variations in experience, not disease. Recurrent episodes of automatic responding reduce synaptic activity in the PFC, but new modes of experiencing the world and new means for regulating one's emotions and behaviors can just as easily build new synaptic connections in the same (or nearby) regions.

From subjective reports we know that most addicts never feel that they have lost all control over their impulses. Rather, most addicts report that control has become more difficult because it is buffeted by a variety of psychological and social factors: it has become less automatic—more nuanced but less reliable [50]. And from epidemiological reports the story is clear: most addicts recover [1], and most of those recover without treatment [2–4]. This would seem impossible if regions of the PFC responsible for self-control did not remain highly plastic.

In fact, a detailed understanding of neuroplasticity is the best antidote to the disease model of addiction. Yes, the prefrontal cortex is malleable. Yes, it can undergo major changes in synaptic organization in response to drug taking. But it can and must undergo synaptic reorganization anyway, and it does so throughout a lifetime of learning. Spontaneous recovery from addiction is common, it has been studied in depth, and it certainly must embody cortical plasticity, though in a direction opposite to that highlighted by disease model advocates. Neuroplasticity (e.g., synaptogenesis) is the norm when people recover from medical problems like strokes or concussions [27, 51], but it also underpins second language learning [52] and the acquisition of new skills in adulthood. People *learn* addiction through neuroplasticity, which is how they learn everything. They maintain their addiction because they lose some of that plasticity. Then, when they recover, with or without treatment, their neuroplasticity returns. Their brains start changing again. With the onset of addiction, plasticity is devoted to new means for acquiring pleasure or relief. With recovery, plasticity is devoted to goals with far-reaching personal value and the skills necessary to attain them.

If it's Not a Disease, then What Is it?

In an earlier section, I outlined a number of processes by which brains change as people (and their habits, and their personalities) develop. The repetition of particular experiences modifies synaptic networks. This creates a feedback cycle between experience and brain change, each one shaping the other. New patterns of synaptic connections perpetuate themselves like the ruts carved by rainwater in the garden. Thus, brain changes that result from repeated learning experiences naturally settle into brain habits—which lock in mental habits. And the experiences that get repeated most often, most reliably, are those that are most compelling. In fact, *desire* is evolution's premier agent for getting us to pursue goals repeatedly. Thus, intense and/or recurrent desires will naturally change the *rate* and *depth* of learning by augmenting the feedback cycle between experience and brain change.

In this sense, I would say that addiction is an outcome of learning, but learning that has been accelerated and/or entrenched through the recurrent pursuit of highly attractive goals. There are many reasons why this cycle of goal pursuit, accompanied by the fadeout of alternative goals, becomes tighter and more invariant over time. Some are social and cultural, others societal and economical. The reasons I have highlighted in this article have more to do with the cascading nature of developmental constraints—the narrowing of possibilities into probabilities, states into traits [53]. Looked at from a biological perspective, this tendency is embodied in the reconfiguration, self-perpetuation, and consolidation of synaptic networks in structures that mediate desire, attraction, attention, memory, and cognitive reflection and control [54, 55].

Desire is at the top of the list when it comes to emotional states that propel learning. And while this standard feature of the psychological repertoire can explain the locking in of habitual attractions, we must still ask whether there is something special about addiction that makes it so difficult to overcome. In fact, there seem to be at least three specific mechanisms that accelerate our attraction to addictive rewards and entrench addictive activities—without making it a disease.

The first is the tendency toward delay discounting, which creates a narrowed beam of attention toward imminent rewards. That is precisely the state addicts find themselves in time after time. One of dopamine's chief functions is to highlight available goals. Immediate goals are available goals, and striatal networks surge with dopamine whenever those goals are cued by associated stimuli or memories. Another function of striatal dopamine is to inhibit awareness of competing goals (e.g., going out on a date, finding a movie to watch). In fact, that's how the striatum narrows the beam of attention. As a result, addicts become stuck in a bleak here-and-now, nearly identical from one day to the next. It is this entrapment in the immediate that calls for treatment approaches that might help addicts stretch their sense of personal time, consistent with Ainslie's powerful concept of *intertemporal cooperation* [56]. Movement in this direction can be facilitated by some form of interpersonal scaffolding (e.g., targeted dialogue in group or individual therapy) intended to hold this cooperation in place—until the addict can recreate it at will. The second mechanism is the motivational *amplification* caused by addictive rewards. We know that synaptic patterns get reinforced with each repetition of the same kind of experience, whether it's playing the piano, baking bread, or smoking

crack. And we know that repetition boosted by strong motivation is the most effective driver of synaptic shaping. (Actually, strong motivation determines not only the frequency of repetition across occasions but also the resilience or purity of attention within occasions.) Then imagine the impact of a longed-for reward that only lasts a few hours, or maybe just a few minutes. Drugs wear off, drinking sedates, the money's spent, or sexual pyrotechnics become boring. Addictive rewards whet the appetite and leave frustration, loss, and often depression in their wake. Moreover, because they are universally perceived as selfish and indulgent, they unleash great gouts of shame [50]. Because shame is such a painful emotion, it exacerbates the need for resolution, regulation, or escape.

In a nutshell, addictive rewards pack a double whammy. Desire flares again after only a few hours, a day at most, and brings with it a host of other compelling emotions. Physiological consequences, including withdrawal symptoms with certain drugs, make it a triple whammy. The cycle of acquisition and loss then recurs with increasing frequency, the same neural passages get dredged again and again, and the trajectory of learning is progressively reinforced.

The third mechanism that enhances addictive learning is the fusion between personality development and the consolidation of addictive habits. Not only desire but also negative emotions, like anxiety and shame, fuel synaptic configurations that strengthen themselves over development, as in the crystallization of depressive or anxious personality traits. The addictive habit thus converges with other habits consolidating within one's personality, such that addiction complements or reinforces preexisting tendencies. Synaptic networks are not only self-reinforcing but also mutually reinforcing, in a brain that likes to conserve structure and resources, as do all living things. The mechanics of this process involve multiple brain regions, interlaced to form a web that holds the addiction in place—as part of one's personality structure. Thus, intense emotions, focused attention, and cognitive habits harness one another, and together they gouge deep ruts in the neural underpinnings of the self.

So, what exactly is addiction? It's a habit that grows and self-perpetuates relatively quickly, when we repeatedly pursue the same highly attractive goal. Or, in a phrase, *motivated repetition that gives rise to deep learning*. Addictive patterns grow more quickly and become more deeply entrenched than other, less compelling habits, because of the intensity of the attraction that motivates us to repeat them, especially when they leave us gasping for more. Often, emotional turmoil during childhood or adolescence initiates patterns of personality development that anchor the search for addictive rewards, serving as sources of relief and comfort. But there are other points of entry too, based on various intersections of dispositional and environmental factors. However it is entered, and however it is eventually left, addiction is a condition of recurrent desire for a single goal, but also an aspect or phase of personality development that leaves enduring footprints in neural tissue.

Why can't we just Get along?

Will a developmental-learning model of addiction ever make peace with the disease model? That would

provide one kind of happy ending. It would encourage proponents of the disease model and those who study the development of addiction to talk with each other, share data and ideas, and derive higher-order explanations. Yet I don't think this is in the cards. Not because the disease model is so far off base scientifically. Some of the brain changes observed in addiction may be sufficiently ominous to exemplify both pathology and learning, as is the case in autism and schizophrenia. In fact, defining a category at the intersection of pathology and development is the stated goal of the burgeoning field of developmental psychopathology [57]. As with depression and anxiety disorders, the delineation between learning and pathology is not a line but a zone.

Yet the baggage accompanying the disease model may preclude a happy marriage. Society's understanding of addiction can be seen as advancing through three broad stages (a somewhat similar model has recently been proposed [58]). First, beginning in the Victorian era, addicts were considered morally flawed and indulgent, sinners by choice or by happenstance. The appropriate response to addiction was to punish the addict through scorn, isolation, disenfranchisement, or incarceration. The proper resolution to the problem of addiction was to shame and punish the addict who might, with luck, go back to being good. This set of beliefs and attitudes was gradually overwritten by the disease model of addiction in the middle of the twentieth century. This change was driven by the emphasis on helplessness in Alcoholics Anonymous, beginning in the 30s, and the evolution of residential treatment centers that stressed obedience to therapeutic regimes, beginning in the 50s. Finally, the proliferation of neuroscience in the 80s and 90s sealed the deal by specifying the substrate of the disease, namely the brain. Now specific neural changes could be pinpointed as the source of addiction, and the disease model reached its zenith.

According to the disease model, the appropriate solution to addiction is to be found in the realm of medicine. Specifically, addicts should be urged (convinced or compelled) to follow the advice handed down by medical practitioners. As emphasized by Nora Volkow in dozens of policy statements, the solution to addiction isn't shame. Rather than confess to being immoral, addicts are advised to confess to being incapable. The only hope to control addiction is to accept a regime imposed from outside, from the halls of medical authority, in order to subdue a problem located on the inside, in the mind itself (an approach to the treatment of mental disorders that has governed psychiatry throughout its history—with some unfortunate consequences). It is this baggage that seems destined to clash with the ethos of a third, more progressive view of addiction.

What I see as the third stage in our understanding of addiction is not restricted to reinterpreting the role of choice [58], though that's part of the package. Rather, it's a developmental model of the kind outlined in this article, highlighting a learning trajectory that consolidates in habitual patterns of thinking and feeling. This view of addiction admits the potency of social factors, like isolation and dislocation [59]. It makes sense of the impact of adversity in early development, as demonstrated by large epidemiological studies from the 80s to the present. It is consistent with a far more nuanced view of addiction, embodying personal, philosophical, and societal factors, as elaborated in a recent special issue of *Frontiers in Psychiatry* [60]. And

finally, it builds on our advancing knowledge of the neurobiology of individual differences in development [57, 61].

According to a developmental-learning conceptualization, the appropriate response to addiction is neither shame and isolation nor submission to a therapeutic regime. Rather, it is further growth. The cure for addiction can't be a medical regime that returns the addict to some previous level of stability or homeostasis. Rather, growth beyond addiction exemplifies developmental progress, powered by one's own efforts. In this light, addiction can be viewed as a stage of individual development, and it must therefore be addressed through individual strivings based on individual perspectives, goals, and capacities. A developmental-learning model of addiction suggests that positive change must be conceived and pursued from within.

The final two stages in our understanding of addiction, the disease model and the developmental-learning model, achieve some of their plausibility on the basis of brain research. But the role of neuroscience in these two stages of conceptualization could not be more different. Neuroscience helped shore up the disease model by identifying deviations from what is considered standard neural architecture. Although it's never been made clear exactly how this standard could be determined, we could say that the project of the brain disease model draws on the principle of Bneuronormativity.[^] In contrast, the developmental-learning model embodies our advancing conception of *neuroplasticity*. A project focused on neuroplasticity replaces the search for norms with an emphasis on the brain's capacity to change, and it confirms our intuition that there are many different ways to move forward [10, 14].

Thus, both models borrow something from neuroscience—a detailed breakdown of the biological landscape underlying addiction. But they are fundamentally different in their perception of that landscape. The brain is either a normative thing that can go wrong and then be repaired, or it is an open system that can develop in a multitude of directions, integrating the meaning of experience according to its own proclivities. No doubt this process of integration can be greatly facilitated by the cognitive scaffolding and emotional support provided by other people. Yet, neither the spirit nor the specifics of change can be dictated, either by professional authorities or by society in general. Since addiction is viewed as a phase of individual development, so is the pathway most of us find for moving beyond addiction.

Citation

Lewis, Marc. (2017). *Addiction and the Brain: Development, Not Disease*. Neuroethics. 10. 10.1007/s12152-016-9293-4.

This article is distributed under the terms of the Creative Commons Attribution 4.0 International License (CC-BY).

References

1. Lopez-Quintero, Catalina, Deborah S. Hasin, José Pérez De Los Cobos, Abigail Pines, Shuai Wang, Bridget F. Grant, and Carlos Blanco. 2011. Probability and predictors of re- mission from life-time nicotine, alcohol, cannabis or cocaine dependence: results from the National Epidemiologic Survey on alcohol and related conditions. *Addiction* 106: 657–669. doi:10.1111/j.1360-0443.2010.03194.x.
2. Dawson, Deborah A., Bridget F. Grant, Frederick S. Stinson, and Patricia S. Chou. 2006. Maturing out of alcohol depen- dence: the impact of transitional life events. *Journal of Studies on Alcohol* 67: 195–203.
3. National Institute on Alcohol Abuse and Alcoholism (NIAAA) 2006. National epidemiologic survey on alcohol and related conditions. *Alcohol: Research & Health* 29:2
4. Heyman, Gene M. 2013. Quitting drugs: quantitative and qualitative features. *Annual Review of Clinical Psychology* 9: 29–59. doi:10.1146/annurev-clinpsy-032511-143041.
5. Heyman, Gene M. 2009. *Addiction: a disorder of choice*. Cambridge: Harvard University Press.
6. Hart, Carl. 2013. *High price: a neuroscientist's journey of self-discovery that challenges everything you know about drugs and society*. New York: HarperCollins.
7. Alexander, Bruce. 2008. *The globalization os addiction: a study in poverty of the spirit*. Oxford: Oxford University Press.
8. Brady, Kathleen T., and Rajita Sinha. 2005. Co-occurring mental and substance use disorders: the neurobiological effects of chronic stress. *American Journal of Psychiatry*. doi:10.1176/appi.ajp.162.8.1483.
9. Al'Absi, Mustafa. 2006. *Stress in Adiction: biological and psychological mechanisms*. Amsterdam: Academic Press.
10. Szalavitz, Maia. *Unbroken brain: a revolutionary new way of understanding addiction*. New York: St. Martin's Press.
11. Maté, Gabor. 2008. *In the realm of hungry ghosts*. Toronto: Vintage Canada.
12. Levy, Neil. 2013. Addiction is not a brain disease (and it matters). *Frontiers in Psychiatry* 4:24. doi:10.3389/fpsy.2013.00024.
13. Hall, Wayne, Adrian Carter, and Cynthia Forlini. 2015. The brain disease model of addiction: is it supported by the evidence and has it delivered on its promises? *The Lancet Psychiatry*. doi:10.1016/S2215-0366(14)00126-6.
14. Lewis, Marc. 2015. *The biology of desire: why addiction is not a disease*. New York: PublicAffairs.
15. Robinson, T.E., and K.C. Berridge. 2000. The psychology and neurobiology of addiction: an incentive-sensitization view. *Addiction* 95: 91–117. doi:10.1046/j.1360-0443.95.8 s2.19.x.
16. Kalivas, Peter W., and Jane Stewart. 1991. Dopamine trans- mission in the initiation and expression of drug- and stress- induced sensitization of motor activity. *Brain Research Reviews*. doi:10.1016/0165-0173(91)90007-U.
17. Kalivas, P.W., and J.E. Alesdatter. 1993. Involvement of N- methyl-D-aspartate receptor stimulation in

- the ventral teg- mental area and amygdala in behavioral sensitization to cocaine. *The Journal of Pharmacology and Experimental Therapeutics* 267: 486–495.
18. Volkow, Nora D., George F. Koob, and A. Thomas McLellan. 2016. Neurobiologic advances from the brain disease model of addiction. *New England Journal of Medicine* 374: 363–371. doi:10.1056/NEJMr1511480.
 19. Berridge, Kent C., and Terry E. Robinson. 1998. What is the role of dopamine in reward: hedonic impact, reward learn- ing, or incentive salience? *Brain Research Reviews*. doi:10.1016/S0165-0173(98)00019-8.
 20. Robinson, Terry E., and Kent C. Berridge. 2003. Addiction. *Annual Review of Psychology* 54: 25–53. doi:10.1146/annurev.psych.54.101601.145237.
 21. Tindell, Amy J., Kent C. Berridge, Jun Zhang, Susana Peciña, and J. Wayne Aldridge. 2005. Ventral pallidal neu- rons code incentive motivation: amplification by mesolimbic sensitization and amphetamine. *European Journal of Neuroscience* 22: 2617–2634. doi:10.1111/j.1460-9568.2005.04411.x.
 22. Everitt, Barry J., and Trevor W. Robbins. 2013. From the ventral to the dorsal striatum: devolving views of their roles in drug addiction. *Neuroscience and Biobehavioral Reviews* 37. doi:10.1016/j.neubiorev.2013.02.010. Elsevier Ltd: 1946–1954.
 23. Goldstein, R.Z., and N.D. Volkow. 2002. Drug addiction and its underlying neurobiological basis: neuroimaging evidence for the involvement of the frontal cortex. *The American Journal of Psychiatry* 159: 1642–1652.
 24. Goldstein, Rita Z., and Nora D. Volkow. 2011. Dysfunction of the prefrontal cortex in addiction: neuroimaging findings and clinical implications. *Nature Reviews. Neuroscience* 12: 652–669. doi:10.1038/nrn3119.
 25. Volkow, N.D., and J.S. Fowler. 2000. Addiction, a disease of compulsion and drive: involvement of the orbitofrontal cor- tex. *Cerebral Cortex* 10: 318–325. doi:10.1093/cercor/10.3.318.
 26. Greenough, W.T., J.E. Black, and C.S. Wallace. 1987. Experience and brain development. *Child Development* 58: 539–559. doi:10.2307/1130197.
 27. Doidge, Norman. 2007. *The brain that changes itself. Stories of personal triumph from the frontiers of brain science*. London: Penguin.
 28. Edelman, Gerald. 1978. *The mindful brain: cortical organi- zation and the group-selective theory of higher brain func- tion*. Cambridge: MIT Press.
 29. Blakemore, Sarah-Jayne, and Suparna Choudhury. 2006. Development of the adolescent brain: implications for exec- utive function and social cognition. *Journal of Child Psychology and Psychiatry, and Allied Disciplines* 47: 296–312. doi:10.1111/j.1469-7610.2006.01611.x.
 30. Kober, Hedy, Peter Mende-siedlecki, Ethan F. Kross, Jochen Weber, Walter Mischel, Carl L. Hart, and Kevin N. Ochsner. 2010. Prefrontal-striatal pathway underlies cognitive regula- tion of craving. *Proceedings of the National Academy of Sciences of the United States of America* 107: 14811–14816. doi:10.1073/pnas.1007779107.

31. Mischel, W., E.B. Ebbesen, and A.R. Zeiss. 1972. Cognitive and attentional mechanisms in delay of gratification. *Journal of Personality and Social Psychology* 21: 204–218.
32. Marsch, L.A., and W.K. Bickel. 2001. Toward a behavioral economic understanding of drug dependence: delay discounting processes. *Addiction*. doi:10.1046/j.1360-0443.2001.961736.x.
33. McClure, S.M., D.I. Laibson, G.F. Loewenstein, and J.D. Cohen. 2004. Separate neural systems value immediate and delayed monetary rewards. *Science* 306: 503–507. doi:10.1126/science.1100907.
34. Bjork, James M., Reza Momenan, and Daniel W. Hommer. 2009. Delay discounting correlates with proportional lateral frontal cortex volumes. *Biological Psychiatry* 65: 710–713. doi:10.1016/j.biopsych.2008.11.023.
35. Foddy, Bennett, and Julian Savulescu. 2010. A liberal account of addiction. *Philosophy, Psychiatry, & Psychology* 17: 1–22.
36. Brewer, Judson A., and Marc N. Potenza. 2008. The neurobiology and genetics of impulse control disorders: relationships to drug addictions. *Biochemical Pharmacology* 75: 63–75. doi:10.1016/j.bcp.2007.06.043.
37. Fisher, Helen E., Arthur Aron, Debra Mashek, Haifang Li, and Lucy L. Brown. 2002. Defining the brain systems of lust, romantic attraction, and attachment. *Archives of Sexual Behavior* 31: 413–419. doi:10.1023/A:1019888024255.
38. Burkett, James P., and Larry J. Young. 2012. The behavioral, anatomical and pharmacological parallels between social attachment, love and addiction. *Psychopharmacology*. doi:10.1007/s00213-012-2794-x.
39. Toates, Frederick. 2014. *How sexual desire works*. Cambridge: Cambridge University Press.
40. Salamone, J.D., M. Correa, A. Farrar, and S.M. Mingote. 2007. Effort-related functions of nucleus accumbens dopamine and associated forebrain circuits. *Psychopharmacology*. doi:10.1007/s00213-006-0668-9.
41. Assadi, Seyed M., Murat Yucel, and Christos Pantelis. 2009. Dopamine modulates neural networks involved in effort-based decision-making. *Neuroscience and Biobehavioral Reviews*. doi:10.1016/j.neubiorev.2008.10.010.
42. Steinbeis, N., J. Haushofer, E. Fehr, and T. Singer. 2014. Development of behavioral control and associated vmPFC-DLPFC connectivity explains Children's increased resistance to temptation in intertemporal choice. *Cerebral Cortex*: 32–42. doi:10.1093/cercor/bhu167.
43. Hershfield, Hal E., Daniel G. Goldstein, William F. Sharpe, Jesse Fox, Leo Yeykelis, Laura L. Carstensen, and Jeremy N. Bailenson. 2011. Increasing saving behavior through age-progressed renderings of the future self. *Journal of Marketing Research* 48: S23–S37. doi:10.1509/jmkr.48.SPL.S23.
44. Figner, Bernd, Daria Knoch, Eric J. Johnson, Amy R. Krosch, Sarah H. Lisanby, Ernst Fehr, and Elke U. Weber. 2010. Lateral prefrontal cortex and self-control in intertemporal choice. *Nature Neuroscience* 13: 538–539. doi:10.1038/nn.2516.
45. Wiers, Reinout W., Bruce D. Bartholow, Esther van den Wildenberg, Carolien Thush, Rutger C.M.E. Engels, Kenneth J. Sher, Jerry Grenard, Susan L. Ames, and Alan W. Stacy. 2007. Automatic and

- controlled processes and the development of addictive behaviors in adolescents: a review and a model. *Pharmacology Biochemistry and Behavior*. doi:10.1016/j.pbb.2006.09.021.
46. Tian, Xing, and David E. Huber. 2013. Playing Bduck duck goose^ with neurons: change detection through connectivity reduction. *Psychological Science* 24: 819–827. doi:10.1177/0956797612459765.
 47. Low, Lawrence K., and Hwai-Jong Cheng. 2006. Axon pruning: an essential step underlying the developmental plasticity of neuronal connections. *Philosophical Transactions of the Royal Society of London. Series B, Biological Sciences* 361:1531–1544. doi:10.1098rstb.2006.1883
 48. Connolly, Colm G., Ryan P. Bell, John J. Foxe, and Hugh Garavan. 2013. Dissociated grey matter changes with prolonged addiction and extended abstinence in cocaine users. *PLoS ONE*: 8. doi:10.1371/journal.pone.0059645.
 49. Morales, Angelica M., Buyean Lee, Gerhard Helleman, Joseph O'Neill, and Edythe D. London. 2012. Gray-matter volume in methamphetamine dependence: cigarette smoking and changes with abstinence from methamphet- amine. *Drug and Alcohol Dependence* 125: 230–238. doi:10.1016/j.drugalcdep.2012.02.017.
 50. Flanagan, Owen. 2013. The shame of addiction. *Frontiers in Psychiatry* 4: 1–11.
 51. Doidge, Norman. 2015. *The brain's way of healing*. London: Viking.
 52. Li, Ping, Jennifer Legault, and Kaitlyn A. Litcofsky. 2014. Neuroplasticity as a function of second language learning: anatomical changes in the human brain. *Cortex*. doi:10.1016/j.cortex.2014.05.001.
 53. Lewis, Marc D. 1997. Personality self-organization: cascading constraints on cognition-emotion interaction. *Dynamics and Interdeterminism in Developmental and Social Processes* 193–216.
 54. Lewis, Marc D. 2010. Desire, dopamine, and conceptual development. *Child Development at the Intersection of Emotion and Cognition*: 175–199. doi:10.1037/12059-010.
 55. Lewis, Marc D., and Rebecca M. Todd. 2007. The self-regulating brain: cortical-subcortical feedback and the development of intelligent action. *Cognitive Development* 22: 406–430. doi:10.1016/j.cogdev.2007.08.004.
 56. Ainslie, George. 2001. *Breakdown of will*. Cambridge: Cambridge University Press.
 57. Cicchetti, Dante, and Donald J. Cohen. 2006. Developmental psychopathology, Vol 3: Risk, disorder, and adaptation (2nd ed.). In *Developmental psychopathology, Vol 2: Developmental neuroscience*, xvi, 944.
 58. Pickard, Hanna, S.H. Ahmed, and Bennett Foddy. 2015. *Introduction: alternative models of addiction*. Lausanne: Frontiers Media.
 59. Alexander, Bruce K., Robert B. Coombs, and Patricia F. Hadaway. 1978. The effect of housing and gender on morphine self-administration in rats. *Psychopharmacology* 58: 175–179.
 60. Pickard, Hanna, Serge H. Ahmed, and Bennett Foddy. 2015. Alternative models of addiction. *Frontiers in Psychiatry*. doi:10.3389/fpsy.2015.00020.
 61. CA, Nelson Charles A., J.P.P. Joseph, P. McCleery, and C.A. Nelson 3rd. 2008. Use of event-related potentials in the study of typical and atypical development. *Journal of the American Academy of Child &*

Adolescent Psychiatry 47: 1252–1261. doi:10.1097/CHI.0b013e318185a6d8.Use.

PRACTICAL GUIDE FOR IMPLEMENTING A TRAUMA-INFORMED APPROACH

SAMHSA's 2014 Concept of Trauma was a landmark publication that has influenced service provision beyond the areas of behavioral health and health care. In 2014, SAMHSA also released Treatment Improvement Protocol (TIP) 57, Trauma-Informed Care in Behavioral Health Services. Trauma continues to be a cross-SAMHSA priority, given its significant role in behavioral health prevention, treatment, and recovery. The primary goal of this practical guide is to expand the discussion presented in SAMHSA's earlier resources, specifically focusing on tools and strategies for implementing a trauma-informed approach (TIA).

This guide highlights the need for organizational assessment of readiness and capacity before implementing TIA and describes strategies for such assessments. The guide focuses on implementation strategies across the following 10 domains:

1. Training and Workforce Development
2. Governance and Leadership
3. Cross Sector Collaboration
4. Financing
5. Physical Environment
6. Engagement and Involvement
7. Screening, Assessment, and Treatment Services
8. Progress Monitoring and Quality Assurance
9. Policy
10. Evaluation

The guide is intended for anyone involved in organization-level change, including practitioners, state and local officials, policymakers, federal and non-federal funders, peers, and family members.

Section 1: Introduction

Trauma can be a life-changing experience. Traumatic events can happen at any age to any person and may affect an individual's daily life and cause long-lasting harm to the individual's physical and mental health and well-being. Traumatic events may be experienced by an individual, a generation, or an entire community or

culture. Trauma recovery and healing is possible through appropriate and adequate support at the individual, family, and community levels.

Systems and organizations that implement a **trauma-informed approach (TIA)** create safer environments for their staff and the individuals they serve. They deliver services with the best chance of achieving optimal health outcomes. Creating a safe environment, for both physical and emotional safety, requires intentionally and comprehensively incorporating trauma-informed principles and practices into an organization's structure, service delivery, and culture. It is important that agencies and organizations evaluate their current practices and procedures and take actionable steps to incorporate TIA strategies within their policies and practices. Agencies and organizations should not use procedures and practices that retraumatize and remind individuals and communities of past trauma (e.g., traumas such as use of restraints, seclusion, or invasive procedures in the medical system). These practices can unintentionally re-harm and recreate traumatic experiences for individuals who have a history of trauma.

The need to incorporate a TIA is not limited to behavioral health services. It needs to be addressed across other systems as well, such as child welfare, law enforcement, criminal and juvenile justice, education, victim services, physical health care, services for housing insecurity, veterans affairs, and the military.³ These systems can provide more effective services through operationalizing trauma-informed principles and practices that facilitate recovery.

This practical guide builds on SAMHSA's *2014 Concept of Trauma* and *TIP 57: Trauma-Informed Care in Behavioral Health Services* publications and is written in coordination with the federal Interagency Task Force for Trauma-Informed Care. Its primary goals are to:

- Provide implementation strategies across multiple domains—from governance to staff training to evaluation—based on the original *Concept of Trauma* publication
- Encourage leadership to adopt a TIA at the organizational level

This resource is intended for anyone involved in organization-level change, including practitioners, state and local officials, policymakers, and federal and non-federal funders.

TIP: Trauma-Informed Approach Defined

A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist retraumatization.

1.1 Defining Trauma

Trauma results from an event, series of events, or a set of circumstances that an individual experiences as physically or emotionally harmful or threatening, which may have lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.⁴ Trauma is associated with widespread health challenges across demographic groups and can have far-reaching implications across individuals, families, and communities.

TIP: "Three Es" of Trauma

Individual trauma results from an **event**, series of events, or a set of circumstances that an individual **experiences** as physically or emotionally harmful or life threatening and that may have lasting adverse **effects** on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

Worldwide estimates suggest that over 70 percent of people experience at least one traumatic event in their lifetime, with almost 31 percent being exposed to four or more such events.⁵ In the United States, 90 percent of adults report exposure to at least one traumatic event, with women reporting higher rates of direct interpersonal violence, sexual assault, and physical assault than men.⁶ Unaddressed trauma can lead to mental illness and substance use disorders, as well as chronic physical health conditions, including cardiovascular disease and cancer. [3,7-9]

Traumatic events can be a single incident or a long-term chronic pattern and are often categorized as natural or human caused. Examples of traumatic events include, but are not limited to: [11]

- Physical, sexual, and emotional abuse
- Living with a family member with physical or mental health conditions or substance use disorders
- Domestic violence or sexual assault
- Chronic poverty, racism, discrimination, or oppression
- Violence in the community, war, or terrorism
- Living through a natural disaster or other period of distress

Traumatic events are experienced individually or collectively. The context within which the event takes place has implications for how individuals respond and the types of support or services they should receive. [12,13] Trauma occurs at various levels: micro (individual, family), mezzo (groups), and macro (organizations/community). It is essential to acknowledge that these levels are interconnected and contribute to trauma's collective impact.¹⁴ At the community level, systemic causes of trauma sustain its likelihood and the perpetuation of its effects. Historical trauma, defined as collective complex trauma inflicted on a group of people who share a specific identity or affiliation, is an example of community-level trauma. [15]

TIP: Recognize the Long-Lasting Consequences of Trauma in the Developing Years

Adverse childhood experiences (ACEs) are potentially traumatic events that occur in childhood (0–17 years). ACEs can include experiences of violence, psychological or sexual abuse, and neglect, as well as aspects of a child’s environment that undermine their sense of safety and stability, such as parental separation or substance use problems within the household. [10]

1.2 Impact of Trauma

Individuals process traumatic events differently, and those who experience traumatic events may or may not experience any lasting, negative effects.⁴ Previous life experiences, social supports, personal coping skills, early relational health, and community reactions can influence how an individual responds to a potentially traumatic event. Among some cultural groups, there are taboos associated with overt demonstrations of trauma’s typical effects (described below).¹⁶ As a result, people might not look traumatized, so other ways of understanding their experience will be warranted. In addition, structural discrimination against groups, such as the LGBTQI+ community or BIPOC populations, and historical and intergenerational trauma, can exacerbate the effects of individual trauma. As a result of negative experiences with beliefs and actions stemming from White supremacy, structural racism, and social devaluation of people of color, subsequent exposure to traumatic situations can lead to complex trauma.

Impact of Trauma on Individuals

Emotional	Behavioral	Physical	Developmental	Cognitive	Interpersonal	Spiritual
<ul style="list-style-type: none">• Difficulty regulating emotions• Emotional numbness• Post traumatic stress disorder	<ul style="list-style-type: none">• Substance abuse• Self-destructive behaviors• Avoidance of situations, people, and places	<ul style="list-style-type: none">• Physical symptoms resulting from emotional distress, including headaches, high blood pressure, and fatigue• Hyperarousal resulting in muscle tension and insomnia	<ul style="list-style-type: none">• Impact varies by age group• Children and elderly at greatest risk• Changes occur in brain development	<ul style="list-style-type: none">• Impaired short-term memory• Decreased focus or concentration• Feeling alienated or ashamed• Dissociation, depersonalization, and derealization• Flashbacks or re-experiences of the event	<ul style="list-style-type: none">• Withdrawal from family, friends, and community• Difficulty trusting others	<ul style="list-style-type: none">••

Individuals who experience trauma are at greater risk of developing mental health conditions such as anxiety disorders, depression, posttraumatic stress disorder (PTSD), and serious mental illnesses like schizophrenia and other forms of psychosis. [12] Particularly among youth, childhood exposure to trauma is associated with increased odds of adult psychiatric and functional outcomes, after adjusting for a broad range of childhood risk factors. [17] Trauma can negatively impact social, economic, and cognitive functioning and emotional regulation, and prolonged exposure to traumatic events in early childhood may interrupt normal brain development.¹⁸ Ignoring or suppressing experiences of trauma, rather than acknowledging and processing the adversity, has a greater negative impact on an individual’s mental health. [19]

In response to trauma, some individuals may adopt maladaptive coping mechanisms such as unhealthy eating or self-harm. In particular, there is a strong link between trauma and alcohol/substance use, death by overdose, and suicide. [20, 21] Among individuals diagnosed with PTSD, the prevalence of comorbid substance use ranges from 19 to 35 percent and comorbid alcohol abuse ranges from 36 to 52 percent.²² Almost half (47 percent) of individuals with PTSD may also have a comorbid substance use disorder (SUD). Individuals with SUD are also more likely to experience traumatic events, creating a perpetuating cycle. [23]

Trauma is associated with mistrust of the healthcare system. For example, as a result of non-consensual medical interventions and repeated examinations of intersex traits for the benefit of doctors and trainees, many intersex individuals have significant medical trauma and mistrust, which leads to frequent delays and avoidance of care. [24]

Posttraumatic growth is the potential positive psychological change in individuals that may occur after experiencing trauma. It is facilitated by making sense of the traumatic event and its related effects in a way that results in new meaning, personal insight, and understanding of oneself, others, the world, or future

expectations. [25] The concept of posttraumatic growth does not refute, minimize, or invalidate the negative impact and emotional, cognitive, or behavioral consequences frequently associated with trauma; individuals can, in fact, experience posttraumatic growth along with PTSD.²⁶ While not all individuals experience posttraumatic growth, some people do report personal growth following a traumatic experience. [27] The concept suggests that a traumatic experience may inadvertently lead to positive reactions, such as greater appreciation of life, relationships with others, new life possibilities, personal strengths, and spiritual change. [26]

At the community level, the impact of trauma is categorized as physical, social-cultural, or economic.¹⁴ Examples of community trauma can be seen in different areas, including the:

- Physical/built environment, through deteriorated public spaces, degraded infrastructure, climate change, and limited availability of healthy food.
- Social-cultural environment, as evidenced by damaged social networks, low sense of collective effectiveness to bring about change, and experience of fear and shame.
- Economic and educational environment, characterized by intergenerational poverty, long-term unemployment, and limited employment opportunities.

Resource

PTSD is a mental health condition triggered by a terrifying event—either experiencing it or witnessing it. Symptoms may include flashbacks, nightmares, and severe anxiety, as well as uncontrollable thoughts about the event.

This brochure from the National Institute of Mental Health provides information about PTSD, including who develops it, its symptoms, treatment options, and how to find help. The brochure is also available in Spanish.

It is essential to acknowledge that trauma is a social justice issue. [28] Minority and under-resourced communities disproportionately experience trauma. Trauma caused by systemic issues, such as racism, genderism, homophobia and transphobia, poverty, sexism, and ableism, can have severe, long-lasting, intergenerational impacts on individuals and communities. A commitment to TIA implementation requires recognition of the social conditions that produce trauma. Social justice—the elimination of systemic

oppression and institutional barriers with the goal of ensuring equitable access to opportunities and resources for all—needs to be an essential component of a TIA for it to lead to positive outcomes.

1.3 Prevalence of Trauma

Men and women are likely to experience different traumatic events, and women are two times more likely to develop PTSD than men. [29] Women report higher rates of sexual assault or child sexual abuse, while men are more likely to experience accidents, physical assault, combat, disasters, or be a witness to death/injury. [29] Lifetime prevalence of PTSD has been shown to be highest among Black populations.³⁰ Minority youth are more likely to experience trauma, including historical trauma, immigration stressors, natural and man-made disasters, discrimination, and violence, and less likely to access medical and mental health care.³¹ In particular, Black and Latino young men disproportionately experience violence, poverty, incarceration, lack of access to health care, marginalization, and low social status. [32] The historic and intergenerational trauma American Indians and Alaska Natives experience puts them at increased risk of modern-day traumatic experiences. Additionally, LGBTQI+ individuals are nearly four times more likely to experience violent assault than their cisgender, heterosexual counterparts. [33]

1.4 Defining a Trauma-Informed Approach

KEY TAKEAWAY: Elements of TIA

SAMHSA's concept of a trauma-informed approach is grounded in a set of four assumptions, six key principles, and ten implementation domains.

Assumptions:

1. Realize the widespread impact of trauma and understand potential paths for recovery.
2. Recognize the signs and reactions of trauma in clients, families, staff, and others involved with the organization.
3. Respond by fully integrating knowledge about trauma into policies, procedures, and practices.
4. Resist re-traumatization

Principles:

1. Safety.
2. Trustworthiness and transparency.
3. Peer support.
4. Collaboration and mutuality.
5. Empowerment, voice, and choice.
6. Cultural, historical, and gender issues.

Domains of Implementation:

- Governance and Leadership
- Training and Workforce Development
- Cross Sector Collaboration
- Financing
- Physical Environment
- Engagement and Involvement
- Screening, Assessment, Treatment Services
- Progress Monitoring and Quality Assurance
- Policy
- Evaluation

Incorporating a TIA involves understanding the widespread impact of trauma, recognizing trauma symptoms in both staff and care recipients, avoiding re-traumatization, and supporting paths to recovery. For a program, organization, or system to be trauma-informed, it is not enough to provide trauma-specific interventions. An organization or agency must incorporate trauma-informed principles in its culture, policies, procedures, and practices.

A TIA requires all personnel of an agency, including, but not limited to, administrators, providers, staff, and board members, to recognize that a care recipient's history of trauma can affect their:

- Experience, engagement, and receptiveness to the organization's services and supports
- Functioning in the community
- Interactions with staff and other clients
- Sensitivity to guidelines and interventions

In addition, organizations need to implement TIA holistically by recognizing that trauma is not unidirectional and that the micro, mezzo, and macro levels of trauma are intricately connected. Finally, organizations need to

acknowledge the trauma staff and providers themselves experience, either as part of their own personal lives or secondary to working with clients who share firsthand details about their trauma.

Realization	Recognition	Response	Resisting Re-Traumatization
<ul style="list-style-type: none">• Understanding how trauma can affect individuals, families, groups, organizations, and communities• Recognizing that trauma can impact mental health and substance use disorders and often obstructs achievement of desired outcomes• Being aware that trauma is integral to all human service sectors	<ul style="list-style-type: none">• Recognizing signs of trauma through:<ul style="list-style-type: none">◦ Screening & assessment◦ Supervision practices◦ Workforce development◦ Employee assistance	<ul style="list-style-type: none">• Applying the principles of a trauma-informed approach to all areas of functioning of an organization, such as policies, procedures, staffing and organizational culture• Supporting a psychologically and physically safer environment• Ensuring appropriate workforce trainings, leadership buy-in, clear and informed organization mission statements, and trauma-informed manuals	<ul style="list-style-type: none">• Knowing how policies, practices, and interventions can interfere with the well-being of staff and clients as a result of inadvertently triggering traumatic experiences• Acknowledging trauma and its context in all operations to avoid reinforcing or repeating a traumatic experience

Implementing a TIA involves an organizational change process that incorporates 10 implementation domains. This change process, along with the strategies involved, is discussed in Chapter 3. A TIA may start with a redesign of organizational practices to establish standards of care to enhance clients’ strengths and resilience, protect the vulnerabilities of those with trauma history, and develop guidelines to support the delivery of trauma-specific services. Any redesign to incorporate a TIA should begin with a needs assessment and involve people with lived experience, their families, and communities, as part of the design, delivery, and ongoing evaluation of the services. [35, 36]

A TIA adheres to six principles, not merely a set of practices, methods, or procedures. A system, organization, or program must embody each of these principles in how it operates, delivers services, and empowers its staff, people who receive care, and members of the community. A TIA can be generalized and adapted to multiple settings, people served, and practitioners. TIA adaptation in different settings or for a particular population will involve terminology and practices appropriate to that setting or set of individuals served.

Most importantly, an organization needs to consider that there are macro-level influences— including societal norms, generational history, government policies, and laws—that impact the individuals they serve

and their TIA implementation. Understanding and acknowledging that there are overarching generational, cultural, and societal issues that have caused trauma in the past and continue to re-traumatize individuals is the first step toward TIA implementation. A TIA space needs to be collectively created. For a TIA to flourish, the organizational culture will need to value not only lived expertise but also trauma experiences of a person's ancestors that continue to affect the client today. TIA begins with cultural humility at all levels—individuals, organizations, and systems.

Six Principles of a TIA

1. **Safety:** Safety in physical setting and interpersonal interactions
2. **Trustworthiness and Transparency:** Operations are conducted and decisions are made with transparency, consistency, respect, and fairness so as to build and maintain trust
3. **Peer Support:** Support from those with lived experiences of trauma or, in case of children with history of trauma, their family members
4. **Collaboration and Mutuality:** Partnering, leveling of power differences between and among staff and clients
5. **Empowerment:** Individuals' strengths and experiences are recognized and built upon
6. **Cultural, Historical and Gender Issues:** Organization moves beyond the cultural stereotypes and biases

1.5 Framework for This Resource

Multiple frameworks describe the process of planning and implementing a TIA at the systems or organizational level. Most common among these frameworks are:

- Community Connections' Creating Cultures of Trauma-Informed Care (CCTIC)
- Trauma Informed Oregon's Roadmap to Trauma Informed Care
- Traumatic Stress Institute's Whole-System Change Model to Trauma-Informed Care
- American Institutes for Research's Framework for Building Trauma-Informed Organizations and Systems

Although the phases in each framework differ, common themes emerge. A graphic depiction of a comprehensive TIA implementation process that draws upon these themes is shown on the right. The next sections in this resource follow these three phases of TIA implementation:

- Section 2 discusses the process of organizational assessment of readiness, capacity, and planning for TIA implementation.

- Section 3 describes areas involved in the process of TIA implementation and provides strategies across its various domains.
- Section 4 discusses the process of evaluation and ensuring sustainability of the implemented TIA.
- Section 5 includes three case studies that illustrate a TIA in action across different types of systems and organizations.

Each section presents concise, actionable guidance and tools to support TIA integration with policy, practice, and culture at the organizational and systems levels. Strategies and recommendations are provided for each of the 10 implementation domains covered in the original concept paper. Each section includes tips, takeaway messages, and highlighted resources, and concludes with a list of additional resources for topics discussed in the section.

Section 2: Organizational Assessment and Planning for a TIA

KEY TAKEAWAY: Organizational Assessments

Organizational assessments and monitoring should be built into the change process while implementing a TIA. There are typically two kinds of TIA assessments:

- Those carried out early in the process that allow an organization to identify its needs and evaluate its readiness and capacity for making systemic change.
- Those carried out during the systemic change process that allow the organization to evaluate its successes and barriers, modify its TIA implementation activities as needed, and prioritize areas for change.

An organization's readiness and capacity assessments are the first step in implementing a trauma-informed approach (TIA) for systems- or organization-level change. They establish baseline competencies and evaluate organizational readiness for change. A thorough, measurable assessment:

- Helps a system or organization determine areas for improvement and areas of strength across all levels of the system or organization

- Allows an organization to assess capacity and target training activities and strategic planning • Helps the leadership and staff understand the need for a TIA

Provides data to validate TIA need and assess readiness for TIA implementation

This section focuses on the first step of conducting a baseline assessment. However, assessment is also a continuous activity and may not always be a linear process.

During the training and implementation phases, for example, assessment involves the ongoing process of progress monitoring and continuous quality improvement (CQI). During the evaluation and sustainability phase, assessment involves documenting changes to policy, practice, and organizational culture, and evaluating the impacts of a TIA at the staff, client, and organization levels. Section 4 focuses on assessment processes during these other phases.

TIP: Baseline Assessment Is an Essential Component of TIA Implementation

A baseline assessment provides a benchmark for measuring progress and improvement. It reviews an organization's current competencies, identifies areas to address related to a TIA, and creates a reference for continual monitoring and evaluation.

2.1 Steps in Conducting a Baseline Assessment

Conducting a baseline assessment involves the following steps:

1. Form an organizational capacity assessment team
2. Encourage organizational readiness
3. Engage partner organizations and individuals with lived experience
4. Select an assessment tool
5. Decide on data collection and analysis methods
6. Implement the assessment and decide on next steps

2.1.1 Form an organizational capacity assessment team

- Convene an assessment team.
 - Ensure that the team comprises individuals at all levels and departments within the organization, namely, administrators, practitioners and other direct care staff, and human resources staff. Make an explicit effort to include individuals of diverse backgrounds and experiences, as well as any other members of disempowered and under-resourced groups in the community.
 - Invite people with lived experience, who may be current or former clients, to be involved in the assessment team or as an advisory group. Equitably compensate individuals with lived experience

for their time and expertise.

- Establish a clear timeline and expectations for deliverables from the assessment team. ‘

2.1.2 Encourage organizational readiness.

- Measure staff and leadership motivation to adopt and implement a TIA with fidelity.
 - Conduct focus groups and interviews to assess willingness for change and commitment to implement a TIA.
 - Establish a common understanding of trauma and a TIA.
 - Address any concerns identified during organizational motivation assessment.
- Engage executive leadership and ensure leadership buy-in
 - Identify champions to foster internal buy-in. Champions can also help establish cross sector collaborations and reduce any staff resistance.
- Evaluate how a TIA is different from current operations. Identify any current operations that align with a TIA and assess how to build upon those.
- Assess the anticipated and desired impact of change from current operations to a TIA.

2.1.3 Engage partner organizations and individuals with lived experience.

- Identify existing cross sector and cross system collaborations and new, potential collaborations.
 - Determine the extent to which collaborating organizations are trauma-informed and incorporate awareness of trauma in all aspects of their operations and service delivery.
 - Use a strengths-based approach and focus on already implemented trauma-informed programs or practices that have the potential to be expanded.

2.1.4 Select an assessment tool.

- Ensure the assessment tool covers all 10 domains of TIA implementation.
- Based on available resources, both human and financial, consider whether to implement a self-administered assessment tool or hire an external consultant to implement the assessment and interpret the results.
- Remember that many assessment tools can be used to assess readiness and capacity for a TIA across different service systems, although some are specific to a particular sector (e.g., child welfare). The reference list at the end of this chapter provides a range of assessment scales and tools.

2.1.5 Decide on data collection and analysis methods.

- Establish clear data collection methods.
 - Design data collection protocols that identify who will collect assessment data and from whom.
 - Create safety around assessment and ensure that data privacy and anonymity are maintained.
 - Establish secure databases and processes for data management and analysis.
- Remember that organizational capacity assessment data can be analyzed in different ways to reveal insights into areas on which an organization may need to work. For example, consumers and staff may rate the same area (e.g., physical environment) very differently.
- Ensure data collection methods are culturally responsive.

2.1.6 Implement the assessment and decide on next steps.

- If using a self-administered assessment tool, identify the resources needed to implement it.
 - Determine availability and sufficiency of all resource types—financial, physical, and human capital.
- Develop an action plan that considers all 10 implementation domains and includes concrete actions and changes within each domain.
 - At minimum, include organizational priorities based on assessment data, individual responsibilities (e.g., leadership, staff, partners), a timeline and budget for implementation, performance indicators, and monitoring and evaluation activities.
 - Acknowledge existing positive practices and policies and reinforce continued implementation of these across all 10 domains.
- Announce the assessment initiative to the organization's staff and keep them informed and involved at all implementation stages to increase buy-in.

TIP: Consider These Questions When Creating an Action Plan

1. What do you want to change (goals)?
2. Why did you choose these goals?
3. What steps will you need to take to meet these goals?
4. Who will be responsible?
5. When do you want to accomplish these goals?

6. How will you know that you have accomplished your goals? [37]

2.2 Additional Resources

- Trauma Informed Care Project's Trauma System Readiness Tool (TSRT) provides child welfare agencies with a self-assessment for trauma-informed care, including guidance on how to complete the self-assessment.
- American Institutes for Research's and Chapin Hall's Building a Multi-System Trauma-Informed Collaborative includes a system readiness tool and agency reflection tool.
- Trauma Informed Oregon's Standards of Practice for Trauma Informed Care includes a self-assessment with rating scales along the following domains: agency commitment and endorsement; environment and safety; workforce development; services and service delivery; and systems change and progress monitoring.
- Trauma Informed Oregon's Trauma Informed Care Screening Tool outlines the developmental phases of measuring an organization's readiness to implement a trauma-informed approach.
- Southwest Michigan's Children's Trauma Assessment Center's Trauma Informed System Change Instrument (TISC) and TISC Scoring Guide and Psychometrics provide an organizational change self-evaluation.
- The National Council for Mental Wellbeing offers a self-assessment tool titled Organizational Self-Assessment: Adoption of Trauma-Informed Care Practice.
- Community Connections has developed Creating Cultures of Trauma-Informed Care (CCTIC): A Self-Assessment and Planning Protocol.
- The Traumatic Stress Institute's organizational self-assessment tool is designed specifically for youth-serving organizations.
- The National Center on Family Homelessness at the American Institutes for Research has developed the Trauma-Informed Organizational Toolkit for Homeless Services.
- American Institutes for Research's (AIR) Trauma-Informed Care for Displaced Populations: A Guide for Community-Based Service Providers includes TIA implementation strategies along with an organizational self-assessment for agencies serving displaced children and families.
- The Wisconsin Children's Trust Fund's Trauma-Informed Organizational Self-Assessment for Child Abuse Prevention Agencies serves as a guide for child abuse and neglect prevention agencies to implement an assessment as part of the pathway to becoming trauma-informed.
- The University of South Florida's Self-Assessment for Trauma-Informed Care Practices is a tool used to evaluate organizational practices in youth residential settings.
- AIR's Trauma-Informed Organizational Capacity Scale is a validated measure of trauma-informed capacity in health and human services organizations. AIR offers consultation services for organizations

looking to implement the tool.

- The ARTIC Scale (Attitudes Related to Trauma-Informed Care) is a psychometrically valid measure of staff attitudes related to trauma-informed care developed by Tulane University and the Traumatic Stress Institute.
- Coordinated Care Services' and the Institute of Trauma and Trauma Informed Care at the University of Buffalo's Trauma Responsive Understanding Self-Assessment Tool (TRUST) and Trauma Responsive Understanding Self-Assessment Tool for Schools (TRUST-S) are strengths-based organizational self-assessment tools that use SAMHSA's 10 implementation domains as a framework.
- The National Child Traumatic Stress Network's Trauma Informed Organizational Assessment is a tool to help organizations serving children and families who have experienced trauma assess their current TIA practices.
- The University of Buffalo's Center for Social Research's Trauma-Informed Organizational Change Manual contains a self-assessment tool.

Section 3: Implementing a Trauma-Informed Approach

After an organization completes the assessment of its readiness and capacity to implement a strengths-based, trauma-informed approach (TIA), the organization is ready to move into the implementation phase. This phase requires simultaneous and iterative actions in the domains listed in Section 1. This chapter provides implementation strategies for each of these domains.

3.1 Governance and Leadership

Strong governance and leadership with an investment in prioritizing trauma-informed principles and practices are necessary for successful implementation and long-term sustainability of a TIA. A long-lasting initiative must be supported at the highest levels of the organization. Governance and leadership positions must also include individuals with lived experience of trauma. [3]

However, all individuals within the organization play a critical role in prioritizing a TIA. [38, 39] To demonstrate a genuine investment in TIA [3, 40], organizations can:

- Show transparency with organizational operations and decisions, with a goal of building and maintaining trust at all levels, including regular, open communication with staff, partners, clients, and families regarding the organization's TIA commitment.
- Ensure individuals with trauma histories are in governance and leadership positions and involved in planning (i.e., "leveling of power").

- Identify a “champion” in a position of authority with a dedicated role of instilling trauma-informed principles and practices into the organization. This person also can help support staff in promoting and practicing a TIA.
- Ensure leaders model a TIA within their organization and encourage individuals at all levels to check one another when actions do not align with a TIA.

Resource

The Center for Health Care Strategies, Inc. has created a resource that provides tips on implementing trauma-informed care within an organization. It describes the importance of open communication and engaging clients in planning, as well as hiring and supporting a trauma-informed workforce.

TIP: Review Roles and Structures with a TIA Lens

Review organizational structures with an eye toward ensuring consumers have meaningful representation in governance, a TIA champion has authority to advance a TIA within the organization, and there is clarity on all staff roles (clinical and non-clinical) in supporting TIA within the organization.

3.2 Training and Workforce Development

Implementing a TIA across organizations and systems involves intentional strategies for recruiting, hiring, training, and retaining both clinical and non-clinical staff. To facilitate this, organizations can:

- Hire a trauma-informed workforce.
 - Use behavioral interviewing techniques to screen for TIA skills, such as empathy, understanding,

and trust.

- Train staff in a TIA.
 - Begin TIA training early in the onboarding process.
 - Implement ongoing training that focuses on: [37]
 - General trauma theory, focusing on trauma’s impact on children, youth, and families in the various domains listed in Section 1.
 - An overview of trauma-informed principles and domains, including practical, culturally and linguistically relevant, and equitable implementation strategies at the organizational and practitioner levels.
 - The effects of working with individuals who have trauma histories, including strategies to deal with secondary traumatic stress.
 - Diversity, equity, and inclusion (DEI) to create belonging and avoid othering of Black, Indigenous, and people of color (BIPOC) communities as well as people with disabilities and people who identify as LGBTQI+.
 - Train non-clinical staff, such as organizational leadership, administrative personnel, reception staff, and security guards, along with clinical staff.
- Prevent secondary traumatic stress in staff.
 - Provide training that helps staff understand and recognize secondary traumatic stress.
 - Offer opportunities for staff to explore their own experiences with trauma, especially the ways in which trauma impacts their work.
 - Support the well-being and health of staff through multiple practices, such as avoiding extremely high caseloads and demanding hours.
 - Provide trauma-informed reflective practice and clinical supervision

Resource

The Texas Department of Family and Protective Services provides a free, foundational training on trauma-informed care to assist families, caregivers, social service providers, and members of the public in understanding trauma and its impact, child traumatic stress, effects of adverse childhood experiences (ACEs), and strategies for TIA implementation. This training is available to providers in all states.

TIP: Ask About TIA Implementation Experience During Hiring Process

While interviewing candidates, assess the following areas using the example questions provided: [41]

- Experience working with clients exposed to trauma
 - *Our agency is working to become more trauma-informed. How do you define trauma? How might past experiences affect a person's current situation? Describe how this might inform the services you provide.*
- Experience working with adults/youth exposed to trauma
 - *Describe your experience working with adults/youth with histories of multiple placement failures, high levels of aggression, trauma, or violence. What lessons did you apply from this experience?*
- Understanding of a safe, trauma-informed environment
 - *What does a trauma-informed work environment look like to you?*
- Relationship-building skills
 - *What techniques have you found to be effective in developing trusting relationships and rapport with clients?*
- Responding to difficult/stressful situations
 - *Tell us about a time when you found yourself in a stressful situation at work. How did you respond?*
- Incorporating self-care
 - *What have you done to display healthy self-care skills during the past year?*

After initial training, organizations can offer continued support and assistance in multiple ways: [42]

- **Recognize differences in staff needs:** Staff members may vary in their needs as they deal with intense

situations or events with their clientele. Some may need a 15-minute break after seeing a client to calm themselves before returning to work, while others may need to speak with a mental health consultant or engage in a reflective supervision session. Ensure these provisions are in the organization's human resources policies.

- **Anticipate challenging situations:** Organizations can offer supportive check-ins for staff before anticipated intense or difficult conversations with clients or others.
- **Engage staff in decisions affecting them:** Organizations can involve staff in activities like setting ground rules about how meetings are carried out, discussing expectations around communication, and welcoming differences of opinions among the staff.
- **Offer opportunities for staff to come together:** Bringing staff together in safe, trusting, respectful spaces for formal or informal gatherings will both help bolster their working relationships and help create a strong emotional support system.

Resource

A brief developed by the Center for Health Care Strategies, Inc.'s Trauma-Informed Care Implementation Resource Center provides practical strategies for encouraging staff wellness in trauma-informed organizations.

This document describes the impact of work-related stress on staff well-being. It provides self-care and organizational strategies, as well as case studies of organizations implementing them.

3.3 Cross Sector Collaboration

A TIA is most effective in reaching positive outcomes when implemented consistently and collaboratively across various human services sectors.⁴³ Organizations often focus on offering individual services; however, from a client perspective, multiple systems are engaged and intricately connected in people's lives. If individuals and their families receive trauma-informed services through one organization but not others they interact with, TIA's effectiveness is highly reduced. Integrated, collaborative, community-wide, cross sector TIA implementation is essential.

One way to establish a cross sector TIA is to create a trauma-informed referral network that includes all service providers within a community or system of care. This network can be achieved through efforts like

convening a multi-agency TIA implementation task force that offers collaborative TIA training opportunities across the community or inviting clients to serve on advisory boards across agencies.

Another strategy is to establish a community-based learning collaborative. A community-based learning collaborative brings together multiple service-providing agencies within the community with the goal of facilitating implementation of interventions and innovations. This community-level, systemic approach to TIA implementation increases the likelihood of its sustained and long-term impact.

Resource

The guide *Building a Multi-System Trauma-Informed Collaborative* from the American Institutes for Research provides a framework for coordinated TIA implementation across multiple agencies that serve children, such as health care, child welfare, juvenile justice, and early child development. The guide offers the underlying theoretical basis, as well as specific strategies for coordinated and collaborative TIA implementation.

3.4 Financing

Identifying a sustainable financing strategy is necessary to fund TIA, including resources for staff training; development of safe facilities; provision of screening, assessment, treatment, and recovery supports; and development of cross-agency collaborations. Traditional payment systems and billing codes often create barriers to implementing TIA, since there are few direct reimbursement mechanisms specifically for trauma-informed activities. Organizations can use several strategies to address these challenges and maximize financing opportunities:

- **Diversify funding streams by using a combination of sources to support TIA implementation:** Potential sources include public insurance programs, commercial insurance, client self-pay, state and federal grants, and private philanthropy.
- **Determine what potential TIA activities, procedures, staffing, or encounters are covered by funders or payers under current agreements:** This process should include cross-referencing with funding options available for TIA implementation through initiatives or other special programs; that is, certain evidenced-based practices or quality improvement initiatives that may align with trauma-informed activities are reimbursable

- **Incorporate trauma-informed activities into existing reimbursable services:** Organizations can think strategically about how implementation changes made for a TIA fit into activities that are already provided and billed.
- **Consider accountable care models, which provide more incentives for investing in a TIA by rewarding value over volume:** Accountable care depends on coordinated care management and multidisciplinary collaboration, both of which align with TIA methodology.

Resource

Although there is no billing code specifically for a TIA, organizations can use billing codes strategically for reimbursement of direct trauma care services. The National Council for Mental Wellbeing has a list of common billing codes that can be used to support trauma-informed services.

3.5 Physical Environment

Within a trauma-informed organization, the environment must foster both physical and psychological safety for both clients and staff. [3, 38, 39] Individuals with lived experience of trauma should have a key role in identifying areas of strength and opportunities for improvement to make the physical and psychological experience more trauma-informed. When reflecting upon the physical environment, organizations should ensure that the neighborhood where services are offered is safe for collaborating providers and families.

A physically safe environment in a trauma-informed organization may have some of the following characteristics: [3, 40, 44]

- Well-lit exterior areas that do not allow for congregating outside entrances/exits, security guards available as needed, and monitoring of who is entering and exiting the building
- Low noise levels
- Signs that are warm, welcoming, and positive
- Seating arrangements that allow adequate space between individuals and clear sight lines of those entering a room
- Private areas to de-escalate stressful situations, promote calm, and attend to self-care
- Non-binary and gender-fluid spaces and activities

A psychologically safe environment would: [3, 39, 40, 44]

- Include training for clinical and non-clinical staff in how to communicate effectively with clients and greet them in a welcoming and respectful manner.
- Ensure staff maintain healthy interpersonal boundaries and appropriately manage conflict.
- Provide staff and clients schedules and structures that are predictable and give adequate notice when there are changes.
- Respect the physical boundaries of staff and clients and provide options like leaving office doors open.
- Offer gender-responsive services, embrace traditional cultural connections, be culturally relevant, and address historical trauma.

3.6 Engagement and Involvement

Engagement of individuals with lived experiences, those in recovery, and those receiving services, and their families, is fundamental to TIA implementation within any service organization. This engagement needs to be intentional, meaningful, empowering, and ongoing as well as implemented across all organizational levels. Organizations can use multiple strategies to ensure this engagement: [45]

- Show empathy and ensure those receiving services and their families feel safe in the organization's physical space.
- Inquire about the individual's needs and those of their family, actively listen to their answers, and act upon those needs.
- Intentionally engage those in recovery, individuals receiving services, and their families in making decisions, encouraging them to speak up, and empowering them to make choices.
- Collaborate with and listen to individuals and families while developing service delivery plans and giving them options.
- Invite and encourage peer support or develop a peer support program; peers can offer support in the form of understanding and encouragement toward growth and resilience.

KEY TAKEAWAY: Peer Support

Encouraging peer support is a promising engagement strategy for TIA. Peer support principles include that it: [46]

- Is not mandatory
- Is non-judgmental
- Is empathetic
- Is respectful
- Requires honest and direct communication
- Involves mutual responsibility
- Is about sharing power
- Is reciprocal

3.7 Screening, Assessment, and Treatment Services

A TIA involves implementing screening and assessment to support consumers and identifying their needs to tailor services accordingly. Screening and assessment that adhere to TIA principles involve:

- Developing a trusting and collaborative relationship with individuals who have experienced trauma and are seeking services.
- Preventing under-recognition of trauma that can lead to neglect or re-traumatization.
- Providing an opportunity for information gathering.

Trauma screening should be universal and involve brief inquiry to assess history of trauma, reactions to trauma, and specific behavioral health needs. Screening typically is limited to yes or no questions that allow a provider to identify if and what trauma has occurred and determine appropriate follow-up assessment, referral, or urgent response. Screening should be clear, straightforward, culturally appropriate, and culturally sensitive. It is essential to remember that trauma often is incorrectly viewed as a weakness and individuals who have experienced trauma may deny it.

Trauma assessment involves an in-depth exploration of the nature, severity, and timing of traumatic events and their associated effects and trauma-related symptoms. Assessment provides an opportunity for a more holistic and extensive examination and should be rooted in trust and safety. An extensively trained individual or clinician must conduct the clinical review, since it can involve psychological assessments, medical records, and interviews and contribute to a formal diagnosis and/or pathway to care. Moreover, trauma assessment should not be a single, one-time event, but a process that builds continuity and trust and establishes a grounded relationship with the individual.

Treatment services must be trauma-specific, culturally appropriate, grounded in evidence, accessible, effective, and adhere to TIA principles. When a comprehensive assessment suggests that formal treatment

of trauma may be warranted as part of an individual's care plan, a clinician may wish to use one or more therapeutic approaches specifically designed to address the trauma symptoms. Multiple evidence-supported interventions to address trauma among adults are available. Some examples of such interventions include: Cognitive Processing Therapy; Eye Movement Desensitization and Reprocessing; Narrative Exposure Therapy; Prolonged Exposure Therapy for PTSD for Adults; Cognitive Behavioral Therapy for Acute Stress Disorder; and Seeking Safety.

TIP: Provide Screening and Assessment Training to Bolster Service Provider Competence

An organization must ensure service provider competence in administering screening and assessment questions and dealing with the full range of emotional responses that may accompany such inquiry.

It is recommended that training on how to conduct screening and assessment be part of TIA training and follow-up technical assistance

Resources

SAMHSA's TIP 57 on Trauma-Informed Care in Behavioral Health Services has a section on Creating an Effective Screening and Assessment Environment that outlines considerations for how to approach a screening and assessment process.

Additionally, the National Council on Mental Wellbeing's Trauma-Informed Care Screening and Assessment Toolkit provides:

- Links to resources for organizations planning to incorporate peers into their workforce
- Considerations and questions for culturally sensitive trauma-informed care assessment
- Critical elements within a TIA screening and assessment process
- A flowchart detailing a trauma-informed, resilience-oriented progressive screening and assessment process

- A trauma-informed, resilience-oriented Principles Assessment Tool for organizations to assess existing policies, practices, procedures, and outcomes in the framework of TIA principles
- A list of trauma screening and assessment tools

3.8 Progress Monitoring and Quality Assurance

Implementing a trauma-informed approach is an ongoing change process that involves a shift in knowledge, perspectives, attitudes, and skills throughout an organization. Achieving this type of systems change requires continuous quality improvement. The following strategies can help organizations put structures in place to track progress:

- Prior to starting implementation, identify action steps and corresponding performance indicators for each goal. Results from the organizational assessment (detailed in Section 2) can guide an organization in identifying these goals and potential measures.
- Create a specific workgroup tasked with monitoring progress and continuously reassessing goals.
- Consider a variety of indicators to track progress and monitor impact, such as staff and client satisfaction, staff engagement, and health outcome metrics. Remember that some parameters of progress, such as increased sense of client wellness or building of stronger rapport with the client, are important but may not be easy to measure and monitor.
- When selecting metrics, leverage existing quality improvement efforts, many of which require organizations to collect specific metrics.
 - Organizations working to become a patient-centered medical home or center of excellence, or working to meet Medicare quality measures, may already collect and monitor care quality metrics that align with TIA initiative outcomes.
- Collect and incorporate ongoing feedback from multiple sources to monitor the “temperature” of the organization during implementation.
 - Regularly ask staff, clients, and family members to assess the level of transparency, safety, and trust they feel within the organization.
 - Consider dedicating time in staff meetings for reflective conversations to strengthen staff commitment to implementing a TIA initiative and brainstorm areas for improvement.
 - Solicit feedback. Create an environment where feedback is welcome. Provide multiple ways for clients, staff, providers, and community members to provide feedback (e.g., suggestion boxes in waiting rooms, surveys, listening sessions).

TIP: Consider Using a Quality Improvement Framework

Organizations should consider using a quality improvement framework to guide implementation. These frameworks include structures for continuous feedback and monitoring. Information about commonly used models, such as Model for Improvement, Lean, and Six Sigma, can be found at the Agency for Healthcare Research and Quality website.

Resource

The National Child Traumatic Stress Network has developed a resource titled Screening and Assessment: Considerations for Implementation. It provides these guidelines to consider when selecting a trauma screening or assessment tool.

- Cost: Is the tool free or low-cost?
- Length: Is the tool length justified by the specificity it provides for the given context; how long does it take to complete?
- Age-appropriate: Is the tool appropriate for children and youth (if they are the clientele)?
- Format: Is the tool administered in a paper-pencil format or online; is the tool self-administered or does it require an interviewer?
- Language: Is there a need for translating the tool into a different language?
- Accessibility and mobility: Is the tool accessible for different respondents? [47]

3.9 Additional Resources

Trauma-Informed Approach or Care Implementation

- The Institute on Trauma and Trauma-Informed Care, Buffalo Center for Social Research, has a

framework for implementing a TIA.

- Massachusetts Childhood Trauma Task Force’s Framework for Trauma Informed and Responsive Organizations in Massachusetts provides guiding principles for establishing a trauma-informed and responsive approach within an organization.
- LeadingAge Maryland’s Guidebook on implementing a TIA is designed to assist nursing homes in becoming trauma-informed organizations.
- The Center for Health Care Strategies brief provides recommendations for healthcare organizations interested in becoming trauma-informed.

Trauma-Informed Approach Training

- A list of resources from the Center for Health Care Strategies’ Trauma-Informed Care Implementation Resource Center provides information on various topics related to hiring, training, and retaining a trauma-informed staff.
- The National Fund for Workforce Solutions’ A Trauma-Informed Approach to Workforce is an introductory guide for employers and workforce development organizations on the topic of TIA.
- Trauma Informed Oregon offers individual modules on different trauma-related topics, such as what is trauma-informed care, why is it important, and differentiating among trauma-specific, trauma-informed, and trauma-sensitive.

Governance and Leadership

- Accelerate Learning Community at the University of Utah maintains a website, Five Ways to Practice Trauma-Informed Leadership (utah.edu), that provides tips on practicing trauma-informed leadership.
- Trauma-Informed Care Training & Education | Relias provides resources on developing a more trauma-informed organization, including trainings, white papers, fact sheets, and other resources.
- Addressing Burnout in the Behavioral Health Workforce Through Organizational Strategies is a resource developed through SAMHSA’s National Mental Health and Substance Use Policy Laboratory. It addresses secondary trauma in the workforce and is part of SAMHSA’s Evidence-Based Resource Guide Series.
- Psychology Today’s Workplace Trauma and Trauma-Informed Leadership is a brief article on the importance of trauma-informed leadership for psychological safety and connection in the workplace.

Cross Sector Collaborations

- The Philadelphia ACE project’s resource The Role of Philanthropy in Fostering Collaboration Through Cross Sector Networks presents a continuum of collaborative relationships and the factors

associated with their success.

- The Restorative Integral Support (RIS) model is a systemic, flexible framework to bring together various systems in a collaborative relationship to build resilience and recovery from ACEs.
- The Family Policy Council’s Community Capacity Development resource provides the essential elements of successful cross sector collaborations and steps to implement those elements.

Financing

- The National Council for Mental Wellbeing provides guidance to organizations on Financing Trauma-Informed Primary Care.
- The Center for Health Care Strategies, Inc.’s Key Ingredients for Successful Trauma-Informed Care Implementation resource details payment considerations for organizations.

Physical Environment

- PACEs Connections’ blog Trauma Informed Physical Environments – Assessment Tools describes trauma-informed physical environments and how to assess an environment.
- Region 3 Behavioral Health Services, Kearney, Nebraska’s resource Agency Environmental Components for Trauma Informed Care provides assessments for a positive trauma-informed care environment, a non-trauma-informed care environment, and residential settings.
- The National Council for Mental Wellbeing’s Recommendations for Trauma-Informed Design brief describes the importance of using trauma-informed principles in the design of physical environments to promote physical, mental, and social health.

Engaging Persons With Lived Experience

- Guide for Sharing Lived Experience is a resource from PsychHub that describes topics such as what is lived experience and why is it beneficial to engage individuals with lived experience.
- The National Child Traumatic Stress Network’s What’s SHARING POWER Got to Do with Trauma-Informed Practice encourages providers to share power in the context of trauma-responsive practice.
- The National Child Traumatic Stress Network’s webinar on Compensation for Family and Youth Involvement: Why It’s Critical discusses the importance of providing compensation for family and youth involvement.
- Youth Move National’s Creating a Youth Advisory Board focuses on topics such as key decisions for forming a youth advisory board and building relationships with youth.

Screening, Assessment, and Treatment Services

- The National Child Traumatic Stress Network has a repository of resources on screening and assessment developed by the network.
- The National Council for Mental Wellbeing's Trauma-Informed Care Screening and Assessment Toolkit for Community Mental Health and Substance Use Care Organizations and Mobile Crisis Units provides an overview of screening and assessment and their critical components and a list of tools and resources.
- The U.S. Department of Veterans Affairs' National Center for PTSD provides a Trauma Screening Questionnaire (TSQ) designed for use with individuals who have experienced all types of traumatic stress.
- The Network of Infant/Toddler Researchers' Research to Practice brief, Services for Families of Infants and Toddlers Experiencing Trauma, provides information on evidence-based interventions for infants and toddlers exposed to trauma.
- SAMHSA's TIP 57, Trauma-Informed Care in Behavioral Health Services, includes a chapter on Screening and Assessment.
- The Screening and Assessment of Child Trauma page on the Department of Health and Human Services' Child Welfare Information Gateway website includes a repository of trauma screening and assessment tools.

Progress Monitoring and Quality Assurance

- The Missouri Model helps organizations determine whether they are meeting basic criteria for integration of trauma principles and includes processes and indicators for organizations to identify where they are on the continuum and where they want to be.
- The Roadmap to Trauma Informed Care developed by Trauma Informed Oregon includes considerations for implementing and monitoring a trauma-informed approach. The accompanying Standards of Practice for Trauma Informed Care provides benchmarks for planning and monitoring progress and a means to highlight accomplishments.

Section 4: Evaluation and Sustainability

For the sustainable implementation, learning, and replication of positive TIA outcomes, it is essential for organizations to evaluate their TIA initiatives. It is equally important they undertake overarching changes to policies and procedures to ensure continued implementation of their initiatives. This section provides strategies across these two domains of TIA implementation.

4.1 Policy

Written policies and procedures help sustain a TIA, especially when an organization incorporates it into its mission, operating policies, and bylaws. Putting in place formal policies and procedures that reflect trauma-informed principles ensures these approaches will continue, even with changes in leadership and staff. To ensure policies support a TIA:

- Review and modify agency policies and procedures to ensure a focus on trauma (providing guidelines to support the delivery of trauma-informed services and a commitment to reducing re-traumatization), safety, and confidentiality.
- Embed trauma-informed principles into the organization’s mission statement, bylaws, and operating policies and procedures. Consider sharing the written policies and procedures among partner organizations. By sharing policies that have been successfully implemented, greater alignment between organizations is possible, while reducing the stress associated with its initial development.
- Within policies and procedures, clearly define the roles of individuals with lived experience of trauma in leadership/decision-making positions.
- Clearly communicate with collaborators regarding the organization’s emphasis on using TIA.
- Ensure organizational policies attend to the emotional impacts that working with individuals experiencing trauma has on staff. This intervention can be through offered assistance, such as peer support and mutual self-help, mental health days, and an employee assistance program.
- Recognize that everyone’s experiences are unique and require an individualized approach. Formalize a process for clients, family members, and staff to feel empowered to choose how to address their trauma needs. This empowerment includes offering gender-responsive services, recognizing and addressing historical trauma, and implementing traditional cultural ways of healing.

Resources

Campaign for Trauma-Informed Policy and Practice (CTIPP) is a non-partisan, nonprofit organization that promotes trauma-informed approaches and communities. The organization’s focus and work are grounded in NEAR science, a body of scientific research that includes neuroscience, epigenetics, adverse childhood experiences (ACEs), and resilience. CTIPP’s resource center offers a variety of videos, blogs, podcasts, and written resources on the topics of policy and

policy changes in relation to TIA. It also includes call-for-action events that encourage readers to take an active role in policy change.

4.2 Evaluation

Evaluation is a key component of a successful TIA implementation and often takes place at multiple points in time. Before implementing a TIA, an organization should conduct a baseline evaluation to determine implementation priorities or readiness for a trauma-informed initiative.

During implementation, ongoing evaluation can help determine whether the program is having an impact and how it is affecting the quality of services. The evaluation includes collecting feedback from providers, leadership, and staff, as well as those receiving services. In the long term, an organization should evaluate whether change efforts are sustained and if further refinements are needed.

There are several validated tools available to evaluate an organization's progress in becoming trauma-informed. Consider examining the following target outcomes when developing an evaluation:

- To what extent is the organization or system trauma-informed?
- Does being trauma-informed improve the quality of the organization's services?
- Does the quality of the services improve clients' abilities to meet their service goals?
- To what extent has the larger community engaged in collaborative TIA implementation?

Resources

Since 2014, the San Francisco Department of Public Health (SFDPH) has implemented a practice change model, centered in implementation science, to support organizations in nurturing and sustaining trauma-informed practices. Evaluation was a key component of the model and was designed to capture how well the training promotes learning and implementation of trauma-informed systems (TIS) core principles. Evaluation of the initiative included an attitude scale, effectiveness of training, and participants' experience with implementing change.

SFDPH developed the Tool for Trauma-Informed Work Life (TTIW), an evaluation instrument that

asks staff about the extent to which they experience TIS principles in the workplace. The TTIW measures internal- facing components to determine how well the workplace reflects the six core principles of a trauma- informed system. In 2017, SFDPH published an evaluation report summarizing the findings from process and outcome data collected during the three years of implementation.

KEY TAKEAWAY: Evaluation Questions

Consider questions to help plan a TIA evaluation:

- What is the purpose of the evaluation?
- How will data be collected, managed, and analyzed?
- From whom will the information be collected?
- On what target outcomes will you focus and how will you report them?

4.3 Additional Resources

Policy

- Pacific Southwest Mental Health Technology Transfer Center Network has developed *Creating Trauma-Informed Policies: A Practice Guide for School and Mental Health Leadership*
- The Michigan State website provides an example of a trauma policy.

Evaluation

- The Trauma-Informed Care Implementation Resource Center has resources to help organizations assess trauma-informed care.
- The Traumatic Stress Institute's *Measuring Trauma-Informed Care Series* provides guidance to schools and organizations in planning and implementing effective evaluations of trauma-informed interventions.

Section 5: Case Studies

This section includes three case studies that exemplify a trauma-informed approach (TIA) in practice, with each example from a different human services sector. Each example follows the 10 TIA implementation domains described in Section 1.

5.1 Cambridge Police Department, Cambridge, MA

Beginning in 2015, the Cambridge Police Department (CPD) planned and implemented a trauma-informed initiative in conjunction with the City of Cambridge. The goals of this initiative were to:

- Create department policies, culture, and capacity that focus on the wellbeing of staff and prevent re-traumatization.
- Increase staff knowledge and skills in responding to individuals who experience trauma.
- Improve interactions with the public by responding in a trauma-informed manner.

The CPD developed a Guide for a Trauma-Informed Law Enforcement Initiative to serve as a manual for other law enforcement agencies and community organizations. The guide shares information about the CPD initiative, logistics for implementation and evaluation, and lessons learned. The CPD implementation team learned a key lesson from this initiative that implementing a TIA is more than a one-time training or screening tool. It requires a shift in culture, focused staff support, and continued educational policies.

Governance and Leadership

- Leadership team at the CPD was supportive of the initiative and actively involved in communicating their support and participating in the training.

Training and Workforce Development

- The staff attended a three-day training focused on mindfulness and resilience, understanding trauma, and incorporating trauma-informed practice into work.

Cross Sector Collaboration

- The planning team for the initiative included the police department, city government, community agencies, and trauma experts.

Financing

- The initiative was funded through grants from Massachusetts Office for Victim Assistance.
- The CPD ensured that the budget for training included the expenses for the physical space needed for the training, speaker fees and travel, food, materials, and supplies.

Physical Environment

- A structural change to the physical environment included redesigning the interview room to be a more comfortable space to talk with individuals who have experienced trauma.

Engagement and Involvement

- The CPD collaborated with community organizations that work with individuals who experience trauma across all phases of implementation, leading to the inclusion of different perspectives and learning.

Screening, Assessment, and Treatment Services

- To provide support to officers who experience a traumatic event, the CPD offered stress management resources and formed Peer Support and Resilience Teams.

Progress Monitoring and Quality Assurance

- The training for the initiative included clear goals with measurable learning objectives. In addition, progress was monitored at the trainings through check-ins and check-outs to incorporate staff perspectives.

Policy

- A new policy that required detectives to implement a trauma-informed interview procedure when interviewing individuals who experience trauma was put in place.

Evaluation

- The CPD brought in an outside researcher to conduct an evaluation to determine the effectiveness and

impact of the training. The evaluator collected data through pre/post-surveys for the trainings and interviews with detectives, patrol officers, and supervisors.

5.2 Fall-Hamilton Elementary School, Nashville, TN

Fall-Hamilton Elementary School began its transformation into a trauma-informed school in 2015. The school uses a whole-school approach, moving away from a focus on student compliance to ensuring a feeling of safety, nurturing, and support among the students. The aim is to focus on key relationships at all levels—between adults and students, among the staff, and among the students. The implementation was rolled out gradually and intentionally, as described in this video.

Governance and Leadership

- Leadership, especially the principal, recognized that teachers need to be supported in understanding and catering to their students' needs, namely, that TIA is not a checklist but a shift in mindset for all staff and across all areas of the school.

Training and Workforce Development

- The school started with monthly professional development sessions on TIA for the teachers in March 2016 and continues to offer intermittent sessions.
- New hires receive a letter explaining the philosophy and practice of TIA. They are also connected to related resources before their first day of employment at the school.
- The school has had on staff a full-time trauma-informed practitioner trained in Adverse Childhood Experiences (ACEs) since 2016 and a full-time social worker since 2020.

Cross Sector Collaboration

- The school partnered with a local nonprofit organization to establish a Family Resource Center (FRC) which serves as a hub for family support. The FRC brought together various community organizations, including churches, businesses, and universities, and provided monetary help and volunteer hours.
- The school provided training on ACEs for collaborating partners.

Financing

- The school received multiple grants to begin TIA implementation. For example, a Building Stronger

Brains grant from the State of Tennessee funded the school's staffing of the trauma-informed practitioner.

- A Panda Express Leadership Grant funded the implementation of the Leader In Me program for three years.
- When the Metro Nashville Public Schools moved to a student-based budgeting system, the district gave school leadership autonomy to budget funds to match their needs and strategic plan.

Physical Environment

- Classrooms use warm lighting, calming colors, and essential oil diffusers. In 2020, the school moved to school-wide flexible seating as an option.
- Teachers use mindfulness as a key strategy. Every classroom has a “peace corner” where students can go to calm down and reflect. These corners are equipped with a comfortable seat and a timer; some also have stuffed animals, or a worksheet where students can document and monitor their feelings and reactions.

Evaluation

- Outcome data the school collected revealed that TIA implementation was associated with:
 - 96 percent reduction in office referrals
 - Zero suspensions between 2018 and 2022
 - 90-95 percent teacher retention rate
- Fall-Hamilton was in the top 5 percent in Tennessee for academic growth in 2021-2022.

Engagement and Involvement

- The school implements the Leader In Me program:
 - Offers students a class in leadership and teaches them seven habits practiced by leaders.
 - Empowers students by having them lead other students in different activities, from the classroom to sports.
 - Allows students to apply for school-wide activities/chores, for example, as data collectors, calculating attendance numbers, and managing breakfast for younger children.

Screening, Assessment, and Treatment Services

- By 2020, nearly 275 of the 320 students were receiving either individual or group support services from the school counselor, social worker, or community mental health provider.

- In 2020, the school implemented a school-wide mindfulness and movement program in partnership with BeWell in School, which included weekly classroom-based mindfulness classes. In addition, the school hired a full-time teacher certified in mindfulness and yoga to implement the program in designated de-escalation spaces.
- The school offers teachers support through the “Tap in/Tap out” program, which allows teachers to call on a peer when they need to take a break or need to step back from a tense situation. Teachers use a specific mobile app to locate help. Importantly, teachers know that asking for help is not only supported but promoted at their school.

Progress Monitoring and Quality Assurance

- The school holds bi-weekly social-emotional learning (SEL) team meetings to discuss case load and evaluate the effectiveness of support for students and staff.
- The school implements a Check-in Check-out (CICO) system for selected students:
 - Students are paired with an adult who is not their classroom teacher.
 - At the beginning of the day, this adult has a brief check-in that starts with greeting the student, asking a question about something the student is interested in, and then establishing a small attainable goal (social, academic, or executive).
 - Staff and students check out at the end of the day to evaluate the goal.
 - This mentor-mentee relationship allows monitoring of progress and demonstrates to the students that there is an adult that is excited to see them in the morning and again right before they leave.

Policy

- The leadership at the school changed multiple policies, including adding peace corners and including co-regulation, self-regulation, and de-escalation as first-line strategies for staff to implement school-wide.

5.3 Center to Advance Trauma Informed Health Care, San Francisco, CA

The vision of University of California–San Francisco’s (UCSF’s) Center to Advance Trauma Informed Health Care (CTHC) is a healthcare system designed and resourced to be a protective factor that interrupts the impact of childhood and adult trauma on preventable illness, preventable death, and disparities in health. Key programs CTHC runs include:

- Since 1993, the Women’s HIV Program (WHP) has provided interdisciplinary medical and psychosocial

primary care to cis and transgender women living with HIV and other complex health and social conditions. For the past 10 years, WHP has been developing a trauma-informed model of care for its patients and working to develop the field and movement of trauma-informed health care. In 2013, WHP and the Positive Women's Network–USA co-led a National Strategy Group on Trauma-Informed Primary Care that developed and published the core components of an effective response to recent and past trauma in adult healthcare settings.

- The UCLA/UCSF ACEs Aware Family Resilience Network (UCANN) is a University of California multi-campus initiative co-led by the Department of Pediatrics at the David Geffen School of Medicine at University of California–Los Angeles and UCSF CTHC to implement the State of California's ACEs Aware initiative. The initiative is a first-in-the-nation effort to screen and respond to adverse childhood experiences (ACEs) throughout California's 14+ million member Medicaid system.
- The Whole Family Wellness Study seeks to interrupt intergenerational trauma by studying how to effectively engage and support the caregivers and families of children receiving care in pediatric healthcare settings.
- The Health, Empowerment, and Recovery Services (HERS) program is developing and studying trauma-informed approaches to outpatient substance use treatment, with a focus on opiate addiction. The HERS+ program focuses on trauma-informed treatment of stimulant addiction among Black women.

Governance and Leadership

- The Director of CTHC, the center's interdisciplinary leadership team, WHP physician and social worker leads, and the WHP patient leadership council are all committed to TIA implementation across programs.

Training and Workforce Development

- In WHP, the clinic had an outside expert provide three half-day trauma trainings to clinical and non-clinical staff, including those at partner agencies. The trainer also provided five, hour-long, follow-up interactive trainings over 12 months addressing actual situations clinical staff faced during practice.
- UCAAN, via the ACEs Aware initiative, trains providers throughout California's Medicaid system.

Cross Sector Collaboration

- WHP has strong, long-term collaborations with community organizations, such as an intensive case management agency, a behavioral health clinic, an Afro-Centric expressive arts organization, and a domestic violence agency.

- The Whole Family Wellness program uses a hub-and-spoke model, in which a family care manager ensures collaboration and coordination between the program and outside agencies, such as community-based social service agencies, adult physical and behavioral health services, and housing, legal, and other social supports.
- UCAAN's community grant-making and pilot projects engage community-based organizations, primary care clinics, and Medicaid managed care plans throughout California.

Financing

- CTHC was established with a seed grant from a charitable trust and is sustained by funding it receives principally from state and federal grants.
- WHP is funded by federal Ryan White HIV services grants, reimbursement from Medicaid and other health insurance, limited supplemental support for various staff positions from UCSF, and limited private philanthropy.
- UCANN/ACEs Aware is funded by the California Department of Health Care Services.
- The Whole Family Wellness program is funded by Genentech.
- HERS and HERS+ programs are funded by clinical service grants from SAMHSA and a HRSA Special Projects of National Significance (SPNS) grant.

Physical Environment

- WHP staff and patients worked together to redesign the clinic to make it feel safe, calm, and inviting for everyone. Additionally, the clinic provides chair massage, food, acupuncture, and a therapy dog in the waiting room (before COVID, and again soon) to enhance the experience for patients and staff.

Engagement and Involvement

- WHP conducts formative focus groups with its patients to include patients' voices in every aspect of WHP's operations. WHP seeks ongoing patient feedback during monthly Patient Leadership and Advocacy Group (PLAG) meetings.
- UCAAN has a well-supported Community Council which provides input and oversight on a variety of operational policies, trainings, and products.

Treatment Services

- Care at WHP includes various trauma-specific interventions, including individual and group therapy, psychiatry, substance use counseling, an Intensive Outpatient Program (IOP) for stimulant use, and

medication-assisted treatment for alcohol and opiate use, in addition to comprehensive primary care.

- CTHC’s trauma-informed substance use programs are provided at WHP and at a variety of other locations caring for women living with HIV throughout San Francisco.

Progress Monitoring and Quality Assurance

- WHP innovated a trauma-informed method of chronic care management that guides its allocation of resources and delivery of care. It developed an algorithm for stratifying patients by their risk of death. The stratification assists in determining the patients’ treatment plans and is readdressed every month by the entire interdisciplinary team.

Policy

- WHP also instituted a policy that all staff receive high quality, regular reflective supervision.

Evaluation

- Baseline evaluation data from WHP show that patients who had experienced childhood and/or adult trauma were significantly more likely to report post-traumatic stress disorder, depression, and anxiety symptoms; significantly more likely to report potentially harmful alcohol and drug use; had a significantly poorer quality of life; and were significantly less likely to report being on and adhering to HIV medications. [48]
- Published baseline data for the healthcare team provided a better understanding of the opportunities and needs for trauma-informed systems change. [49] Other studies by WHP have demonstrated positive impact of expressive therapy intervention and a clinic-based group intervention. [50, 51] WHP has also published data informing the emerging field of trauma-informed health care. [52-54]
- UCAAN is in its second year of existence and is being rigorously evaluated across all domains by the RAND Corporation on behalf of California’s Department of Health Care Services.

Citation

Substance Abuse and Mental Health Services Administration: *Practical Guide for Implementing a Trauma-Informed Approach*. SAMHSA Publication No. PEP23-06-05-005. Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2023.

This work resides in the public domain, unless otherwise indicated.

THE EFFECT OF TRAUMA ON THE BRAIN AND HOW IT AFFECTS BEHAVIORS | JOHN RIGG | TEDX AUSTIN



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://cod.pressbooks.pub/therecoveryprocess/?p=328#oembed-1>

COMPASSION DOESN'T MAKE YOU TIRED: UNMASKING AND ADDRESSING COMPASSION FATIGUE

Section One: Compassion Fatigue, Vicarious Trauma, Secondary Trauma, Burnout, Lions, Tigers, and Bears (Oh My)

Compassion is an extraordinary gift. Some people welcome it and wear it gracefully with their loved ones, neighbors, even their favorite TV characters. Some run from it as if it's ticking loudly, remembering hurts whose scars still sting as much as the pain they replaced. And some people rip through the wrapping. It fits like a glove, and they never take it off, not even when they sleep.

You might be a counselor, might be a cop, might be a sponsor, a coach, a doctor, a nurse, a cleric, or a service member. You might be a friend whose friend is in trouble, a parent who aches when the world is cruel, a caregiver watching life and dignity wither with age or disease.

Something made you open this book.

Definitions?

For the purpose of this exploration, please don't worry too much about what the word "compassion" means.

- If you Google it, you'll find things like "sympathy," "empathy," "sorrow," "suffering with," "suffering together," "empathy that inspires a desire to help," and a number of variations on those themes.
- Some experts emphasize the difference between "sympathy" on one hand and empathy (or "suffering with") on the other, because the latter includes a sense of identification.
- Others place compassion one step beyond empathy, in that it leads to positive action.

And if you look up "compassion fatigue":

- You'll see that it's often called "secondary trauma," which some sources equate with and some clearly distinguish from "vicarious trauma" (which is an actual disorder).
- Some describe compassion fatigue as an excess of compassion and others as depletion of compassion (or

a depletion of physical, emotional, or spiritual strength).

- Apparently compassion fatigue is either synonymous with burnout or a precursor to burnout. Perhaps it's the renegade flame that leaves us burned out when it—well— burns out.

So beware the term “compassion fatigue.” Not only is it wobbly, but it's also a catch-all term. There are several conditions whose signs or symptoms overlap with those attributed to compassion fatigue. These are conditions that people might own and address much sooner if they didn't pounce on “compassion fatigue” as the explanation.

What if You Have it?

If you're “diagnosed” with compassion fatigue—or if you just want to avoid it—most of the advice you'll get will be generic, positive, helpful: Take some time off, build a support network, join a gym, take a bubble bath. But that advice may also be a bit of a tease, especially if you're carrying a bottomless caseload, pulling down double shifts, or topping off a full-time job with all-night caregiving.

Who has time for a bubble bath?

But what if there's something else going on, but instead of searching your experience for a deeper understanding, you stop digging at “compassion fatigue”? With that catch-all term as your explanation, you might limit your efforts to standard stress-management techniques.

Those techniques may be positive, even important, but they won't address many of the conditions that might be behind your current challenges.

In the “Thought/Discussion Questions” pages that follow is a quick inventory, a few questions about your life these days.

Let's see why you opened this book.

Thought/Discussion Questions, 1-1

- Why did you pick up this workbook? (If you're not sure, you can just take a guess.)
- What are you hoping to get out of this workbook?
- What do you think of when you hear the word “compassion”?

- What do you think of when you hear the term “compassion fatigue”?

Thought/Discussion Questions, 1-2

- What’s one helping, healing, or caregiving role you’re in, and what are its challenges?
- If you’re in another helping, healing, or caregiving role, what is it and what are its challenges?
- Please show how strongly you agree or disagree with these statements, on a scale of 0 to 10 (0 = “I don’t agree at all” and 10 = “I agree completely”):
 - The first role I described above is rewarding, and I believe it’s good for me.
 - The second role I described above is rewarding, and I believe it’s good for me.
 - I’d like to learn more about this topic and think about how I might use the information.
 - The first role I described above is stressful, and it wears me out.
 - The second role I described above is stressful, and it wears me out.

Section Two: Thoughts on Compassion

This book is unashamedly pro-compassion. Compassion is:

- One of our most significant strengths and one of our greatest joys,
- An important tool of the survival instinct,
- An essential building block for morality, and

- An unmistakable call to action.

Without it we would be empty, selfish, rudderless, and probably bored.

Compassion and Survival

The survival instinct is not just about the survival of the individual. It can't be. Our bodies are wired, not just to keep us alive, but also to keep the species going. Think about it: Why else would sex be such an incredible draw, with such essentially silly acts feeling so good sometimes, and some people willing to kill or die for their desires?

And why would people dedicate and even sacrifice their lives to save the lives of other people, in many cases people they've never met? It makes sense that things like compassion and protectiveness would be hard-wired into the species, because strict adherence to "every man for himself" would eventually whittle us down to a few strong but very exhausted men.

Compassion and Morality

Even some of the developmental psychologists will tell you: our own experience of pain is often the first step toward perceiving and identifying—and identifying with—the pain of others. Many of us start noticing when we're adding to the pain of others and finding it a little uncomfortable. That makes it possible to evaluate our actions and their consequences, experiment with moral codes, and embrace some of the codes that are offered us.

And—at some point—we start to make moral decisions influenced by the absence or presence of compassion. We decide to cause pain or not to cause pain, to let people suffer alone or to do whatever we can to help, even if it's just to bear witness and care what happens to them— which, ironically, is often the most powerful act of healing we can offer.

Compassion and Reward

Like sexuality, hunger, creativity, and other tools of the human survival instinct, compassion hooks into our natural reward system. The many neurochemical processes in that system influence our decisions by rewarding certain choices through pleasure, joy, a sense of satisfaction or fulfillment, etc. And acts of compassion—particularly when they produce positive results—can be enormously satisfying for the people who perform them.

In spite of all the pain they see and the sacrifices they're making:

- Many people stay in helping or healing roles all or most of their lives.
- Their capacity for compassion becomes an essential skill, often their favorite part of their identity as human beings.
- When something they do proves useful, comforting, or empowering, it brings them joy.
- With time, their compassion grows deeper, as their love of each person resonates with their love of every other person who has entered their lives.

Compassion and Joy

This is pure speculation, but consider the possibility that compassion and joy have the same root in the human mind and spirit.

- Compassion brings us, not only pain at others' pain, but also joy at others' joy, and at the connection that compassion forges among us.
- Both compassion and joy—and whatever their combined power might be—are meant to flow right through us, uninterrupted. Unfortunately, we have many ways of stopping them, trapping them, analyzing them, justifying, denying, minimizing, exaggerating, distracting ourselves from them, and losing ourselves in them.
- Compassion gets caught on our fears, angers, anxieties, resentments, guilt, jealousy, obsessions, compulsions, and preoccupations. After all, we're busy people.
- We can easily short-circuit compassion through our belief that we're supposed to be able to “fix” people or take away their pain.

But what if we learned how to “un-trap” compassion and let it—and all the joy and pain it carries—flow freely through us? Would it make us tired? Or would it renew us every second?

Thought/Discussion Questions, 2-1

- How has compassion (yours and/or anyone else's) supported your well-being or survival?
- What role, if any, do you remember compassion playing in the development of your morality?

- What role has compassion played in your life, your work, and/or your sense of purpose?
- What (if any) are some ways in which having compassion might have felt rewarding to you?

Thought/Discussion Questions, 2-2

- Based on your experience, what do you think is the relationship between compassion and joy?
- What are some things in your life (or your mind) that seem to block your compassion?
- Please show how strongly you agree or disagree with these statements, on a scale of 0 to 10 (0 = “I don’t agree at all” and 10 = “I agree completely”):
 - Compassion is an important strength for me, and/or an important part of who I am.
 - I take joy in feeling compassion and in helping people.
 - For me, the benefits of compassion outweigh its challenges.
 - I think I’m “too compassionate” or “too soft-hearted.”
 - When I feel compassionate toward people, I tend to let them take advantage of me.

Section Three: Thoughts on Fatigue

The clash between resilience and stress is a fascinating drama. Its hero, the human being, is also the villain—and the battlefield. The script is outdated, written ages ago, but full of twists and turns and ultimately unpredictable. Sometimes it’s a comedy and sometimes a tragedy. In the words of the American actor, director, writer, and producer Orson Welles, “If you want a happy ending, that depends, of course, on where you stop your story.”

Resilience and Stress

We’re born with bodies well designed to thrive under moderate and temporary periods of demand, pain, and

danger, with ample time in between to calm down, rest up, and replenish. The lions and tigers and bears (oh my) come into our caves. We fight them off or run away. Then we have time to calm down and tuck into a nice plate of platypus before the next adventure.

On every level—including the body, belief systems, thoughts, feelings, motivations, actions, relationships, communities, and spiritual connections—we're organized to handle those waves of challenge and relief. Through everything from chemical reactions to human choices, we're wired to seek balance, whatever it takes. If we're in danger, our bodies mobilize for our protection. If we get too tense, body and mind respond in ways designed to make us calm.

This dance of opposites builds what they call “resilience,” sometimes described as the ability to bounce back after adversity, or to bounce forward into greater strength.

Of course, in the real world, we find that our stress is sometimes overwhelming and sometimes unrelenting, and usually not the kind we can run away from or beat down with our fists. So some of those physical and chemical systems meant to save our lives get very confused. Their strategies for keeping us in balance can go overboard, creating even more imbalance, injuring components of the stress system, and keeping them from working correctly. So in some cases:

- We get tired,
- We get jumpy,
- We get numb,
- We get scared,
- We get angry,
- We get sad,
- We get distant,
- We get obnoxious,
- We get compulsive,
- We get guilty,
- We get hopeless, and/or
- We get spooked.

Consequences

With effort and support, we usually get over our reactions, but sometimes we develop illnesses:

- These can be temporary or chronic.
- They can seem to be happening on physical, neurological, psychological, social and/or spiritual levels, and they can be happening on more levels than we realize.
- No matter how many levels we're affected on, the **intensity** of the reaction usually comes from that

physical, chemical process originally meant to keep us safe from the lions, tigers, and bears. These natural chemicals fuel whatever fire is burning.

- Often it's impossible to distinguish between reactions on one level and those on another, and usually we don't need to, because they're not really separate anyway.
- What matters is that we care for ourselves on each level, be gentle with ourselves and others, and let safe and respectful people into the healing process.

Any of this sound familiar? Whether it's your own adversity or someone else's, accidental or deliberate, a problem or a tragedy, understandable or incomprehensible, an event or a lifetime pattern, it's the same set of muscles, bones, organs, chemicals, immune responses, thoughts, feelings, relationships that are affected. It's the same body, the same mind, the same spirit, reacting to big or little things in big or little ways.

So if you're experiencing challenges that might be related to stress or threat in the past or present, please know that these reactions:

- Are normal and understandable,
- Might be complicated,
- Might be happening on more than one level,
- Should be stabilized,
- Should be respected, and
- Deserve care and attention.

And definitely, definitely, there are things you can do to restore your strength and use what you've learned to help you follow whatever purpose draws you through this world.

Thought/Discussion Questions, 3-1

- Please describe the way you feel under mild/moderate and temporary stress or threat.
- Please compare the way you feel **after** mild/moderate and temporary stress or threat.
- How can you tell when your life is out of balance (physically, mentally, spiritually, etc.)?
- What sorts of difficult things (if any) have happened in your life because of stress or imbalance?

Thought/Discussion Questions, 3-2

- In the past, what's been successful in helping you reduce your level of stress and fatigue?
 - In the past, what's been successful in helping you deal with the stress you can't eliminate?
 - Please show how strongly you agree or disagree with these statements, on a scale of 0 to 10 (0 = "I don't agree at all" and 10 = "I agree completely"):
- There are people in my life who are good at helping me deal with stress and fatigue.
 - I have a lot of other internal and external resources for dealing with stress and fatigue.
 - I frequently seek out and use all of these resources for dealing with stress and fatigue.
 - I've experienced a lot of problems in the past because of stress.
 - Much of my present life is stressful, and it's wearing me out.

Section Four: The Morality of Compassion

Robert Merton, the sociologist who first developed the concept of “unintended consequences,” started out as a magician. And in spite of the fact that some unintended consequences are wonderful (like penicillin magically appearing after somebody left the bread out), it always seems like the negative ones are more common.

Responsibilities

When an important instrument of your life or your work is your capacity to care about (and care for) others, anything that weakens or distorts that instrument can pose a danger to you and/or the people you serve. The consequences can also pose danger to the surrounding families, organizations, systems, or communities. Commitment to a role of service also requires commitment to vigilance, responsibility, self-honesty, self-knowledge, and self-care.

Faced with the enormity of human problems and pain, strong people are often tempted to plunge in with little or no regard for their own safety or well being, caught up in a larger purpose and calling. The rewards of selfless service can numb many kinds of pain. Unlike cars, human beings can run for a long time on fumes, and our little internal rubber bands can stretch a long, long way before they snap. It's very easy not to know when we're in danger, or to forget that our own danger can endanger others.

The Wounded Healer

The concept of the “wounded healer” is an interesting one. People who have first-hand or otherwise intimate experience of a serious human challenge often carry a great depth of wisdom, understanding, empathy, compassion, commitment. But those qualities come at a price, and the healer’s wounds are real. Service to others may heal the spirit, but there’s a lot of other stuff in there that can continue to cause problems, even in the most enlightened beings.

There is much debate on what constitutes healing, how much healing it takes to change life patterns, whether deep wounds can ever really be healed, etc. But when it comes to caring for another or participating in someone else’s healing process, there seems to be consensus on one thing: We must be psychologically stable and actively engaged in a process of healing, recovery, renewal, self-care, and vigilance toward our own health and well-being.

If “old wounds” only meant pain, it wouldn’t be such a problem. But in the real world, unhealed psychological wounds often lead to distorted patterns of thought, behavior, identification, or attachment. Often the most serious casualty is respect. People who carry these unhealed wounds might:

- Treat other people with disrespect, without meaning to or even being aware of it;
- Treat their own bodies with disrespect;
- Fail to respect their commitments;
- Fail to respect professional boundaries; and even
- Fail to respect their own moral codes or the ethical codes of their occupations.

It’s all for the greater good, they say. They’re helping people—lots of people. And so we have:

- The not-for-profit organization run by a selfless and dedicated leader who bullies and manipulates staff, creating social chaos in the workplace;
- The caseworker who overlooks dangerous conditions because the caseload is so overwhelming;
- The counselor who crosses the line into emotional or sexual involvement with a client;
- The recovery coach who sinks slowly back into patterns of alcohol or drug use and struggles to keep this separate from the coaching role;
- The doctor who takes on an air of cold detachment with patients to avoid feeling vulnerable or making mistakes, and in the process diminishes the healing process;
- The caregiver who unwinds after a long and frustrating shift by downing a large pizza;
- The teacher who nods off behind the wheel out of sheer exhaustion—
- You finish the list!

Compassion and Ethics

The forces that distract the helper from vigilance can be powerful and persuasive, but we have choices. If we sort through what's happening, name it, and speak honestly about it, those choices can become very clear.

And decisions made in clarity can carry a sort of peace, no matter what chaos surrounds us.

Issues of self-knowledge and self-care are moral and ethical issues. Always. Trust is sacred, easily shattered, and sometimes lost forever.

Thought/Discussion Questions, 4-1

- In what ways do you think compassion might be an instrument of your work or caregiving role?
- What kinds of things have you been doing to keep that instrument “in tune”?
- Please describe any problems that have resulted from something you did out of compassion.
- Please describe any problems resulting from something someone else did out of compassion.

Thought/Discussion Questions, 4-2

- What kinds of measures have helped you be vigilant and keep from harming yourself or others?
- What kinds of things have helped you stay honest with yourself about yourself?
- Please show how strongly you agree or disagree with these statements, on a scale of 0 to 10 (0 = “I don’t agree at all” and 10 = “I agree completely”):
 - I have effective skills for staying vigilant and avoiding negative consequences.
 - I have safe, trustworthy people in my life who will give me honest “reality checks.”
 - I’m willing to make tough moral decisions when it comes to my actions and their effects.

- Things I've done out of compassion have caused a lot of unintended trouble.
- If compassion is an instrument, my instrument is out of tune these days.

Section Five: Deconstructing “Compassion Fatigue”

At a training on “Compassion Fatigue,” you can watch the participants’ faces and see the wheels turning.

- Yes! They’re overworked, overwhelmed, underpaid, and exhausted.
- Yes! They’re proud of their compassion and commitment.
- Yes! It’s a significant strength.
- No! They don’t want to crash and burn out.

Where, oh where is that magic spigot they can turn up or down until their blood runs just the right amount of compassion?

Never mind! Don’t worry! You don’t need a magic spigot. It’s not about too much or too little compassion. It’s not even compassion that’s the problem. You may already know what the problem is, in which case you can stop reading and go take a bubble bath.

But if you’re curious, the next section—“What Does Make You Tired?”—takes you through a “divide-and-conquer” process, to get you started toward some relief. It won’t solve any of these problems, you understand, but it might help you adjust your compass.

The word “deconstructing” is very useful. It comes from a French concept, and it usually means a lot of complex, impressive, philosophical things. But here it just means breaking down and looking objectively at the phenomenon known as compassion fatigue, noticing the differences among the many challenges that might be at work, and reaching a more accurate understanding.

So the rest of this book will look at some of the things that might really be happening when people show signs of “compassion fatigue.”

If the problem isn’t compassion, what is it? The challenges we’ll take a closer look at in the next section are by no means the only possible answers, but they are fairly common ones.

Challenges that Might Masquerade as “Compassion Fatigue”

- **A Troubled World** With bad news and conflict as a frequent backdrop for our efforts, it can be hard to

keep a resilient spirit. But hope is not impossible, and the very compassion that leads us into helping and healing roles can have transformative effects when it plays out on a larger scale. We can have the courage to love and be forces for healing in the world.

- **Focus on Problems and Deficits**A focus on problems and deficits has been a large part of many cultures for a long time. Even large systems of education, health, and human services seem to be organized around recognizing and dealing with problems. This makes it hard to have strength and energy. But if we have enough courage, we can help shape our cultures into places where strength-based approaches can flourish and we can conjure up a little more hope and joy.
- **Neglected Self-Care**Sometimes what seems to be compassion fatigue is really regular old fatigue, the product of neglecting important aspects of our own self-care. In helping roles, it's easy to gloss over self-care, because we're busy responding to so many needs and pressures. But our well being, and that of the people we'd like to help, depend on our health and energy levels. We can use some elements of change theory to help us set up healthier patterns of self-care.
- **Our Own Unhealed Wounds**Often the experiences that teach us compassion also leave deep wounds that follow us through life and make us more vulnerable to stress and loss of resilience. When we're exposed to others' pain, those wounds can awaken our own pain, and we can react in ways that make us less effective as helpers and healers, and possibly dangerous to others or ourselves. Each of us is responsible for knowing our vulnerabilities and staying active in our own healing processes.
- **Identification—Too Much or Too Little**The ability to identify with others is an important skill that contributes to many areas of life and functioning, including compassion. Especially in a helping or healing role, identifying with others too much or too little can cause problems. If we identify too much, then our resilience can get lost in their pain, or we can end up focusing most of our attention on our emotional reactions to their pain, so we can get distracted and fail to meet their needs OR take care of ourselves. If we identify too little, we can feel alienated and lose our compassion, which makes us much less effective and puts the people we serve at risk.
- **Distorted Roles/Relationships**A helping or healing role can be challenging enough without the common human tendency toward flawed thinking or perception of other people and of our roles and relationships with them. This might take many forms, but these kinds of situations can put us under heavy stress—and heavy stress can make us more vulnerable to these kinds of situations.
- **Frustrating Survival Skills**People who are facing physical and/or emotional challenges might act in several ways that we think of as troublesome psychological “symptoms,” but it might give us more useful information if we think of them as survival skills, even if they make our helping roles more difficult. It's important to listen beyond the “symptoms” and foster healthier skills.
- **Exposure to Others' Pain and Trauma**In some cases, too much exposure to the stories and effects of others' trauma can lead to a disorder called “vicarious trauma,” which can interfere with our sense of hope, meaning, or spiritual connection. If you're assessed for and diagnosed with this disorder, it's important to have peer support and professional help that's appropriate to your stage of recovery from

this condition—and the first stage is just the process of getting safe and stable.

- **Commitment to Difficult Situations** Sometimes helping or healing situations we're deeply committed to—or can't leave for important survival-related reasons—can be difficult in many ways. It's important to seek support from people who won't judge us or give us simplistic advice, but will help us clarify our thinking and see any options or resources we might not have thought of under our current levels of stress.
- **Working in Toxic Systems** Many organizations dedicated to helping people are run by people who have some significant unaddressed issues. These issues can affect the way the organizations are run, the way staff are treated, and the amount of support staff receive. If these kinds of factors might be adding to your stress, it's important to find out how healthy your organization is, how its functioning is affecting you, and what courses of action would be healthy for you.
- **Doing it All By Yourself** We need other people, particularly when we're working in helping or healing roles, or when we're in caregiving roles. We need good “sounding boards,” people who can listen, reflect back, and help us find strength, confidence, and hope. We don't need to confide in people who will criticize us, make simplistic suggestions, or play up the drama in the situation. We can find sources of mutual support online or in our communities.

Section Six: A Troubled World

There's an old Chinese curse: “May you live in interesting times.” We live in interesting times.

If we took a map of the world and started to shade in red all the places where pain, shame, poverty, deprivation, illness, corruption, injustice, persecution, fear, grief, guilt, retribution, and rage are staples of everyday life, we'd soon be looking at a bright red map of the world.

Underneath each of those red splotches lie the seeds of more pain, in the next generation and in many generations to come—and the momentum of history seems bent on making it worse.

More and more people speak of the struggle to keep their spirits alive in the face of these overwhelming realities. The sheer volume and complexity of challenge in the world leaves each of us powerless against it. For the loving, responsible soul, even a small chunk of the world can seem unsteady and unsettling against this backdrop.

- What does all this uncertainty mean for the work we're trying to accomplish?
- With everything falling apart, what do our small efforts mean?
- If love is the answer, why does caring sometimes make us hurt more?

Broken Bones

In *New Seeds of Contemplation*, the American poet, monk, and mystic Thomas Merton wrote that “As long as we are on earth, the love that unites us will bring us suffering by our very contact with one another, because this love is the resetting of a Body of broken bones.” Doesn’t it feel like that sometimes? A Body of broken bones.

The illusion that each of us is fundamentally separate—that the world is, should be, and must be “dog eat dog,” “cat eat mouse,” “nation against nation,” etc.—keeps those dogs eating dogs, cats eating mice, and human beings stretching our concept of inhumanity. Every day, people suffer and die for an illusion.

Choices

Merton saw two choices in response to the pain of disunion: to hate—which only brings us more of the same—or to love. And love, “by its acceptance of the pain of reunion, begins to heal all wounds.” In the overwhelming barrage of scary news stories, it’s easy to forget the equally overwhelming (but significantly under-reported) passage of love back and forth among our little lives, every day, in every nation.

At any moment—this moment, for example:

- There are billions of people doing things that are selfish, cruel, and cowardly, and billions of people facing pain, loss, indignity, and death.

—but—

- There are also billions of people doing things that are kind, loving, generous, and brave, and billions feeling relief, gratitude, wonder, and joy.

Is there hope? Who knows? We’re powerless over much of the world’s fate, and for those of us in helping or caregiving roles, this sense of global helplessness may resonate with our powerlessness over so many aspects of the well being of the people we serve. In these roles, it’s helpful to remember that, even if we can’t do much about the big things, there’s a lot we can do about many of the small things. It’s the same with the world.

You’ve probably seen the love of a few people transform the lives of individuals, families, possibly whole communities. What might the love of many—even most—people do? We may be powerless against the volume and complexity of challenge in the world, but:

- We’re not powerless over our own everyday choices.
- We’re not alone.
- In our own little lives, we can learn to reach out in courage, to accept the pain of reunion, the resetting

of this “body of broken bones.”

Of course, this won't work if we think we're supposed to fix the world, or get all bitter and sulky because it is what it is. With all the clever ways we have of trying to block out the pain of living, we just end up locking ourselves in with the pain.

We've chosen to care. It's in our nature to care. If we keep the pipes clear:

- We can handle whatever they carry.
- We'll be loved as much as we love—perhaps even more
- The large or small part we can play will be just the right part for this moment.
- The next moment will take care of itself.

We **will** be conduits of healing. And whenever even some small drop of healing passes through us, it heals us, too.

Thought/Discussion Questions, 6-1

- Off the top of your head, please make a quick list of big problems in the world.
- How do you see people dealing with that reality? Ignoring it? Getting weighed down by it?
- Please describe some ways you feel separate from other people, nations, cultures, etc.?
- Please describe some ways you feel united with other people, nations, cultures, etc.?

Thought/Discussion Questions, 6-2

- What are some of the good qualities you've seen in yourself and/or in others?
- What are some kind, unselfish, courageous, dignified things you've seen people do or say?
- Please show how strongly you agree or disagree with these statements, on a scale of 0 to 10 (0 = “I don't agree at all” and 10 = “I agree completely”):
 - I believe in the power that love can have in the world, when people act out of love.

- I believe I have choices, and that even the small things I can do can help make things better.
- I choose to have the courage to love, to care, and to reach out to others.
- The world is really messed up. I worry about not making it through all these problems.
- There's so much danger, it's best to just focus on protecting ourselves and our own.

Section Seven: Focus on Problems and Deficits

If we never noticed problems and dangers, we'd be a very happy but short-lived species. A number of structures and circuits in our brains are organized to:

- Catalogue signs of pain and danger,
- Spot them a mile away,
- Imagine all the potential consequences, and
- Think of ways of fixing them.

These functions have evolved incredibly far, just not far enough to notice that they're not our only—or even our most useful—functions. When they get too frisky, we have things like anxiety, depression, and posttraumatic stress disorder. The rest of the time, they just try to boss us around.

And so we've been steeped in the traditional focus on what everybody's doing wrong and how we can make them (or ourselves) better—better children, parents, partners, pets, students, clients, patients, neighbors, warriors, workers, whatever. Whole systems have been organized around:

- Identifying and assessing problems, bad behaviors, questionable character traits, areas of ignorance, and substandard skills;
- Planning and providing services designed to address these problems, bad behaviors, etc.;
- Evaluating and rewarding people's progress (or punishing their lack of progress), based on how much their problems have grown or shrunk; and
- Funding/reimbursing services based on how many problems systems have addressed.

If you grew up in the world, you've probably noticed this. If you work in one of the many health, education, human service, public safety, criminal justice, or military fields, you might be drowning in it. Many people take this negative, problem focus for granted. But the fact that we're used to something won't stop it from eating

away at our strength, our compassion, our happiness, our initiative, or our capacity for hope. We might just carry it deeper.

Swimming Upstream

Many fields have been trying to move toward a focus on strengths, skills, resilience, health, well-being, and recovery, because we've seen the underside of our traditional negative focus. We've seen:

- The illogic of trying to make people stronger by directing attention to their weaknesses;
- The shattering damage that our problem focus can have on people who carry heavy loads of vulnerability;
- The reactive stance that our systems are locked into, if we have to wait until problems get bad enough before we can address them;
- The vast amount of time and resources it takes to address all the full-blown problems, compared to the reasonable amount it would have taken to prevent those problems; and
- The weight of all this on the people who work in those systems.

Each of these attempted shifts in focus is a major cultural change, like turning the Titanic before we hit the iceberg. To change policies, practices, and funding structures, we first have to get through all those brain parts that keep patiently pointing out problems—multiplied by the thousands of people whose feelings of effectiveness have always depended on doing things the way they've always been done.

Change Agents Have More Fun

If you feel powerless, weighed down by the negative momentum in your field, situation, etc., why not do something powerful? Change agents are needed at all levels, including:

- The strong leaders who envision strength- and health-based approaches and have the courage to move their systems through a process that ultimately transforms them;
- The practical visionaries who figure out ways of making this happen in the real, human world;
- The early adopters, opinion leaders, and champions who “sell” these approaches to their neighbors, colleagues, or fellow employees (and the occasional boss); and
- The courageous souls who are willing to let go of the way they've always done things, try something new, point out how the model might be improved, and join the process of trying to make it work—and work more effectively.

Whatever your skills might be—thinking, doing, analyzing, synthesizing, talking, writing, listening, connecting, reflecting, or getting other people to do all that stuff—your skills are needed, and they will be appreciated. Your efforts will be energized, and who knows? You and your fellow change agents might just be successful.

It might take a long time, but at some point even those bossy old brain parts will have to realize the old way just costs too much and hurts too much, and then they'll start to turn the wheel— maybe even in time to avoid the iceberg.

Thought/Discussion Questions, 7-1

- In your life, how have people (family, schools, media, etc.) taught you to focus on problems?
- What are some examples of a problem focus in the field you're working (or volunteering) in?
- What effects of the problem focus have you seen in people you know, and/or in yourself?
- Describe your vision of what a strength-based field or family would look like, feel like, and do.

Thought/Discussion Questions, 7-2

- What strengths, skills, and convictions do you have that could help you make that vision reality?
 - What would be the best role for you as a change agent in creating a strength-based culture?
 - Please show how strongly you agree or disagree with these statements, on a scale of 0 to 10 (0 = "I don't agree at all" and 10 = "I agree completely"):
- I believe in the strengths of the people I serve, and I'm willing to find and encourage them.
 - I believe in my skills and my ability to help create a more positive work or family culture.
 - I believe in my strengths, and know I'll be okay even if the culture doesn't improve.

- My life and options have suffered because of my exposure to that negative, problem focus.
- I think our field, society, family, etc. will always have a negative focus. It is what it is.

Section Eight: Neglected Self-Care

In words attributed to the renowned Swiss psychiatrist and psychotherapist Carl Jung, “Sometimes, Mr. Freud, a cigar is just a cigar.” Sometimes “compassion fatigue” is just fatigue, fallout from a lack of self-care.

Startling new research indicates that:

- Even people driven by a strong sense of purpose need sleep!
- Doctors and nurses can get sick!
- Counselors and coaches can give themselves bad advice!
- There is no minimum daily requirement for caffeine!
- Other people’s well-being is not necessarily more important than your own!
- Putting off going to the doctor doesn’t make your symptoms go away!
- A job that requires superhuman stamina and doesn’t allow for basic self-care may not actually be a good job!
- The work we do at the last minute under intense pressure actually isn’t more effective or impressive than the work we start earlier and do at a more comfortable pace!
- Skipping breakfast and lunch and having a big dinner at 10 p.m. doesn’t make you lose weight!
- People who work themselves into an early grave actually end up helping fewer people, rather than more people!

Whatever time or effort we invest in self-care is time or effort well invested, but for many people, it’s a difficult investment. We know we’re strong, we’ll be okay, we have a purpose to fulfill, people are counting on us, and all the other very reasonable excuses for not fulfilling this basic responsibility to ourselves and the people we serve. Being of service to our fellow human beings can be a dramatic calling. Self-care is much less dramatic—until the lack of self-care tips us over into illness, injury, family trouble, job trouble, or hurting someone.

Choosing Self-Care

If it’s someone else who’s neglecting self-care, it’s simple:

- Whatever they're not doing enough of, they should do more. Whatever they're doing too much of, they should do less—or none at all, if less doesn't work for them.
- Whoever they need to connect with, or get help or support from, they should connect with them. Whoever they need to stay away from, they should stay away from them.

If it's you, of course, it's much more complicated. When you address these complications, you might try thinking about Prochaska's and DiClemente's five stages of change. [1] A few examples:

Prochaska's and DiClemente's Five Stages of Change

	Stage of Change	What It's Like	What Might be Helpful
1	Precontemplation	Not considering the need to do anything differently	Gather information on the subject and just look into it, keeping an open mind.
2	Contemplation	Thinking about changing, but still many conflicting thoughts and feelings, and not ready to commit to it	List and talk about obstacles, pros and cons (change vs. same), points of ambivalence, and differences between what you want and what you're getting.
3	Preparation	Experimenting with little change efforts	Just try little experiments with change, and don't worry about whether or not you want to commit to those changes. Notice your thoughts about the change process, and where those experiments seem to be leading you.
4	Action	Solidly into doing things differently	Make sure you're ready, and you've really engaged in the first three stages, before you decide you're in the Action stage. Make sure you have a firm foundation, jump in, then reward yourself for change in healthy ways.
5	Maintenance	New ways of doing things become part of life.	Don't give up or beat yourself up if you occasionally slide back into old patterns. Just start over, get whatever help you need, and build on all your successes.

When an individual or human service organization engages in healthy self-care, that sends a message that you mean what you say and shows the people you serve that being healthy can work. And if the only way to stay healthy is to say “no” to an opportunity to make a real difference, just know that another opportunity to make a real difference will come along.

If this is really part of what you were put on earth to do, it **will** happen.

Thought/Discussion Questions, 8-1

- Please list some of the things you say to yourself when you're deciding not to do acts of self-care.
- Please describe a problem you or someone you know has had because of neglected self-care.
- If you were trying to talk someone you love into exercising self-care, what would you say?
- If someone said that to you about your own self-care, what would you tell them?

Thought/Discussion Questions, 8-2

- What are some self-care measures that you're not doing, but you think you might enjoy doing?
- Of the 5 stages of change, what stage do you think you're in re: self-care in general, and why?
- Please show how strongly you agree or disagree with these statements, on a scale of 0 to 10 (0 = "I don't agree at all" and 10 = "I agree completely"):
 - I believe that if I take care of myself, I'll ultimately be more useful to others, in better ways.
 - I believe I'm ready to try to improve self-care in one or more important areas of life.
 - I believe I'm capable of improving self-care in one or more important areas of life.
 - I believe self-care is less important than helping others, so it should go on the back burner.
 - I believe in self-care, but I'm so overwhelmed that there honestly isn't time for it.

Section Nine: Our Own Unhealed Wounds

Whether it's Ernest Hemingway quoting Friedrich Nietzsche or a little girl quoting Kelly Clarkson, "What doesn't kill you makes you stronger" is always a little bit of a stretch. There are plenty of things that don't kill us—toothpaste, for example—but don't make us stronger.

Many challenges that feel like the overflow of other people's pain are really the resonance of that pain against our own unhealed experience. We may be "strong at the broken places," (Hemingway this time), but we're also

more vulnerable. And how much of the healing process we've completed seems to be less important than how well aware we are of our vulnerability— and how willing we are to address it.

Desensitization vs. Accumulation

Many patterns of our own physical nature lead us to think that unpleasant experiences—pain, danger, loss, betrayal, disrespect, discrimination, humiliation—should get easier with repeated application. After all:

- Muscles build with repeated stress, each time a little stronger, each time overcoming a little more resistance.
- Immunity comes from exposure, so people who've had chicken pox won't get it a second time, and we make vaccines from proteins grown in bodies that have learned how to fight the disease.

After a while, we just get used to things, right? Not necessarily. Our bodies sometimes take the opposite direction:

- Many people have allergic reactions, with the body reacting badly—sometimes violently or even fatally—to an otherwise innocuous substance.
- In many cases the body reacts more severely with each exposure. For example, people who are exposed to toxic mold may not be strongly allergic at first, but prolonged mold exposure might intensify their reactions.
- Sometimes the body develops autoimmune disorders, with immune functions going haywire and the body attacking itself.

In other words, sometimes we don't get used to things. When we look at the human stress system (mentioned in Section 3, "Thoughts on Fatigue,"), we notice that it's mild or moderate, brief, and intermittent stress that builds strength, resilience, and resistance to fatigue. Stress that's extreme or relentless often has the opposite effect. For example:

- Many people who experience multiple losses find fresh remnants of past losses in their present grieving processes, and trauma often builds on and magnifies past trauma.
- Overwhelming experiences like the loss of a loved one, surviving a disaster, living in an abusive household, or growing up with poverty and racism might make us more vulnerable to future pain, and more likely to have our ghosts awakened by the pain we see around us.
- In their desire to protect us, ancient brain structures record, catalogue, and later recognize the sights and sounds of pain and danger. It makes sense that these primitive protectors would react strongly to the signs of pain and danger in other people's lives.

So if our own early experience of pain is part of the developmental process that first “grows” our capacity for compassion for the pain of others, it may also make us more vulnerable to being triggered through exposure to that pain. The result might be troublesome emotions that we’re told to interpret as “compassion fatigue,” but it might also include a tendency to distort our identification with, perceptions of, or relationships with, the people we’re committed to serving, the subject of the next two sections.

The Healing Healer

There are written and unwritten rules about the therapist’s or the counselor’s need for therapy or counseling, the sponsor’s or peer mentor’s duty to work with a sponsor or mentor, the priest’s need to spend some time on the other side of the confessional window, etc. The reflection of our own past pain in the present can provide some rich opportunities for insight and growth in these processes.

But when we’re caught up in another person’s illness and/or healing, we may be tempted to use our sessions with our own healers as a sort of supervision, getting our therapist’s or mentor’s take on how we’re addressing the challenges we find in the people we serve. And if we’re skillful in how we manipulate the session, we can get some good advice on how to handle our work—and leave the session without having addressed what we most need to address.

With this or any of the challenges caught under the umbrella of “compassion fatigue,” it often comes down to the topic of Chapter 4, “The Morality of Compassion.” When we hold the well-being of another in our hands, we have a moral and ethical obligation to keep our hands as strong, as gentle, as clean, and as skillful as possible.

With that much at stake, we can’t afford to overlook any avoidable risk.

Thought/Discussion Questions, 9-1

- Please describe how you feel under extreme, repeated, or long-lasting stress, threat, or adversity.
- Please describe how you feel **after** extreme, repeated, or long-lasting stress, threat, or adversity.
- Please describe how past adversity in your life might have added to your compassion for others.
- Please describe how your past adversity might have increased your vulnerability to others’

pain.

Thought/Discussion Questions, 9-2

- Please describe the professional help and peer support you've had for any unhealed wounds.
 - What kinds of thoughts, feelings, or actions would make you think you might need more help?
 - Please show how strongly you agree or disagree with these statements, on a scale of 0 to 10 (0 = "I don't agree at all" and 10 = "I agree completely"):
- I'm grateful for the understanding, compassion, and strength that adversity has given me.
 - I know what my areas of vulnerability and signs of risk are, and I look out for them.
 - I put a high priority on getting the emotional, psychological, or spiritual help I need.
 - It's better to just move on than to dwell on the past. I'm fine now, and that's what matters.
 - Bad times have only made me tough. They have nothing to do with my present problems.

Section Ten: Identification—Too Much or Too Little

Caring and service toward others are very intimate things, and the quality of the relationship affects, not only the one receiving care, but also the one giving it. This and the next chapter look at some ways in which the thoughts and actions of the helper or caregiver can get distorted and make the relationship more challenging. The first of these has to do with our sense of identification with the people we serve.

Identification with others is an important building block in many areas of life. For example:

- The process of learning new skills uses some of the brain structures and circuits involved in the process of identifying with others. When we identify with people, we're more likely to imitate their actions.
- The survival of the species depends on our identification with and willingness to cooperate with and

care for others in our family, community, culture, country, or whatever other group we see as united with us.

- Depending on how we set the boundaries of what is united with us and what is “foreign,” we might develop a sense of belonging to (and in many cases being drawn to) one group and feeling separate from (and in some cases alienated from) another.
- Acceptance of others can be strongly influenced by whether or not we’re able to identify with them, which is influenced by learned beliefs and shared experiences, characteristics or connections, and by the way we look for and interpret those experiences (for example, identifying only with our own family or culture vs. identifying with people in general).
- Identification is important in the early development of empathy and compassion, which starts when our perception of others’ feelings reminds us of our own experience—and actually invokes some of those feelings—and we start to care and want them to be well.
- Caring for others doesn’t require that we identify with them in every way, but healthy identification—and the sense of belonging and comfort it carries, make caregiving and other helping roles easier, safer for everyone, more pleasant, and more effective.

Like most good things, identification bounces back and forth between too little and too much. At either end of the scale, it can distort our perceptions and make relationships more difficult.

Challenges

Not everyone in a helping, healing, or caregiving relationship over-identifies with the person served, but when it does happen, it often takes on one of two forms:

- **Seeing ourselves (or our past or future selves) in others:** When over-identification with people makes it hard to see the ways in which they’re different from us, we’re seeing ourselves instead of them. So, for example:
 - We might treat people as we’ve been treated (or would like to be treated), not realizing it isn’t appropriate for them, isn’t safe for them, or isn’t meeting their needs. We might be very hard on them, or we might swing in the opposite direction, making excuses for them and failing to give them honest feedback.
 - We might fail to see people’s progress as progress, or their solutions as solutions, because they’re different from our own, so we might feel betrayed, angry, or alienated. They might resent our expectations, blame themselves for letting us down, or sense that we’re not really seeing, hearing, or understanding them.
 - Rather than responding to their pain, we might lose ourselves and start feeling their pain as if it were ours, shifting the focus to us and making us less effective.

- **Seeing our own emotions in others:** This is a pattern we're more likely to fall into when we're unaware of our more uncomfortable underlying emotional experiences.
 - We might, for example, "project" our feelings of anger on others, like a movie projector casting images on a screen, and start to perceive **them** as angry.
 - We might react to that perceived anger by feeling hurt, angry with them, afraid of them, etc. They might feel hurt, confused, misunderstood, afraid, and/or angry at our reactions. This can use up a lot of our emotional energy, and theirs.
 - In any case, we're disowning important feelings that we should be dealing with, there isn't a lot of helping or healing going on, and it might be harmful to them.

If our natural capacity for acceptance and compassion are connected to our ability to identify with someone, it makes sense that a healthy level of identification is important in a helping or healing relationship. This can be threatened or diminished in a number of ways. For example:

- A professional caregiver might be treated as an inferior by the person receiving services, or by the family, and it might feel degrading or humiliating. To tolerate the situation, the caregiver may have to close off the healthy sense of identification that would otherwise have made the caregiving role easier and more pleasant and effective.
- A case manager might have a hard time feeling a sense of identification with service participants from another culture, due to influences that have created a sense of alienation from that culture. This might make empathy difficult and the job unpleasant. When the participants perceive this and feel insulted, the helping relationship suffers.
- A counselor who has negative perceptions of the military might feel alienated from service members and treat them as "other," or say potentially damaging things (like shaming them or failing to accept them for their service or for their actions at war).

In many ways, the ability to identify appropriately—not too much, not too little—is a skill, an important ingredient of compassion, and an essential quality in any formal or informal helping or healing relationship. Given the potential harm at each end of the scale, it is the absolute duty of every service provider to do whatever it takes to find the appropriate middle ground, or to hand the service relationship over to someone who can navigate it more safely and effectively.

Thought/Discussion Questions, 10-1

- Describe a relationship in which you felt like someone else's feelings or identity was your own.
- Describe a relationship in which you felt you had nothing in common with someone.
- Describe a relationship in which you felt connected with, but clearly separate from, someone.
- Describe a situation in which you felt someone seemed to be projecting him/herself on you.

Thought/Discussion Questions, 10-2

- Describe a situation in which someone treated you as alien or "other." How did it feel to you?
 - Could any of those conditions be the case now with someone you're helping or caring for?
 - Please show how strongly you agree or disagree with these statements, on a scale of 0 to 10 (0 = "I don't agree at all" and 10 = "I agree completely"):
- I'm conscious of how easy it is to over-identify with people, or feel alienated from them.
 - If I see signs of over- or under-identification, I take steps to make the relationship safer.
 - I've gotten good at feeling close to people, but still clearly seeing the differences between us.
 - When the people I'm helping feel pain, it often hurts me as if it's my own pain.
 - I don't have anything in common with the people I'm helping. We're from different worlds.

Chapter Eleven: Distorted Roles or Relationships

Two words that have even more definitions and different sets of symptoms than "compassion fatigue" are "countertransference" and "codependence." Sometimes a challenge that's taken for compassion fatigue is really one of the many experiences most commonly lumped under one of those two terms. But rather than jump off one slippery rock just to land on two more, let's call this chapter "Distorted Roles or Relationships." It describes three varieties.

Seeing Ghosts

In the intimacy of a helping or healing relationship, when we look at someone we're serving and see qualities of someone else in our lives—mom, dad, the ex-husband, that nasty teacher, etc.—it can trigger uncomfortable emotions and counterproductive actions. This is a natural and normal part of being a human being with a brain that wants to protect us from harm. But if we don't notice these kinds of reactions, or if we lose sight of their origins, it might turn into what people most often refer to when they use the term “countertransference.” We might start:

- Believing our feelings are normal and even necessary responses to the person we're serving
- Seeing in this person some motives or characteristics of others in our lives, even though he or she may not have those particular motives or characteristics
- Resenting the person we're serving for actions or attitudes that really belong to others in our lives

People often remind us of other people, but if the experiences they remind us of were intense, and if we're unaware of the power of this association and its effects, it can be uncomfortable and potentially harmful to both parties in the helping relationship. The fallout from a situation like this might be interpreted as compassion fatigue. But the rest-and-relaxation techniques suggested for compassion fatigue won't be enough to solve these kinds of problems. Like some of the other challenges this book mentions, they'll also require more work, including self-awareness, insightful people to provide reality checks, and professional help.

Romantic or Sexual Relationships

The line between appreciating someone's attractiveness and considering the possibility of romantic or sexual involvement is absolutely important—and even more important when it comes to the people we serve in helping or healing roles. It seems that, like many lines between right and wrong, this one is harder to see as we get closer to it. Stress, fatigue, lack of self-care, lack of effective supervision, unhealed wounds, or any of the other challenges described in this book can make people more vulnerable to falling into this particular trap. And it is a trap:

- Elements of intense intimacy in healing roles and relationships can be compelling.
- People might start with flirtation and approach the line in subtle and gradual ways.
- The helper might be attracted to someone who would otherwise make a good partner— or to someone too vulnerable or volatile for safe involvement under any circumstances.

Unfortunately, no matter how healthy or admirable they are, this is a relationship of unequal power, and the inequality can last for years after the formal relationship is over. The potential for manipulation, coercion,

abuse of power, betrayal of trust, and triggering of psychological vulnerability is enormous, even if the helper would never do any of those things on purpose.

Taking Responsibility for Others' Choices

For many people, an important division between joyful, effective service and exhausting, ineffective, and possibly harmful service is our ability to keep sight of the differences between others' responsibilities and our own. This one walks many thin lines. When we're in formal helping roles, we're responsible for doing everything we can morally, legally, ethically, reasonably, and humanely do to promote safety and well being. We're responsible for:

- Our words and actions, and for anticipating their possible consequences;
- Knowing our limitations and doing whatever is necessary to compensate; and
- Noticing signs of danger and taking all appropriate precautions.

Beyond that, when people make self-destructive choices in spite of our best efforts, we're not responsible for those decisions, or for their consequences. But we can **feel** like we're responsible, and this can lead to one of the conditions that people in the substance use disorder field used to (and some still do) refer to as "codependence" (a catch-all term that's interpreted in a few ways and applied to a number of different experiences). Whatever we call it, if we— consciously or unconsciously—feel responsible for other people's choices, we might:

- Try to control their actions in angry, manipulative, or otherwise inappropriate ways.
- Do things for them that they're strong enough to do for themselves; or
- Blame ourselves for their decisions or actions, or for the consequences of those actions.

Finding the right label to identify a challenge is often less helpful than looking at exactly what's going on in this particular situation, why it's happening, what resources (internal and external) there are to address it, and how we might stabilize the situation and change course before things get really sticky. When helpers and healers apply our knowledge, skills, and resources to our own wounds and misconceptions, amazing things can happen. What we learn can help us right now, and once we've come to understand it at depth, it can help everyone in our care.

Thought/Discussion Questions, 11-1

- Please describe an experience you've had where you weren't aware that someone reminded you of someone else, so you couldn't quite figure out why they bothered you, attracted you, etc.
- What kinds of signs would tell you that you were reacting to someone in the present as if he or she were someone in your past?
- What factors might make people more vulnerable to sexual attraction to people they serve?
- What steps would you take if you found yourself strongly attracted to someone you served?

Thought/Discussion Questions, 11-2

- Please describe a time when someone you were trying to help made some harmful decisions. How did you feel about that, and how did you react to it?
 - If someone you know was feeling responsible for someone else's harmful decisions, what would you tell him or her?
 - Please show how strongly you agree or disagree with these statements, on a scale of 0 to 10 (0 = "I don't agree at all" and 10 = "I agree completely"):
- I've noticed that certain characteristics tend to "hook me," so I'm on the lookout for them.
 - I know the danger signs, and I have a plan I can follow in case I fall for someone I serve.
 - When I'm tempted to take responsibility for others' decisions, I challenge those thoughts.
 - My reactions to people in the present have nothing to do with other people I've known.
 - It's okay to get romantically involved with people you serve, if you don't have sex.

Section Twelve: Frustrating Survival Skills

When we take on human service roles, we're often driven by compassion for people whose wounds, illnesses,

age, disabilities, and/or other circumstances have caused them pain and left them more vulnerable than people should have to be.

And what we often discover is that most people have plenty of cognitive, emotional, and behavioral strategies for comforting their own pain, keeping a sense of control, and staying psychologically safe. Some of these strategies are called healthy coping skills. Others are often called symptoms, but they make more sense if we think of them as **survival skills**.

In the helping professions, sometimes what's causing our challenges is **not** a lack of sleep, an excess of compassion, or a deep and unhealed wound. Sometimes it's just that people are doing really troublesome things that frustrate us, and our frustration is exhausting. We know that:

- Their symptoms are normal and expected facets of their illnesses.
- Some of their symptoms might be manipulative and hard to manage or tolerate.
- Some of their symptoms might lead the powers-that-be to deny them services.
- We're responsible for doing all we can to keep them safe and help them heal.

Three strategies for coping with **other** people's survival strategies might be to: 1) choose to serve a population whose challenges you can handle, 2) understand these challenges in terms of the survival instinct, and 3) become a collector and teacher of healthy survival skills.

1. Choose the Right Challenges

From "Aboulia" to "White Coat Hypertension," for each disorder listed in the *Diagnostic and Statistical Manual of Mental Disorders*, there are some people who can't tolerate working with its symptoms, some who are okay with it, and some who absolutely love it. So the first strategy is to work toward finding a situation/population that puts you in that third category. Life is too short, people are too vulnerable, and you can accomplish a lot more if you love your work.

2. Understand the Survival Angle

Section 2, "Thoughts on Compassion," opened the subject of the human survival instinct, its power, and its role in making compassion so powerful. The next chapter touched on some of the physical and psychological processes that keep us alive and functioning under stress and threat, then restore us to balance after the threat is over. Many aspects of our lives are organized around survival.

When we call a symptom a "survival skill," we mean it. Even some highly counterproductive symptoms get their power from: 1) the fact that at some point they've helped the person's emotional survival or 2) the brain's belief that they're necessary for survival. A few examples:

- Children may seem to be "in denial" about troubles at home and may refuse to trust the adults who try

to help them. In reality, though, they might be much safer if they avoid awareness of home circumstances, and not trusting may be an important survival skill.

- People in situations of pain and powerlessness may turn to alcohol, drugs, overeating, delusional thinking, stirring up drama, “gangbanging,” running away from home, and many other risky or harmful choices, because that’s their best guess at an effective way to survive their circumstances. Even if it kills them, it was meant to do the opposite.
- Each of the many post-trauma effects—including a number of mild, moderate, and severe physical and psychological conditions—is a natural aftermath of the body’s extreme reactions to stress and threat, reactions designed only for survival and functioning. These reactions and effects get their power from the survival instinct.
- Many mental illnesses are driven by slight changes in brain functioning or in levels of natural chemicals, often the over-functioning of a survival-related process.
- Drugs of abuse are imitators of chemicals that are native to the human brain and important to functioning and/or survival. When people are addicted, powerful chemical processes in the brain tell them they need more of the drug to survive.

This definitely doesn’t mean that anything anyone does is okay, or that everyone should be willing or able to tolerate cruel, chaotic, or self-destructive behavior. It just puts human experience in an accurate perspective that helps us understand the intensity and tenacity of so many of these conditions. A growing number of strength-based therapeutic approaches are looking at symptoms as survival skills, looking at “resistance” as ambivalence to be worked through and “rolled with,” etc. They seem to see the most obnoxious symptoms as attempts to communicate needs, fears, pain, and other challenges. They find strengths under every rock.

3. Become a Teacher of Survival Skills

If you can act on the first strategy and find people you’re comfortable working with, and try on the notion of symptoms as survival strategies and attempts to communicate, you might find some measure of relief. The next step is to build up your repertoire of healthy survival skills and prepare to pass them along. If we try to take away people’s defenses before they have anything they trust to replace those defenses, chances are it won’t work—or things will get worse. But if you think of it as a transaction—you give them skills, and at some point they feel safe letting go of the old ones—they may or may not get better, but **you’ll** get better.

Thought/Discussion Questions, 12-1

- Please describe some frustrating psychological symptoms that some people you serve exhibit.
- For each symptom, tell what that survival skill might be trying to communicate, or how it might contribute to their sense of emotional safety or comfort.
- For the people you serve, what healthier skills could they use to accomplish the same things?
- Please describe any survival skills that are particularly frustrating or annoying to you, and why.

Thought/Discussion Questions, 12-2

- Please describe the things you like about the people you serve.
- Describe a person or type of person you've served whose survival skills **haven't** bothered you.
- Please show how strongly you agree or disagree with these statements, on a scale of 0 to 10 (0 = "I don't agree at all" and 10 = "I agree completely"):
 - I routinely ask myself what the survival skill behind the symptom might be.
 - I routinely ask myself what people might be trying to communicate with these behaviors.
 - I keep learning new healthy survival skills and teaching them to the people I serve.
 - Even if you call it a symptom, if people break the rules, they can't continue to get services.
 - The behavior of the people I serve really bothers me, but I can get them to change.

Section Thirteen: Exposure to Others' Pain and Trauma

Sometimes our challenges really do lie in the pain and fear we witness, the stories people tell us, the slowly encroaching losses we watch them sustain from day to day. We're exposed to traumatic experiences in the lives of others, and to the effects of those experiences, and it becomes too much. The human imagination is

powerful, and sometimes—even if our level of identification with others is healthy and realistic—the weight of their pain can still overwhelm our own stress systems. Sometimes the sponge is just full, and it won't hold any more.

Effects of intense, painful, and/or threatening experiences run on a long continuum. They start with mild and temporary challenges like feeling jumpy or distracted, and extend all the way to serious/chronic physical illnesses or behavioral health conditions (like depression, anxiety disorders, posttraumatic stress disorder, personality disorders, or substance use disorders).

Exposure to trauma and its effects can make us vulnerable to vicarious trauma, a condition described in DSM-V, the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*.

- We can get it from exposure to others' trauma, from witnessing events or hearing first-hand accounts (in-person accounts, rather than coverage on television, radio, newspapers, etc.).
- This condition shares some symptoms with posttraumatic stress disorder (PTSD), though these symptoms are often milder than those of PTSD. Some of the treatments and management strategies are also similar. Vicarious trauma is often linked with loss of a sense of spirituality, sense of meaning, or capacity for hope.

Vicarious Trauma and Other Challenges

Some of the challenges explored in this workbook are also thought to make us more vulnerable to Vicarious Trauma. So why not write this book about Vicarious Trauma and just address the other challenges separately as variations? Several reasons:

- This isn't a clinical book about a particular diagnosis, just an exploration of many kinds of human experiences.
- The effects of fatigue, lack of self-care, or any of those potential contributing factors can be very troubling—even very dangerous—and still not come close to qualifying as trauma.
- The more we invoke the word “trauma” without being sure that's what it is, the more it raises the sense of drama in the situation, and the less useful the word “trauma” will be in the situations where it really does apply. It's best not to diminish the experience of people who have lived through trauma by using the term lightly or inaccurately.
- We have in our popular culture a great and growing tendency toward fuzzy thinking. Rather than use a diagnosis as a catch-all term and try to fit lots of things into it, why not just address it as one of the many kinds of conditions that might be in evidence?

Of course, if any of the other challenges mentioned in this book is either making you more vulnerable to

vicarious trauma or just tagging along with it, these need to be addressed individually, too—but in a context that includes the whole that all these challenges make.

Diagnosis and Treatment

If something's going on that constitutes a real disorder, then it's far beyond the scope of this workbook to diagnose it or recommend treatment. There are some screening and assessment instruments listed in the resource pages, but even if you're a clinician, you're going to want someone else with the appropriate skills and credentials to help you on that journey.

With trauma treatment—or with any sort of treatment, if post-trauma effects are even part of what's going on—it's always important to use approaches that are appropriate to the person's stage of trauma recovery, perhaps using the stage model developed by Judith Herman:

- In **Stage One, Safety and Stabilization**, it's just about slowing the body's reactions to trauma, creating a sense of safety, noticing what we're thinking, feeling, and noticing around us, learning to understand/manage reactions to these experiences, connecting with people we find it safe and comfortable to be with, and **not** trying to dig into our heads and pull out a lot of traumatic memories and emotional reactions. When memories and emotions do arise, we respect them and share them with someone safe.
- In **Stage Two, Remembrance and Mourning**, it's all about putting the pieces together, in collaboration with skilled professionals who are willing and able to help us gain more skills in noticing and managing our physical and emotional reactions. This way, they can help us safely reconnect with feelings and/or memories that are uncomfortable—things that in some cases might have been hard to remember—and integrate them into our grieving processes and our acceptance and understanding of life and of ourselves.
- In **Stage Three, Reconnection**, it's all about reconnecting, not only with the people around us and the texture of our lives, but also with our senses of meaning, purpose, and spirituality.

As always, the most important agents of healing are human: ourselves, our loved ones, people who have “been there,” and compassionate people who are trained to help us walk through the process and skilled in finding our strengths and teaching us the skills of balance and resilience.

Thought/Discussion Questions, 13-1

- Without naming names, what are some of the painful stories you've been hearing or witnessing?
- How have you been reacting to those painful stories?
- If you suspect you have vicarious trauma, why do you think it's that and not another issue?
- If you do have vicarious trauma, what stage of trauma recovery are you in, and why?

Thought/Discussion Questions, 13-2

- If so, what kind(s) of professional help do you think you need, and where would you find it?
 - And what kinds of things can you do right now to help your recovery from vicarious trauma?
 - Please show how strongly you agree or disagree with these statements, on a scale of 0 to 10 (0 = "I don't agree at all" and 10 = "I agree completely"):
- I'm ready and willing to seek professional help, to find out if this is vicarious trauma.
 - I'm willing to have them assess my stage of recovery, and to choose appropriate services.
 - I'm ready and willing to seek mutual support with others who've had similar experiences.
 - I've been exposed to many, many stories and effects of other people's pain and trauma.
 - These stories are having severe emotional or behavioral effects on me.

Section Fourteen: Commitment to Difficult Situations

So what about the times when absolutely important helping roles or relationships are far too troublesome, exhausting, and/or costly to you on personal or financial levels? What about:

- The very frustrating and/or utterly depleting job (long hours, physical demands, bad person/job fit, scapegoating situation, etc.) that you honestly can't leave for practical reasons—like you can't find another one and you need the pay and the benefits?

- The caregiving role that you seem to be carrying all alone, while other loved ones swoop in occasionally, give you advice or quick and cursory assistance, then swoop out?
- The number of calls and amount of paperwork needed for approval of desperately needed services—approval often based on financial, rather than human, considerations?
- The situations that force you to neglect the people who sustain you, so you can be with the people you're trying to sustain—people whose health, life, and dignity are at stake?
- The life dreams you've given up so you can commit to a helping, healing, or caregiving role you really believe in and are solidly committed to seeing through to the end?
- The struggle to keep your effectiveness and commitment to the healing work you love, in an atmosphere of scarcity, where all the attention seems to go to the bottom line?
- The sudden or slowly encroaching absence and grief that can enter your life when your loved one's personality, rationality, or ability to communicate is lost to age or illness?

This section is about those very difficult life experiences associated with the helper's role, experiences that may last a long time or a short time, but sometimes seem to stretch on ahead forever. Having fear, pain, and/or resentment about your helping role definitely doesn't negate or diminish your love or your commitment. It just means some experiences are hard, including:

- The painful things that can happen to people's bodies and minds;
- The losses that people sustain—from the loss of loved ones to the loss of life dreams;
- Situations that force us to choose between values that are absolutely important to us;
- The amazingly broad and intense ambivalence we can feel in human situations; and
- Limitations in our time, energy, and endurance, regardless of our level of commitment.

Loneliness

There's an incredible loneliness in being the central person responsible for the care and comfort of another, when there are so many circumstances we can't control or change. For example:

- If you're working in a professional helping or caregiving role, you may have good supervision and mentorship—or you may have been “thrown into” a counseling, caregiving, case management, or support relationship where you're out of your depth and left to guess at answers to questions you've never faced before.
- If you're a single parent or grandparent, you spend each day as the central point of responsibility for this messy and momentous thing called a developing human life.
- If you're the caregiver for a friend or family member, you might be spending your days and/or nights with someone you love deeply. But in ways you can't explain, you might feel a great loneliness, deepened

by your closeness to the person whose life and well being are now your responsibility. And despite your consistent wish to relieve their pain, their vulnerability dictates that some of the things you do will bring them pain.

It's important not to carry this all by yourself, and Chapter 16 has some suggestions for choosing your own helpers and “sounding boards.” If you feel this loneliness, it's important to acknowledge it to yourself, and to talk about it—in most cases, not with the person you're helping, but with supporters who will understand it and not try to talk you out of feeling it. In a strange and comforting way, this loneliness can deepen your connection with the one you're helping, who may be grappling with an even stronger and more global sense of loneliness.

The Serenity Prayer

Even in the most confining situations, we all have decisions to make every day—sometimes far too many decisions. The Serenity Prayer, written by the American Theologist Reinhold Niebuhr, can be a useful tool in big and small decisions. It works even if you're an Atheist and you have to cover up the first word: “God, grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference.”

The things we can't change include, of course, many elements of the situations we're in, the traits and decisions of other people, and our own basic nature and biology. The things we can change include our own ways of looking at the world, our habitual thought patterns, our choices, our words, and our actions. Sometimes our changes might influence others' actions or the situations around us, but often they don't. And what about those other intimidating words?

- **Serenity**—letting our fears float by around us, rather than define or preoccupy us— often opens us up to clearer thinking and perception. At the very least, it feels better.
- True **acceptance** of circumstances we can't change often has an amazing tendency to immediately precede actual outside changes in those circumstances. Coincidence?
- **Courage**—which usually implies that we're acting in spite of fear—helps us understand that we have the option not to be limited by our fears. And so it reduces fear.
- In a situation we can't “fix,” **wisdom** might tell us how to tolerate the negative and the perplexing, take comfort and joy from the positive, and keep an open mind and heart.

Thought/Discussion Questions, 14-1

- Please describe the many difficult elements of your current helping or caregiving situation.
- What are some of the seemingly conflicting thoughts and feelings you have in this situation?
- What are some of the values you have that are in conflict with one another in this situation?
- Do you feel a loneliness in your current situation? If so, please describe it.

Thought/Discussion Questions, 14-2

- What are some of the challenges you face when you consider talking to people about it?
- If the Serenity Prayer worked for you in this situation, what might that change in you?
- Please show how strongly you agree or disagree with these statements, on a scale of 0 to 10 (0 = “I don’t agree at all” and 10 = “I agree completely”):
 - I’m navigating a hard situation—not perfectly—but with serenity, acceptance, and courage.
 - The situation is very difficult, but every day I choose to stay in it, for very good reasons.
 - I have people I can talk to who accept me and understand my conflicted feelings.
 - Most of the time I feel like my situation is really hopeless.
 - I don’t feel like it’s me choosing to stay in this situation. I feel completely trapped.

Section Fifteen: Working in Toxic Systems

If we were all floating around this world detached from our human environment, we could find the core of every asset and every challenge within ourselves. But we’re not. Our connections reach out in all directions, and our lives and decisions intersect those of multiple people, groups, systems, and cultures. If you spend your days working to address others’ illness, pain, or deprivation, the point where that experience meets the effects of your other troubling experiences—including your early, pivotal experiences—can be a very turbulent place.

And if you’re working in an organization, chances are some of the people around you—possibly even the people who are steering the ship—are being blown about by the same winds, and may have been since their early, developmental years. That level of turbulence can distort the way people live their lives, treat one another,

do their jobs, and shape and run their systems. The challenges you might interpret as “compassion fatigue” might not be your challenges alone. They might include the many effects of working in a deeply troubled organization.

How it Happens

Remember the image of the “wounded healer” described in Chapter Four, “The Morality of Compassion”? The experience of pain can be a catalyst for compassion, and for the decision to make the comfort and healing of others the focus of our life’s work. Dedication to that work can eclipse everything else, including self-care and an honest assessment of our own health.

Under those circumstances, truly good and well meaning people can do a lot of good—and a lot of harm. The higher their level of achievement, influence, and charisma, the more profound and conspicuous good they can do in the lives of the people they serve—and the more harm they can do to the health and functioning of their organizations and the people who work there.

When people’s counterproductive survival skills have helped shape their system’s culture, practices, and policies (stated or unstated), the natural tendency is to protect the system’s delicate balance by sealing it off from outside influences. The result is often called a “closed system.” Members of the system—the family, the organization, the service system—still have connections with outsiders, but more and more of its elements become hidden to those outside the system and unchallenged by those inside the system. The dysfunction is locked in place.

Identifying a Toxic System

How can you tell if you’re working in a toxic system? You might find the answer in your “gut” reactions, but you might also need to look for specific signs, for example:

- Leaders who are tyrannical (in obvious or subtle ways) or ineffectual
- Rigid caste systems, “warring camps,” secrecy, gossip, conspiracies, and tests of loyalty
- Approval or tolerance of aggressive, competitive, and domineering behaviors
- Negative consequences for telling the truth; blatant requirements that employees lie
- Tolerance, encouragement, or expectation of “workaholic” patterns; cutting staff or paid hours but expecting the same or higher levels of productivity
- Systematic scapegoating and withdrawal of support in order to force employees to leave
- An atmosphere of crisis, fear, frustration, resentment, depression, and entrapment

It’s easy to fall into closed, toxic systems. They often appear dynamic and highly focused on their mission.

If you were raised in a troubled family, a troubled organization might feel like home. Whether or not your internal warning bells are ringing, the organization's leaders might seem inspiring, blurred boundaries might feel like family, and harsh treatment might resonate in the shadowy corners of your self-concept. Even the idea of leaving might feel like a betrayal.

What Can You Do?

Guiding you through an effective response to a toxic work environment is far beyond the scope of these two pages. An excellent resource for this is William L. White's *The Incestuous Workplace: Stress and Distress in the Organizational Family*. [2] According to White, we must identify the toxic elements of the environment and our roles—and ways in which we add to these difficulties.

He identifies three strategy options for the employee caught in a distressed or toxic organization: “You can take an activist stance to change the organization or the nature of your relationship to it. You can take on a self-containment strategy, which allows you to disengage from some of the more negative aspects of the relationship. Or, you can leave” (Page 200).

“It's time to consider leaving when our needs are not being met, when new, discomforting elements have been brought into the relationship, and when all efforts to correct the loss of reciprocity have failed. In short, it's time to leave when the price we're paying is greater than what the organization is paying, and I'm not referring exclusively to money here” (Page 212).

But don't worry: There is life—often much better life—after leaving a toxic situation. The decision isn't easy, and leaving can be painful. But out of these experiences often come renewed health, accelerated growth, and a stronger and deeper sense of meaning and purpose.

Thought/Discussion Questions, 15-1

- What are some signs of health in your organization, and how do you contribute to that health?
- What are some troubling elements of your organization, and how do you add to the distress?
- What is your history of employment in healthy vs. distressed or toxic organizations?
- What opportunities and resources do you have for making your organization more healthy?

Thought/Discussion Questions, 15-2

- If you're leaning toward leaving the organization, what are your main reasons for doing that?
 - Who are, or might be, good sources of support in dealing with your work situation?
 - Please show how strongly you agree or disagree with these statements, on a scale of 0 to 10 (0 = "I don't agree at all" and 10 = "I agree completely"):
- My organization is basically healthy, and over time we address its challenges effectively.
 - I have the strength, skills, and opportunities to make my organization more healthy.
 - I want to leave, but I have a good game plan, and I'm at peace with my decision.
 - I'm overwhelmed by the negativity here, so I can't tell if the problem is them or me.
 - I'm intensely unhappy here, but I'm determined not to let them force me out.

Section Sixteen: Doing it All By Yourself

You can find hundreds, maybe thousands of explanations of resilience, but they all seem to name a common key: human connection. From the moment we're born, caring relationships help build our stress and immune systems, enhance our strength and confidence, protect us from stress and trauma, and help us heal and recover. We need people.

In professional helping, healing, coaching, or support roles, we need wise, expert supervisors, mentors, and colleagues to help us improve our work and our confidence. In caregiving roles, we need people who can listen and people who can provide practical, hands-on help and referral to needed resources. Believe it or not, we can't—and we shouldn't have to—do everything ourselves. It takes a village, not just to raise a child, but to care for human beings in general.

Sounding Boards

Whatever roles you occupy, you need good sounding boards. At times, you may need:

- Witnesses whose listening presence—not fixing, just listening—tells you you're not alone, not the only one who knows the challenges you're facing;

- People you can safely tell about your role-related thoughts, feelings, and actions, even those that raise deep guilt or shame, and see in return their look of acceptance and understanding—or, better yet, that smile that says, “Yes, I’ve been there, too!”;
- People who know how to ask the right questions respectfully, to help you look more objectively at your assumptions and conclusions, and to suggest other considerations;
- People who can tell you what and where the resources are and give you good pointers for approaching the appropriate people and making your case;
- People who know how to find your strength and courage, even when you feel weak and scared, who can help you believe in and build on all your strengths and resources; and
- People who can jump in and be with you when you’re overwhelmed or in crisis.

In the search for sounding boards, it’s also important to recognize and do your best to avoid confiding in people who would make things worse, rather than better. For example:

- People who tend to criticize you may have good motives, and some of their criticism might even be accurate, but for most people, being on the receiving end of a lot of criticism isn’t helpful. It can deplete energy, destroy hope, and neutralize courage.
- Some people are uncomfortable with complex situations, or they just don’t understand the complexities of your situation. They’ll tend to suggest solutions, often repeatedly, wanting only your well being, but those solutions may not reflect the realities.
- Some people encourage you to be weak or dependent. They’ll ignore or minimize your strengths, and do things for you that you could and should be doing for yourself. Or they might “awfulize,” reflecting your reality back to you in very negative ways and treating you as an object of pity because of your current challenges.

Connecting With Support Resources

Finding the time to locate and consult good sources of support can be a difficult task if your work or your life seems all-consuming, but we have an amazing ability to accomplish things once we’ve made them priorities. Here are some examples of ways of seeking mutual support:

- If you work in a health or human service field, you and your colleagues might think about starting a support group or network. If no one has time to meet in person, why not try a conference call once every week or two? At the very least, you might run across one or two people who would make good mutual sounding boards for you.
- If you’re a caregiver, there may be support groups connected with a hospital or with the type of illness, injury, or disability the person has sustained (for example, a support group for caregivers of veterans with

traumatic injuries). A local faith community, public library, community center, or community college might also sponsor a group.

- Many kinds of support groups are listed online, and some meet online. There may be groups for you, and groups for the people you're helping—because they need support, too. For caregivers, there are websites that offer ways of coordinating information about caregiving needs and the health of the people receiving care. A few examples are listed in the “Web Sites” appendix, to give you some ideas for the search process.

Helping People Help You

The boxed-in section on the next page is designed to help in-home caregivers communicate with potential sources of help, support, and respite care. It's a message to people who'd like to help, but don't know what would be helpful. So if you're a caregiver, you might print or copy that page and give it to people who might want to help. And if you're not a caregiver but you know one (and who doesn't?), it might give you some ideas about how to offer your assistance. In any case, it's an example of one way of telling people what kinds of help are really helpful.

Ways You Can Help in the Caregiving Process

If someone you know needs care or has a significant caregiving role, you might really want to help the caregiver and/or the person receiving care, but might not know what to offer or how to ask. Here are a few thoughts to consider as you think about how to approach the situation.

- When illness, age, or disability keep people from being able to take care of some basic needs, this can disrupt their lives, adding many layers of complication to even the simplest tasks.
- This can also separate people from their communities, creating deep isolation. Contact with friends, family, and people in their work or social circles can make all the difference.
- Some people in these situations want to avoid all but the people closest to them, because they're ashamed of or embarrassed by their circumstances. You can let them know their circumstances are nothing to be ashamed of, but if they'd rather have their privacy, it's important to respect that. Their caregivers can tell you if there are other ways you can help.
- Caregiving can be an intensive, all-consuming process. People in primary caregiving roles

often give up many aspects of their lives—including their own basic self-care. Friends who care about the caregiver or the person receiving care can really help.

Offering Help

- Most people don't like to ask for help, and many people simply won't ask. They may feel they should be able to do it all by themselves, or not want to impose on people. So if you've said, "Just let me know if there's anything I can do to help," they probably won't. It's up to you to make it easy for them to guide you to the ways you can really make things easier.
- One possibility might be to say something like, "I'd like to spend one morning a week helping out. What would be most helpful to you, and when would be the best day to do it?"
- Sometimes people are shut in or overwhelmed with their circumstances, so they have a hard time getting out to stores or cooking. You might arrange to pick up some things for them when you're at the store, or cook something you know they like and take it over to them, separated into meal-sized or portion-sized containers. Rather than offering to do it sometime and leaving it to their initiative, it's better to go ahead and schedule it with them.
- One good way to help is to offer respite care, to be there and attend to basic tasks and safety concerns while the caregiver runs errands, goes to a support group, gets some sleep, etc. But again, rather than saying, "If you'd ever like me to be there for respite care, just let me know," you might say something like, "I'd like to spend six hours a week doing respite care, so you can do other things. If you'd like that, can we go ahead and schedule the first visit?"

Coordinating Help and Care

- If the situation is overwhelming, people may have a number of complex needs (rides for medical treatment, people to take "shifts" helping with caregiving, etc.). In most cases, neither the caregiver nor the person receiving care has the time or the peace of mind to sit down and coordinate this, or to ask a lot of people for help.
- Anyone who's willing and able to take on the role of coordinating needed help is worth his or her weight in gold. If you're not the primary caregiver or the person receiving care, you'll have an easier time asking people for help than they would.

- You'll need to make calls asking people for help, make a schedule of who's going to

Thought/Discussion Questions, 16-1

- How have the healthy human connections in your life protected, healed, and supported you?
- Please list some people who are, or might be, helpful mentors for you.
- Please list some colleagues who are, or might be, good sources of support.
- Please list some people in your family who are, or might be, good sources of support.

Thought/Discussion Questions, 16-2

- What factors can make it hard to ask for support, and how might you overcome those factors?
- If people want to help or support you, what should they know in order to really be helpful?
- Please show how strongly you agree or disagree with these statements, on a scale of 0 to 10 (0 = "I don't agree at all" and 10 = "I agree completely"):
 - I have good sounding boards in my life. We provide effective support for one another.
 - I've developed good "radar" for spotting and avoiding "bad" sounding boards.
 - I'm willing and able to tell people what I need and how they can be helpful.
 - I don't need much help or support. I'm supposed to be the one doing the helping.
 - I've been burned by people I confided in, so I can't trust people with private information.

Chapter Seventeen: Untangling the Knot

Don't you wish it were simple? Even the no-brainers, like the fact that everybody needs enough sleep, can raise questions and conflicts and complications. Most often, many things are going on all at once, and cause and effect have looped around one another so many times that nobody knows which is which. Sometimes we just have to look at the areas of challenge separately, before you can see how they all fit together.

Here's a quick summary of each of the challenges and suggestions described in the past 11 sections:

Challenges and Suggestions, Chapters 6 through 16

Chapter	What the Chapter Addressed	Suggestions in the Chapter
	A Troubled World	Suggestions on a Troubled World
6	<ul style="list-style-type: none"> • There's a lot of uncertainty. • Illusion of separateness causes conflict and taxes compassion. • Love might even transform lives, families, communities. • We can handle the consequences of caring. • Whatever we can do is enough. 	<ul style="list-style-type: none"> • Remember that good things are happening, too. • We can have the courage to love and accept the pain of reunion. • Don't try to block out the pain of living—it makes it more painful. • We can let ourselves be conduits of healing, which heals us, too.
	Focus on Problems and Deficits	Suggestions on Problems and Deficits
7	<ul style="list-style-type: none"> • Natural ability to spot danger/ problems promotes survival. • In excess, it causes problems. • Whole systems are organized around problems and deficits. • It eats away at hope, strength, initiative, compassion, and joy. • Moving to strength-based focus is a major cultural change. • Many kinds of change agents are needed in these efforts. 	<ul style="list-style-type: none"> • Try not to focus on and react to problems and deficits. • Figure out how to prevent them. • Question "the way things have always been done." • Think about how things might be done more effectively. • Identify the skills you have that might help change the culture. • Have the courage to be a change agent in your system.
	Neglected Self-Care	Suggestions for Neglected Self-Care
8	<ul style="list-style-type: none"> • Sometimes the challenge is just fatigue from lack of self-care. • We may think putting things ahead of self-care will help more people, but it won't. • It's hard to choose self-care when the demands are high. • People move through stages of change. Different approaches work in different stages. • If you work toward self-care, you can help more people. 	<ul style="list-style-type: none"> • Question what you tell yourself when you neglect self-care. • Give yourself the advice you'd give someone else. • Learn more. Keep an open mind. • Weigh the benefits of self-care against your current patterns and their possible consequences. • Experiment with self-care, and work on getting ready for more. • Don't beat yourself up if it doesn't work at first. Keep trying.

Our Own Unhealed Wounds

9

- It's only moderate, temporary stress that makes us stronger.
- Our experience of pain may make us more compassionate, but it might also make us more vulnerable to future stressors.
- What seems like "compassion fatigue" may actually be others' pain bouncing off our own unhealed wounds.
- It's our moral and ethical responsibility to get human support and professional help.

Suggestions for Our Unhealed Wounds

- Be aware of your own unhealed wounds and vulnerabilities.
- If you're in a helping/healing position, make sure you have mentors, supporters, helpers, too.
- Assess your need for professional help and make sure you have it.
- When you're with those resources, make sure you address your own experience, and not just get advice for helping others.
- Stay vigilant for signs of your own vulnerability they might trigger.

Identification—Too Much or Too Little

10

- Identification with others is an important foundation for many things, including compassion.
- Healthy identification fosters belonging and makes helping roles safer, more pleasant, and more effective.
- Either too much or too little identification can distort our perceptions and make relationships more difficult.
- If we see ourselves in others, we might act in ways that hurt us and them, or at least make us less helpful and effective.
- If we "project" our feelings on others, we can react negatively to them and fail to recognize or deal with our own feelings.
- If we can't identify with them, we may judge them harshly or fail to see their humanity.

Suggestions for Identification

- Think about where and why you might draw the line between "too little," "just enough," and "too much" identification with people.
- Be aware of your level of identification with different people or categories of people.
- When others' feelings bring out strong feelings in you, look at how much of that is empathy for their experience, and how much is seeing your experience in them.
- Stay vigilant for those times when you perceive in others your own uncomfortable emotions that you'd rather not be aware of.
- If you're in a helping role with people you have a hard time identifying with or feeling empathy for, either refer them to someone else or change whatever you have to change in yourself to accept and work well with them.

Suggestions for Roles/Relationships**Distorted Roles/Relationships**

- 11
- Sometimes we're stressed because of our distorted perception of roles and relationships.
 - Sometimes we see people from our past or outside lives in the people we're trying to help.
 - If that happens, we might see people inaccurately and react to them as if they were those other people we knew.
 - We might be drawn toward romantic or sexual involvement with people we're helping.
 - Those relationships of unequal power can damage us and the vulnerable people we serve.
 - We're responsible for our own actions, for anticipating and avoiding danger, and for knowing and compensating for our own limitations.
 - We're not responsible for other people's choices.
 - When we hold ourselves responsible for others' choices, we can hurt them or ourselves.

- Be aware of any people in your past or outside life (family, romantic or sexual partners, authority figures, etc.) with whom you may have tensions or issues you haven't completely resolved.
- Stay vigilant for extreme or emotional reactions to the people you serve that don't seem to match the reality of your helping relationship with them.
- If you start to feel drawn toward sexual involvement with someone with whom you're in a helping role, take it to your own mentor or counselor as soon as you can.
- If you can't resolve it, find someone else who would be more appropriate to help them.
- Keep a clear distinction between your choices and other people's.
- Notice when you're feeling responsible for their choices, and notice what you do as a result.
- Get help for these issues from your own mentor or counselor.

Frustrating Survival Skills

- 12
- Other people's psychological symptoms may really be their psychological survival skills, but they can still make your helping role more difficult.
 - You can even think of these survival skills as attempts to communicate fear, pain, etc.
 - Different helpers find different sets of survival skills difficult.
 - People often need healthy survival skills before they can let go of the unhealthy ones.

Suggestions for Survival Skills

- Practice looking for survival-related reasons for people's symptoms or behaviors.
- Weigh your frustration against your satisfaction in working with this person or population.
- If serving a different person or group of people is an option, think of whom you'd most like to serve.
- Learn as many healthy survival skills as you can, and teach the people you're helping the skills that might be most useful to them.

Exposure to Others' Pain and Trauma

13

- Traumatic experiences can have many effects, including depression, anxiety, PTSD, etc.
- Post-trauma effects can be mild, moderate, or serious.
- Vicarious trauma is a disorder caused by too much exposure to the stories and effects of others' pain and trauma.
- Any mental health condition needs professional help, peer support, and focus on strength.
- Stages of trauma recovery are 1) Safety and Stabilization, 2) Remembrance and Mourning, and 3) Reconnection.

Suggestions for Others' Pain/Trauma

- If you think you might have vicarious trauma, consult a professional who specializes in assessing and treating trauma.
- Find out the menu of services they provide, and choose people who provide services appropriate for your stage of trauma recovery.
- Connect with your support network about these challenges.
- Connect with others who are recovering from vicarious trauma.
- If this challenge is related to your work, and if it's safe to do so, talk to your mentor and/or supervisor about it your condition.

Working in a Toxic System

14

- Sometimes the problem is that you're working in a deeply troubled system
- Many people with painful life experiences throw themselves into helping roles.
- Many people in these roles tend to neglect their need for self care.
- This can affect the health and functioning of their organizations.
- Some charismatic leaders are also very troubled. Their words or actions can be disruptive, dishonest, unfair, or even cruel.
- Dynamic, dedicated organizations can also be dysfunctional. They might become isolated from outside influences. to protect their ways of doing things.
- It's easy to be drawn into troubled systems. They can look good on the outside, with a compelling sense of mission and purpose.

Suggestions for Working in a Toxic System

- Look honestly at your organization's policies, attitudes, conditions, and expectations.
- Ask yourself: How does it feel to be there? Does what's going on make sense? Am I safe? Am I supported? Can I "speak truth to power" without being punished for it?
- Some organizations can get well, but others can't. Their dysfunction is too strong, and their leaders don't want things to change.
- If the organization can change, you may or may not have the skills and the influence to change it.
- You also might or might not be able to establish yourself as an "island of sanity" in a turbulent place.
- If the emotional price you pay for working there is worth more than the satisfaction and the money you get, it's time to leave. If you do need to leave, you'll still be okay.

Commitment to Difficult Situations

- 15
- Some helping roles or relationships are very difficult, but for one reason or another we can't leave them right now.
 - Conditions may be very difficult, but we may have a strong personal commitment to stay, in some cases to the end.
 - These situations can last a long or short time, but not forever.
 - There's a loneliness to being responsible for another's care.
 - Even if our commitment is strong, it's normal—and even healthy—to have a lot of confusion and conflicting feelings in these situations.

Suggestions for Difficult Situations

- Don't try to carry these situations alone. Find good sounding boards who will understand your conflicting feelings and accept you as you are.
- Do a careful assessment of which elements of the situation you can change, and which ones you can't.
- Find the resources and courage to help you change the elements of the situation that you can change.
- Find the serenity and other resources you need to help you accept the elements you can't change.
- Practice tolerating the negative and confusing aspects, take comfort and joy from the positive, and keep an open mind and heart.

Doing it All By Yourself

- 16
- We need other people. We're not supposed to be able to do everything by ourselves.
 - We all need good "sounding boards," people who can listen and give good support/feedback.
 - People who offer a lot of criticism, people who repeatedly suggest simplistic solutions, and people who stir up drama usually don't make good sounding boards.
 - If you prioritize finding good sources of support, you'll be able to do it, and it will be worth it.
 - If you're in an in-home caregiving role, people who want to help you may need concrete suggestions for doing it in a way that really helps.

Suggestions for Doing it All By Yourself

- When you're looking for good sounding boards, look for:
 - people who know how to listen;
 - people who are safe to talk to;
 - people who will understand, accept you, and not judge you;
 - people who will respectfully help you examine your thinking;
 - people who can guide you to helpful resources;
 - people who can help you find and grow your strengths; and
 - people who can be there for you when you're in crisis.
- Look for mutual-support groups in your field, online, or in your community.
- Let people know how they can help.

Section Eighteen: Putting Strengths to Work

The final worksheet in this manual seeks to wrap up the process by gathering some of the major strengths you have identified in yourself through your answers to workbook questions in the earlier sections.

Inventory: Strengths to Support Compassion

Topic or challenge	Your most important strengths in this area are:	Some of the benefits of these strengths in your life so far:	How you might use these strengths to overcome challenges in this or other areas of your life:
Helping or healing roles			
Thoughts on compassion			
Thoughts on fatigue			
The morality of compassion			
A troubled world			
Focus on problems and deficits			
Neglected self- care			
Our own unhealed wounds			
Identification— too much or too little			
Distorted roles or relationships			
Frustrating survival skills			
Exposure to others' pain and trauma			
Working in a toxic system			
Commitment to hard situations			
Doing it all by yourself			

A Final Note

This is the end of the process. It's supposed to be about untangling and thinking about addressing the many conditions commonly mislabeled "compassion fatigue," but with any luck, it's been about much more than that. How we respond to the pain we see around us is of urgent importance, and not only to people who are in

roles designated as “helping” or “caregiving” roles, but to all of us. It’s a fundamental part of our responsibility as human beings.

There’s nothing like the experience of compassion, like feeling the joy and sorrow of another, moving you to listen, to witness, to help, to do whatever your best self says to do. When we allow ourselves to be part of a healing process, the healing passes through us, and when we witness the lifting of another, we are caught in the updraft.

When compassion flows unobstructed, it can be a source of great relief. When it is obstructed, distorted, or stretched to its limits, the result can be anything from annoying to dangerous.

If you picked up this book, if you made it all the way to the end, that says something about you, your priorities, your commitment, your courage, and your heart. Please don’t try to do it all alone. Please summon all the resources at your disposal, and know that you deserve at least as much kindness and consideration as the people you’re working so hard to help.

Every minute, you make the choice: to love or not to love, to serve or not to serve, to try or not to try. You also choose which opportunities you’ll use to fulfill this purpose.

May you make these choices freely, renew them every moment, and be renewed by them—alive and full of purpose, compassion, and joy.

Citation

Woll, P. (2017). Compassion doesn’t make you tired: Unmasking and addressing “compassion fatigue.” Kansas City, MO: Addiction Technology Transfer Center Network Coordination Office.

This work resides in the public domain, unless otherwise indicated.

Bibliography

Adams, R.E., Boscarino, J.A. and Figley, C.R. (2006). Compassion fatigue and psychological distress among social workers: A validation study. *American Journal of Orthopsychiatry*, 76(1), 103-108.

Ahola, K., Hakanen, J., Perhoniemi, R. and Mutanen, P. (2014). Relationship between burnout and depressive symptoms: A study using the person-centred approach. *Burnout Research*, 1(1), 29–37.

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders*, Ed. Arlington, VA, APA Press.

Babbel, S. (2012). Somatic psychology: compassion fatigue. *Psychology Today*, July 4, 2012.

Baird, S.J. and Rae, S. (2003). Vicarious traumatization, secondary traumatic stress and burnout in sexual assault and domestic violence agency staff. *Violence and Victims*, 18(1), 71-86.

Beattie, M. (1986). *Codependent no more: How to stop controlling others and start caring for yourself*.

Center City, MN: Hazelden.

Beck, C. (2011). Secondary traumatic stress in nurses: A systematic review. *Archives of Psychiatric Nursing*, 25(1), 1-10.

Beck, C. and Gable, R. (2012). A mixed methods study of secondary traumatic stress in labor and delivery nurses. *Journal of Obstetrical, Gynecological and Neonatal Nurses*, 41, 747-760.

Bell, H., Kulkarni, S. and Dalton, L. (2003). Organizational prevention of vicarious trauma. *Families in Society: The Journal of Contemporary Social Services*, 84(4), 463-470.

Bianchi, R.; Schonfeld, I. S.; Laurent, E. (2014). Is burnout a depressive disorder? A re-examination with special focus on atypical depression. *International Journal of Stress Management*, 21(4), 307-324.

Bober, T. and Regehr, C. (2006). Strategies for reducing secondary or vicarious trauma: Do they work? *Brief Treatment and Crisis Intervention*, 6(1). 1-9

Bonanno, G.A. (2004). Loss, trauma and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events? *American Psychologist*, 59(1), 20-28.

Bonanno, G.A. (2009). *The other side of sadness: What the new science of bereavement tells us about life after loss*. New York: Basic Books.

Boreen, J., Johnson, M.K., Niday, D and Potts, J. (2000) *Mentoring beginning teachers*. York, Maine. Portland, ME: Stenhouse Publishers.

Bride, B., Robinson, M., Yegidis, B. and Figley, C. (2004). Development and validation of the secondary traumatic stress scale. *Research on Social Work Practice*, 14, 27-35.

Bride, B.E., Radey, M. and Figley, C.R. (2007). Measuring compassion fatigue. *Clinical Social Work Journal*, 35(3), 155-163.

Briere, J. and Scott, C. (2006). *Principles of trauma therapy: A guide to symptoms, evaluations, education and treatment*. Thousand Oaks, CA: Sage Publications, Inc.

Brotheridge, C.M. and Grandey, A.A. (2002). Emotional labor and burnout: Comparing two perspectives of "People Work." *Journal of Vocational Behavior*, 60, 17-39.

Brown, S. (2009). *Play: How it shapes the brain, opens the imagination and invigorates the soul*. New York: Avery.

Burgess, A.W., Figley, C.R., Friedman, M.J., Mitchell, J.T. and Solomon, J.Z. (1994). *Compassion Fatigue: The Stress of Caring Too Much*. Ellicott City, MD. Chevron Publishing.

Cameron, J. (1992). *The artist's way: A spiritual path to higher creativity*. TarcherPerigee.

Clifton, D. (2005). *How full is your bucket: Positive Strategies for work and life*. New York, NY: Gallup Press.

Colligan, T.W. and Higgins, E.M. (2006). Workplace stress: Etiology and consequences. *Journal of Workplace Behavioral Health*, 21(2).

Dalenberg, C.J. (2000). *Countertransference and the treatment of trauma*. Washington, DC: American Psychological Association.

Dart Center for Journalism and Trauma (2008). *Traumatic stress and the news Audience*. New York, Columbia University.

Day, C. and Gu, Q. (2013). *Resilient teachers, resilient schools*. New York, NY: Routledge.

Dekel, R., Goldblatt, H., Keidar, M., Solomon, Z., Pollack, M. (2005). Being a wife of a veteran with post-traumatic stress disorder. *Family Relations*, 54(1): 24-36.

Diamond, M. (1996). Innovation and diffusion of technology: A human process. *Consulting Psychology Journal: Practice and Research*, 48(4), 221-229.

Erickson, C.A. (1989). Rape and the family. In, Figley, C.R. (Ed), *Treating stress in families*. New York. Bruner/Mazel.

Evans, P. (1992). *The verbally abusive relationship: How to recognize it and how to respond*. Adams Media Corporation.

Fallot, R.D. and Harris, M. (2009). *Creating cultures of trauma informed care (CCTIC): A self- assessment and planning protocol*. Washington, DC: Community Connections.

Figley, C. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York, NY: Brunner-Routledge.

Figley, C. (2002). *Treating compassion fatigue*. New York: NY: Brunner-Routledge.

Figley, C.R. (Ed.) (2002). *Treating compassion fatigue*. New York, NY: Brunner/Routledge.

Gates, D. and Gillespie, G. (2008). Secondary traumatic stress in nurses who care for traumatized women. *Journal of Obstetric, Gynecological and Neonatal Nursing*, 37, 243-249.

Gelso, C.J. and Hayes, J.A. (2007). *Countertransference and the psychotherapist's inner experience: Perils and possibilities*. Mahwah, NJ: Lawrence Erlbaum Associates.

Grayson, J.L. and Alvarez, H.K. (2008). School climate factors relating to teacher burnout: A mediator model. *Teaching and Teacher Education*, 24(5), 1349-1363.

Guarino, K., Soares, P., Konnath, K., Clervil, R. and Bassuk, E. (2009). *Trauma-informed organizational toolkit*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration; the Daniels Fund; the National Child Traumatic Stress Network; and the W.K. Kellogg Foundation.

Harris, M. and Fallot, R.D. (2001). *Using trauma theory to design service systems: New directions for mental health services*. San Francisco: Jossey-Bass.

Herman, J. (1992). *Trauma and recovery: The aftermath of violence—From domestic abuse to political terror*. New York: Basic Books.

Herman, J. (1997). *Trauma and recovery*. New York, NY: Basic Books.

Hernandez, P., Gangsei, D. and Engstrom, D. (2007). Vicarious resilience: A new concept in work with those who survive trauma. *Family Process*, 46(2), 229-241.

Hesse, A. (2002). Secondary trauma: How working with trauma survivors affects therapists. *Clinical Social Work Journal*, 30(3), 293–309.

Hooper, C., Craig, J., Janvrin, D.R., Wetsel, M.A. and Reimels, E. (2010). Compassion satisfaction, burnout and compassion fatigue among emergency nurses compared with nurses in other selected inpatient specialties. *Journal of Emergency Nurses*, 36(5), 420-427.

Huckshorn, K. (2009). Transforming cultures of care toward recovery oriented service: Guidelines toward creating a trauma system of care. In *Trauma informed care (TIC) planning guidelines for use in developing an organizational plan*. Alexandria, VA: National Association of State Mental Health Program Directors.

Huggard, P.K. and Huggard, E.J. (2008). When the caring gets tough: Compassion fatigue and veterinary care. *VetScript*, 21(5), 16-18.

James, J. W. and Friedman, R. (2009). *The grief recovery handbook*. New York: Harper Collins.

Jenkins, S.R. and Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validation study. *Journal of Traumatic Stress*, 15(5), 423-432.

Jennings, A. (2004a). *Blueprint for action: Building trauma-informed mental health service systems*. Alexandria, VA: National Association of State Mental Health Program Directors and National Technical Assistance Center for State Mental Health Planning.

Joinson, C. (1992). Coping with compassion fatigue. *Nursing*, 22(1): 116-121.

Katz, L.S. and Rubin, M. (1999). *Keep your brain alive*. New York: Workman Publishing Company.

Kearney, M.K., Weininger, R.B., Vachon, M.L.S., Harrison, R.L. and Mount, B.M. (2009). Self-care of physicians caring for patients at the end of life. *Journal of the American Medical Association*, 301(11), 1155-1164.

Ko, S.J., Ford, J.D., Kassam-Adams, N., Berkowitz, S.J., Wilson, C., Wong, M., Brymer, M.J. and Layne, C.M. (2008). Creating trauma-informed systems: Child welfare, education, first responders, health care, juvenile justice. *Professional Psychology: Research and Practice*, 39(4), 396-404.

Kotter, J. P. (1995). Leading change: Why transformation efforts fail. *Harvard Business Review*, 73(2), 59-67.

Kübler-Ross, E. (1969). *On death and dying: What the dying have to teach doctors, nurses, clergy and their own families*. Simon and Schuster.

Kurtz, M.E., Kurtz, J.C., Given, C.C. and Given, B. (1996). Concordance of cancer patient and caregiver symptom reports. *Cancer Practice*, 4(4), 185-90.

Lamb, R., Evans, A. C and White, W. (2009). The role of partnership in recovery-oriented systems of care: The Philadelphia experience.

Link, B.G., Schwartz, S., Moore, R., Phelan, J., Struening, E., Stueve, A. and Colten, M.E. (1995). Public knowledge, attitudes and beliefs about homeless people: Evidence for compassion fatigue. *American Journal of Community Psychology*, 23(4), 533-555.

Marans, S., Berkowitz, S.J. and Cohen, D.J. (1998). Police and mental health professionals. Collaborative responses to the impact of violence on children and families. *Child and Adolescent Psychiatric Clinics of North America*, 7(3), 635-651

Maslach, C., Schaufeli, W.B. and Leiter, M.P. (2001). Job burnout. *Annual Review of Psychology*, 52, 397-422.

Maslow, A.H. (1961). *Toward a psychology of being*. Hoboken, NJ: Wiley.

Mathieu, F. (2012). *The compassion fatigue workbook*. New York, NY: Routledge Taylor and Francis Group.

Mayeroff, M. (1971). *On caring*. New York: Harper & Row Publishers.

Meadors, P. and Lamson, A. (2008). Compassion fatigue and secondary traumatization: Provider self care on intensive care units for children. *Journal of Pediatric Health Care*, 22(1), 24- 34.

Morrisette, P. (2004). *The pain of helping: Psychological injury of helping professionals*. New York, NY: Brunner-Routledge.

Najavits, L.M. (2002). *Seeking Safety: A treatment manual for PTSD and substance abuse*. New York: The Guilford Press.

National Center for Trauma-Informed Care. Trauma-informed care and trauma services. Retrieved January, 2014 from <http://www.samhsa.gov/nctic/trauma.asp>

National Council for Behavioral Healthcare (2011). *National Council Magazine*, Trauma-informed Care Edition, Issue 2.

Neff, K. (2011). *Self-compassion: Stop beating yourself up and leave insecurity behind*. New York: William Morrow

Norcross, J.C. and Guy, J.D. (2007). *Leaving it at the office: A guide to psychotherapist self-care*. New York: Guilford Press.

Nounen, H. (1972). *The wounded healer*. New York, NY: Image Doubleday.

Pearlman, L.A. and Saakvitne, K.W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York, W.W. Norton.

Pearson, G. (2012). Psychiatric nurses and secondary trauma. *Perspectives in Psychiatric Care*, 48, 123-124.

Putman, J. and Lederman, F. (2008). How to maintain emotional health when working with trauma. *Juvenile and Family Court Journal*, 59(4), 91-102.

Prochaska, J.O. & DiClemente, CC. 1984. *The transtheoretical approach: crossing traditional boundaries of therapy*. Homewood, IL: Dow Jones-Irwin.

Remer, R. and Elliott, J. (1988). Characteristics of secondary victims of sexual assault. *International Journal of Family Psychiatry*, 9, 373-387.

Robins, P., Meltzer, L. and Zelikovsky, N. (2009). The experience of secondary traumatic stress upon care providers working within a children's hospital. *Journal of Pediatric Nursing*, 24(4), 270-279.

Robinson, C. (1999). *Take charge of your life*. New York: Broadway Books.

Robinson, K. (2009). *The element: How finding your passion changes everything*. New York: Penguin Group USA.

Rogers, C. (1980). *A way of being*. Boston: Houghton Mifflin.

Rosenberg, T. and Pace, M. (2006). Burnout among mental health professionals: Special considerations for the marriage and family therapist. *Journal of Marital and Family Therapy*, 32(1), 87-99.

Rothchild, B. (2006). *Help for the helper: The psychophysiology of compassion fatigue and vicarious trauma*. New York, NY: WW Norton.

Rothschild, B. (2000). *The body remembers: The psychophysiology of trauma and trauma treatment*. New York: W.W. Norton and Company.

Sabo, B. (2008). Adverse psychosocial consequences: Compassion fatigue, burnout and vicarious traumatization: Are nurses who provide palliative and hematological cancer care vulnerable? *Indian Journal of Palliative Care*, 14(1), 23-29.

SAMHSA (2010). *Recovery oriented systems of care resource guide*. Rockville, MD: Substance Abuse and Mental Health Services Administration, Partners for Recovery.

SAMHSA (2014). *Trauma-informed care in behavioral health services*. Treatment Improvement Protocol (TIP) Series 57, HHS Publication No. (SMA) 14-4816. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Schaubroeck, J. and Jones, J.R. (2000). Antecedents of workplace emotional labor dimensions and moderators of their effects on physical symptoms. *Journal of Organizational Behavior*, 21, 163- 183.

Schwartz, T. (2010). *The way we're working is not working*. New York, NY: Free Press.

Siegel, D.L. (2007). *The mindful brain: Reflection and attunement in the cultivation of well being*. New York: W.W. Norton and Company.

Smith, P. (2012). *Compassion Satisfaction: 50 steps to healthy caregiving*. San Bernardino, CA: Compassion Fatigue Awareness Project.

Stamm, B. (1995). *Secondary traumatic stress: Self-care issues for clinicians, researchers and educators*. Lutherville, MD: Sidra.

Stamm, B.H. (1999). *Secondary traumatic stress: Self-care issues for clinicians, researchers and educators*. Lutherville, MD: Sidran Press.

Tabor, P. (2011). Vicarious traumatization: Concept analysis. *Journal of Forensic Nursing*, 7, 203- 208.

Todaro-Franceschi, V. (2013). *Compassion fatigue and burnout in nursing. Enhancing professional quality of life*. New York, NY: Springer.

Trippany, R.L., White Kress, V.E. and Wilcoxon, A. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors *Journal of Counseling and Development*, 82(1), 31-37.

Van der Kolk, B. (1989). The compulsion to repeat the trauma. *Psychiatric Clinics of North America*, 12, 389-411.

Van der Kolk, B., McFarlane, A. and Weisaeth, L. (2007). *Traumatic stress. The effects of overwhelming experience on mind, body and society*. New York: Guilford Press.

van der Kolk, B.A. (1994). The body keeps the score: Memory and the evolving psychobiology of post

traumatic stress. *Harvard Review of Psychiatry*, 1(5), 253-265. Ledoux, J. (1996). *The emotional brain: The mysterious underpinnings of emotional life*. New York: Simon and Schuster.

van der Kolk, B.A., McFarlane, A.C. and Weisaeth, L. (1996). *Traumatic stress: The effects of overwhelming experience on mind, body and society*. New York: The Guilford Press.

Van der Wath, A., Wyk, N. and Van Rensburg, E. (2013). Emergency nurses' experiences of caring for survivors of intimate partner violence. *Journal of Advanced Nursing*, 69(10), 2242-2252.

Van Dernoot Lipsky, L. and Burk, C. (2009). *Trauma stewardship. An everyday guide to caring for self while caring for others*. San Francisco: Berrett-Koehler.

Von Rueden, K., Hinderer, K., McQuillan, K., Murray, M., Logan, T., Kramer, B., Gilmore, R. and Friedman, E. (2010). Secondary traumatic stress in trauma nurses: Prevalence and exposure, coping and personal/environmental characteristics. *Journal of Trauma Nursing*, 17(4), 191-2000.

Whicker, M. L. (1996). *Toxic leaders: When organizations go bad*. Praeger Publishers.

White, W. (1997). *The incestuous workplace: Stress and distress in the organizational family* (2nd ed.). Center City, MN: Hazelden.

White, W. (2007). Perspectives on Systems Transformation: How Visionary Leaders are Shifting Addiction Treatment Toward a Recovery-Oriented System of Care. (Interviews with H. Westley Clark, Thomas A. Kirk, Jr., Arthur C. Evans, Michael Boyle, Phillip Valentine and Lonnetta Albright). Chicago, IL: Great Lakes Addiction Technology Transfer Center.

White, W. (2011). The Recovery-focused transformation of addiction treatment: An interview with Arthur C. Evans, Jr., PhD. Posted at www.williamwhitepaers.com; published in abridged form in *Counselor*

White, W. and Tuohy, C.M. (2013). Recovery-oriented practice and the addictions professional: A systems perspective. *Advances in Addiction and Recovery (NAADAC)*, Summer Issue, pp. 22-23.

White, W. L. (1986). *The incestuous workplace: Stress and distress in the organizational family*. Center City, MN: Hazelden.

White, W. and Popovits, R. (2000). *Critical incidents: Ethical issues in the prevention and treatment of addiction* (2nd ed.). Bloomington, IL: Chestnut Health Systems/Lighthouse Institute.

White, W.L., Clark, H.W., Kirk, T.A., Evans, A.C., Boyle, M., Valentine, P. and Albright, L. (2007). *Perspectives on systems transformation: How visionary leaders are shifting addiction treatment toward a recovery-oriented system of care*. Chicago, IL: Great Lakes Addiction Technology Transfer Center.

Wicks, R. (2006). *Overcoming secondary stress in medical and nursing practice. A guide to professional resilience and personal well-being*. New York, NY: Oxford Press.

Wicks, R.J.J. (2007). *The resilient clinician*. New York: Oxford University Press.

Woll, P. (2006). *How to get the piranhas out of your head*. Chicago, IL: Human Priorities.

Woll, P. (2009). *The power and price of survival: Understanding resilience, stress and trauma*. Chicago, IL: Human Priorities.

Woll, P. (2014). *Addressing stress and trauma in recovery-oriented systems and communities: A challenge to leadership*. Chicago, IL: Great Lakes Addiction Technology Transfer Center.

ADDRESSING STRESS AND TRAUMA IN RECOVERY-ORIENTED SYSTEMS AND COMMUNITIES

Section 1: The Role of Leadership

We believe that America is facing a public health crisis of major proportions. The health of our citizens, our economic productivity, the stability of our institutions, and our global leadership are all being undermined by social conditions creating toxic levels of stress, which in turn interact with biological vulnerabilities to affect both individuals and communities.

—Andrea Blanch and David Shern¹

What if many of the most daunting challenges to human well being had a common center, and you had the tools to reach into that center and begin to heal, not only human lives, but also the families, communities, and service systems that hold those lives?

What if you found a shield that could protect the people you have served, that could turn away many of the forces that erode the strength you have worked so hard to help them build?

What if these and other tools fit together, worked together, made one another stronger by their mutual presence? But there was only one catch: You had to share them—not just share them, but actively engage others in their use, and keep going even when you hit the hard crust of the way things have always been done.

1. 1 Blanch, A.K. and Shern, D.L. (2011). Implementing the new “germ” theory for the public’s health: A call to action. Alexandria, VA: Mental Health America.

This is where you are right now, as a leader and as a human being. You may think this manual is about trauma-informed care (TIC) within recovery-oriented systems of care (ROSC), but it is really about you—what you are already doing, what you have the opportunity to do, and what you are willing to do.

Step One: Understanding

Progress toward effective responses to toxic stress and trauma has often suffered at the hands of widely held misconceptions, including:

- Treating the word “trauma” as if it were synonymous with posttraumatic stress disorder (PTSD), one of the many conditions that sometimes arise in the wake of trauma
- Thinking of trauma only as something that occurs in an individual in response to an isolated event or a single type of experience
- Taking a narrow view of the types of experiences that contribute to trauma, and thinking of trauma as a purely psychological phenomenon, and entirely separate from the continuum of human stress exposure and response
- Confusing trauma-informed care with trauma-focused (sometimes called trauma-specific) treatment—therapeutic approaches designed to heal the effects of trauma, in many cases by processing memories of traumatic experiences
- The assumption that an organization can implement trauma-informed care (TIC) by holding a “one-shot” training for clinical staff
- The assumption that TIC and ROSC models are entirely separate constructs, to be addressed separately and supported with separate human and financial resources
- A belief that TIC and ROSC are the concerns of behavioral health organizations and systems alone, with little or no relationship to the many health and human service systems that surround them, and the communities they serve

In reality:

Trauma-informed Care

“Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization.”

National Center for Trauma-Informed Care (NCTIC),
Substance Abuse and Mental
Health Services

Recovery

“A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.”

SAMHSA, 2011

- Human experience runs on a continuum that includes mild stress, extreme stress, toxic stress, and the kinds of pain and danger that instill trauma.
- These conditions can come from many types of experiences in the life of an individual, a family, a community, or a culture, and can trigger a wide variety of effects.
- Trauma-informed care and recovery-oriented systems of care are allied and interdependent models, with implications for—and requiring the involvement of—every aspect of organizations, systems, communities, and society as a whole.
- Trauma-informed care nurtures and protects the core of the human being, and recovery-oriented systems nurture

and protect the fruits of the healing process, but their roots and branches are intertwined.

Recovery-oriented Systems of Care

“...a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.”

William L. White

- TIC and ROSC resources are meant to protect, not only individuals and families, but also entire organizations, service systems, and communities.
- TIC and ROSC approaches foster long-term healing, not just from substance use disorders or mental health challenges, but from many of the chronic physical, social, behavioral, educational, economic, and legal problems that join forces to snuff out human hope and potential and destroy individuals, families, and communities.

It is the role and responsibility of every leader to put the resources of trauma-informed care and recovery-oriented systems of care to work.

About This Document

Addressing Stress and Trauma in Recovery-oriented Systems and Communities: A Challenge to Leadership is an exploration of concepts addressed in the Executive Briefing presentation of the same name, developed for the Great

Lakes Addiction Technology Center by Pamela Woll, MA, CADP. It is designed to stimulate thought, start conversations, promote understanding, point out resources, and suggest opportunities for collaboration.

Like the Executive Briefing, this manual provides a high-level overview of:

- Two central considerations in building a truly useful vision to guide planning
- Toxic Stress and Trauma and their growing impact on individuals, families, and communities
- Principles and practices of trauma-informed care
- Where trauma-informed care fits within recovery-oriented systems of care, and in relation to other common health and human service conceptual models
- TIC implementation models and resources
- Considerations for trauma training and staff support
- Challenges to be addressed in the planning process

At the end of each Section is a brief “Action Notes” box, inviting you to look at the current cost of toxic stress and trauma in your system, measures already in place, additional measures and resources you might try, and other partners you might be willing to enlist in these efforts.

Using a Team Approach

The most influential person in your system may be the least likely to have time to read this document—and even less likely to have time to complete the Action Notes—but like virtually everything discussed in the Sections that follow, reading and responding to the manual can be a group effort. For example, an organization—or better yet, multiple organizations or departments within an organization—might:

- Divide the Action Notes strategically—perhaps by role, interest, or influence—among the central people involved in the planning process
- Coordinate efforts among multiple partner organizations, departments, or initiative
- Convene after people have read their sections and started or finished their Action Notes, and discuss what they have learned and what they are willing to do

Ideally, this would take place as part of—or inspire the establishment of—an ongoing TIC/ROSC learning community within the organization. Those who have the time, and those who are willing to carve out the time, can become the resident experts who inform the planning process. Their knowledge must come, not just from books and articles, but also from significant input from staff, volunteers, service participants, family members, and community members.

One note about terminology: When the words “we” and “our” are used in this document, they refer, not to the publishing organization or even to the behavioral health field, but to society as a whole. These words are used deliberately, as a way of emphasizing our collective responsibility, invoking our collective knowledge base, and soliciting our collective efforts. All these are needed—urgently—for the sake of our collective well being.

Action Notes for Section 1

- Is there a team in your organization, system, or community that is already studying the kinds of issues and possibilities addressed in this manual, and would you be willing to share this with them? If not, is there a team—or combination of teams—that would be an appropriate body to explore the concepts and suggestions presented in the manual?
- If you were to design a team—or add to an existing team—to study this manual and pull ideas from it, which individuals, organizations, or departments within your organization, system, or community would you invite into the team?
- Who would you like to see in charge of the team?
- What would your role be?
- At this point, before you read the rest of the document, what do you think the team's greatest challenges might be?
- What do you think the team's greatest (internal or external) resources might be?

Section 2: Transforming the Vision

The greatest danger for most of us is not that our aim is too high and we miss it, but that it is too low and we reach it.

—Michaelangelo²

A well directed response requires vision, which requires clear and well directed sight. But in the avalanche of information available on toxic stress and trauma, it can be difficult to stay focused on the center of all the problems and possible solutions. So here are two challenges— and opportunities—to consider in transforming our collective vision.

2. 2 Attributed without citation in Ken Robinson (2009), *The Element*, p. 260, and often attributed to Michelangelo since the late 1990s.

First Challenge: Focusing on Strength, Resilience, and Recovery

Toxic stress and trauma are widespread, often devastating experiences. Their effects wound the body and the mind, rob families of peace and safety, and far too often prove fatal. There are real victims and, in many cases, real perpetrators. These are medical issues, moral issues, social justice issues, and criminal justice issues. When we learn of the many effects of toxic stress and trauma, our natural reactions include shock, sadness, empathy, and anger.

Under the weight of all these realities, we might find it difficult to take strength-based approaches, yet these approaches are essential to recovery. Strength-based approaches:

- Affirm the dignity and freedom of all people, no matter how many indignities they have suffered, no matter how many challenges they still face
- Walk with “victims” until they understand that they are survivors, and walk with survivors until they take their place as heroes in their own and others’ lives
- Generate hope by identifying and believing in the values, aspirations, attributes, and skills that each individual embodies and cultivates in the healing process
- Make it safe for the individual to reclaim—and in some cases claim for the first time—the power of choice and the power of true connection with healthy people
- Make it safe for the story to be told, heard, honored, and eventually transformed
- Protect, nourish, empower, and sustain, not only people who have experienced toxic stress and trauma, but also the friends, family members, neighbors, and service providers who witness their pain and rejoice in their success

In a field where service plans and service reimbursement are based on diagnoses and symptoms, it may be difficult to move beyond the inclusion of a few strength-based questions in the assessment process, and staff training in pointing out people’s positive qualities. In a community that has experienced the negative effects of some community members’ post-trauma symptoms, it may be hard not to think in terms of “good citizens” and “bad citizens.” In a society where any form of flaw or weakness is stigmatized—often in defense against our own sense of human vulnerability and limitation—it may be difficult to recognize and acknowledge the strength that lives in even the most troubled human being. But we must learn to do all these difficult things, if we want to promote well being, healing, and recovery.

Second Challenge: Looking at the Whole Picture

Toxic stress, trauma, and their effects are most often considered and dealt with on an individual basis—person

by person, experience by experience, symptom by symptom, and diagnosis by diagnosis. This response may point to effective ways of addressing specific symptoms and diagnoses, but it fails to address the synergy of all these elements. It can also have only limited impact on the forces—including some elements of our own service delivery systems and approaches—that spread and perpetuate toxic stress and trauma.

Only a look at the big picture can bring all the little pictures into focus. And although our society has often thought of toxic stress as a social issue and trauma as a therapeutic one, it is both logical and useful to consider them together. For example:

- All these experiences meet in the human body, mind, and spirit, where they combine to wield powerful influence over our development, our physical and neurological health and balance, the way we process stress and emotions, the way we perceive and treat ourselves and others, and the sense we make of our experiences and our worlds.
- The way we react to a particular stressor is sometimes influenced primarily by that stressor, but often influenced by the shape that a combination of stressors has taken in our lives.
- We are, after all, human beings. The many layers of stories we carry with us cannot be reduced to the categories that assessment forms, funding streams, and clinical protocols require. These stories may not dictate the terms of policy, treatment, or recovery support, but they must be honored and must feed the wisdom of all who seek to help. If we know how to listen, each human story becomes a story of strength.

One important implication of all this is that:

- Psychological trauma is the concern, not only of behavioral health and recovery support, but also of medicine, policy, and the community as a whole.
- Social justice is the concern, not only of policy and community leaders, but also of public health, medicine, prevention, intervention, treatment, and recovery support providers.
- Understanding and prevention of trauma—in this generation and the next—is everyone’s concern.

Turning Challenges into Opportunities

Here are a few ways leaders can begin to approach these responsibilities we all share:

- **Use toxic stress and trauma as a lens** through which you can hone your understanding of the many challenges you see in individuals, families, systems, and communities.
- **Use resilience, trauma-informed care, trauma-informed systems, and trauma-informed communities as a lens** through which you can assess potential solutions and guide the development of policies and programs, within and beyond your own system.
- **Incorporate resilience, stress, trauma, and trauma-informed care** into your concepts of recovery-

oriented systems of care and other models that guide your vision.

- **Incorporate a long-term recovery focus** and the integration of recovery support services, rooted in the community, into your concept of trauma-informed care.
- **Commit whatever resources you can to implementing strength-based, recovery-oriented, trauma-informed approaches** in all of the processes, personnel, organizations, systems, and communities you influence—and be open to creative ways of leveraging and sharing resources, to reap the greatest benefit in spite of budgetary limitations.
- **Be a vocal and persistent coalition builder and advocate** of integrative, multidisciplinary, multi-system, big-picture approaches toward addressing the problem of toxic stress and trauma—and all its causes and effects—on community and societal levels.

And here is the beginning of a vision that these measures might help us approach:

- **Behavioral health and recovery support providers and systems** that initiate and conduct integrated, multi-system efforts to identify and intervene in the progression of traumagenic circumstances and post-trauma effects
- **Prevention programs** that collaborate with public health entities and with the range of community-based efforts to promote safe, respectful, and supportive communities, schools, youth-serving organizations, social service providers, and medical care
- **Treatment and recovery support systems and providers** that collaborate with schools and medical, child welfare, and social service systems and their providers in the development and implementation of safe, evidence-based screening, brief intervention, and referral efforts in these community-based locations
- **Behavioral health assessment processes** that are overwhelmingly strength-based and include safe, respectful, non-stigmatizing, evidence-based questions to identify the presence of trauma and the need for trauma-specific assessment
- **Strength-based, evidence-based assessment and appropriate referral** to individualized trauma-informed treatment and recovery support for all children, youth, and adults who need behavioral health services, and trauma-focused assessment and referral of those identified as possible trauma survivors or living in currently traumagenic circumstances
- **Safe, effective, evidence-based trauma-focused treatment** available to all who need it and can safely engage in it, no matter where or why they entered the treatment system
- **Referrals that follow “warm referral” principles and practices**, with support, assistance, and follow-up by the referring provider, and trained and effective peer support during the referral and transition process

The remaining sections describe a variety of tools for moving toward this vision, tools that are meant to be shared and adapted to the strengths and challenges of each community.

Section 3: Resilience, Stress and Trauma

We have learned, given the numbers of trauma survivors and their often debilitating post-traumatic responses, that this constitutes a public health challenge of the first magnitude.

—Susan Salasin³

As we approach the subject of toxic stress and trauma, it is important that we bring with us an enduring vision of resilience, the ground that these weeds invade and the soil that nourishes healing and recovery. In some form, resilience lives even in the most painful circumstances. For the woman or man whose

Resilience

“...the ability to adapt well over time to life-changing situations and stressful conditions.”

SAMHSA

symptoms make getting out of bed and stepping into the shower an almost insurmountable challenge, just showing up at your door and asking for help can be a stunning act of strength and courage.

Toxic stress and trauma have strong and often direct impact on human vulnerability to a wide variety of physical, developmental, medical, psychiatric, behavioral, social, cultural, spiritual, criminal justice, educational, employment, economic, and human rights challenges—many of them life threatening. A few examples:

- The chronic stress inflicted by poverty or low income, unemployment, poor nutrition, racism/prejudice/stigma and discrimination, life in troubled families and communities, environments that reflect a sense of hopelessness, chronic or terminal illness in oneself or a loved one, and a host of other conditions can cause a sort of “weathering” process that can hinder development, wear down human stress and immune systems, and speed up the aging process.⁴
- Acute and chronic exposure to experiences of extreme stress and threat can destabilize human responses

3. 3 Salisan, S. (2011). Sine qua non for public health. National Council Magazine, 2011, Issue 2.

4. 4 Geronimus, A.T., Hicken, M., Keene, D. and Bound, J. (2006). American Journal of Public Health, 96(5), 826-833.

to stress and fundamentally change people's relationship with the memory of traumatic experiences, in some cases leading to conditions such as posttraumatic stress disorder (PTSD).

- The experience of toxic stress and trauma can also raise vulnerability to a variety of other mental health challenges, e.g., anxiety disorders, depressive disorders (including bipolar disorder), personality disorders, conduct disorders, and psychotic disorders.⁵

A Few Clarification Points

Traumagenic Experiences

- Events and circumstances with the potential to overwhelm coping abilities

Trauma

- The individual's subjective experience at the time

Post-trauma Effects

- Physical, psychological, social, and spiritual effects, ranging from mild and/or temporary challenges to increased vulnerability to more serious acute or chronic conditions

- People who experience severe or chronic neglect and/or abuse in childhood are particularly vulnerable to lifelong challenges in attachment and stress and emotion regulation and other symptoms of complex or developmental trauma.⁶
- The use of alcohol or drugs to “medicate” the pain left by toxic stress and trauma can raise the risk of substance use disorders, affect many other areas of functioning, and place people in dangerous situations with high potential for retraumatization.⁷
- Toxic stress and trauma often have lasting physical effects on natural brain chemicals, hormones, muscle tension, heart rate, inflammation, and immune functioning, effects that can raise the risk of many acute and chronic illnesses.⁸ Behavioral reactions to the pain left by trauma (e.g., alcohol and drug use,

5. Heim, C. and Nemeroff, C.B. (2001). The role of childhood trauma in the neurobiology of mood and anxiety disorders: preclinical and clinical studies. *Biological Psychiatry*, 49(12), 1023-1039.

6. Perry, B.D., Pollard, R.A., Blakley, T.L., Baker, W.L. and Vigilante, D. (1996). Childhood trauma, the neurobiology of adaptation, and use-dependent development of the brain: How states become traits. *Infant Mental Health Journal*, 16(4), 271-291.

7. Najavits, L.M. (2002). *Seeking Safety: A treatment manual for PTSD and substance abuse*. New York: The Guilford Press.

overeating, lack of self-care, unprotected sex) can further increase this risk.

- Trauma in one generation can affect future generations, often through its effects on parents' behavior, attachment styles, and modeling of responses to stress; family functioning; cultural identity; and levels of resources available to the family, the community and/or the culture, and through “epigenetic” changes that affect the way our DNA expresses itself.⁹

There are so many pathways (e.g., genetic, biological, behavioral, social, environmental) through which the effects of toxic stress and trauma are passed on— from experience to person, from person to reaction, from reaction to the next person, and from generation to generation—that these conditions might accurately be described as highly contagious and self-perpetuating. Among the strongest factors that can increase individuals', families', and communities' vulnerability are social isolation and lack of access to resources.¹⁰

At the same time, the impact of trauma is clearly an injury, though it may trigger a number of different injuries, illnesses, and disabilities.

The Scope of the Problem

Toxic stressors and traumagenic circumstances are all around us, particularly in the communities served by public health and treatment systems. Growing economic challenges in these communities, and the erosion of funding for services, foster increases in deprivation, fear, frustration, and hopelessness, sometimes leading to escalating levels of crime and violence and diminishing levels of social support, self-care, and help-seeking.

According to Fallot and Harris (2009), “National community-based surveys find that between 55 and 90% of us have experienced at least one traumatic event. And individuals report, on average, that they have experienced nearly five traumatic events in their lifetimes.”¹¹ However, the problem extends far beyond traumatic “events.” Many people—particularly people who find their way to public treatment, child welfare, and criminal justice settings—have lived with multiple forms of prolonged or recurring traumagenic circumstances. The number, intensity, and chronicity of these circumstances often add layers of complexity to people's post-trauma effects and layers of difficulty to the challenge of addressing them.

In the Adverse Childhood Experiences (ACE) Study, Kaiser Permanente and the Centers for Disease Control and Prevention interviewed 17,421 respondents from a general, largely affluent HMO adult (average

8. 8 Scaer, R. (2005). *The trauma spectrum: Hidden wounds and human resiliency*. New York: W.W. Norton & Company.

9. 9 Yehuda, R. and Bierer, L.M. (2007). Transgenerational transmission of cortisol and PTSD risk. *Progress in Brain Research*, 167, 121- 135. Brave Heart, M.Y.H. (2003). The historical trauma response among Natives and its relationship with substance abuse: A Lakota illustration. *Journal of Psychoactive Drugs*, 35, 7–13. Danieli, Y., Ed. (1998). *International handbook of multigenerational legacies of trauma*. New York: Plenum Press.

10. 10 Woll, P., Evans, A.C., Berkowitz, S., Jackson, K., and Achara-Abrahams, I. (2013). *Safety, strength, resilience, and recovery: Trauma-informed systems and communities*. Philadelphia, PA: Department of Behavioral Health and Intellectual disAbility Services.

11. 11 Fallot and Harris (2009). *Creating Cultures of Trauma-informed Care*. Washington, DC: Community Connections, p. 1.

57 years) population. They looked at the prevalence of ten types of adverse childhood experiences (ACEs), including various forms of abuse, neglect, and family dysfunction. A respondent's "ACE score" indicated the total number of types of ACEs he or she had experienced. More than half reported at least one type of ACE, one fourth reported two or more types of ACEs, and one in 16 reported four types of ACEs.¹²

Studies also indicate that the prevalence of ACEs and their consequences among people served in public health and treatment systems is often much higher. According to the National Center for Trauma-Informed Care, "The majority of people in human service and justice systems have trauma histories. Many have experienced multiple sources of trauma. Many service providers and first responders have also been impacted by trauma."¹³

The earlier in life people experience trauma, the more likely they are to experience significant and lasting effects. The ACE study found strong correlation between ACE scores and challenges later in life. Higher ACE scores were associated with dramatically higher rates of:

- Poor self-rated health
- Mental health conditions and sequelae, e.g., self-defined current depression and self-reported suicide attempts
- Behavioral and behaviorally mediated challenges, e.g., poor job performance, poor occupational health, bone fractures, smoking (particularly early-onset smoking), physical inactivity, severe obesity, alcoholism, intravenous drug use, history of having sex with 50 or more partners, sexually transmitted diseases, unintended pregnancy
- Additional health conditions, e.g., chronic obstructive pulmonary disease and other lung diseases, hepatitis, diabetes, stroke, ischemic heart disease, cancer¹⁴

Subsequent studies have confirmed many of these findings, and some have found higher rates of additional challenges in adult life, including mental health issues in general, interpersonal and family difficulties, victimization through sexual harassment or assault, and perpetration of rape and other criminal acts.

If you are part of the behavioral health/recovery support response, you probably see many of your service participants in these descriptions. Whether or not your position holds you responsible for addressing the challenges of toxic stress and trauma, it certainly burdens you with their consequences. Of course, responding to a challenge requires the ability, not only to understand the challenge, but also to envision the solution.

12. 12 Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P. and Marks, J.S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, 14(4), 245-258.

13. 13 Blanch, A. (2012). SAMHSA's National Center for Trauma-Informed Care: Changing communities, changing lives. Rockville, MD: National Center for Trauma-Informed Care, Substance Abuse and Mental Health Services Administration.

14. 14 Felitti, V.J. et al., loc. cit.

The next chapter introduces two central challenges that change leaders face in building a truly useful vision of trauma-informed responses.

Action Notes for Section 3

- Who would be the best people to compile a “ballpark” estimate of the total—and inclusive—human, social, and financial cost of toxic stress and trauma on your organization, your community, your service systems, and the people you serve?

Section 4: Trauma-informed Care

When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization.

—National Center for Trauma-Informed Care ¹⁵

Like human beings, human service fields have been evolving, from primitive approaches that often wounded more than they healed to more careful and effective approaches rooted in an understanding of human strength and vulnerability and a commitment to human dignity.

15. 15 National Center for Trauma-Informed Care. Trauma-informed care and trauma services. Retrieved January, 2014 from <http://www.samhsa.gov/nctic/trauma.asp>

Trauma-informed care has both built on this evolutionary process and provided concrete and conceptual tools and guidelines for further progress.

Unlike trauma-focused or trauma-specific interventions, trauma-informed care is not something to add to an organization's or a system's menu of services, but a new way of thinking about and providing existing services. Elements of systems that must be trauma informed include:

- Practitioners, the services they provide, and their perceptions of the people they serve
- Policies, protocols, and service environments
- Systems, organizations, and organizational cultures
- Partnerships to foster trauma-informed communities

Although it first took hold in behavioral health, trauma-informed care has begun to influence other human service systems as well, including child welfare, criminal justice, and primary medical care. In some areas, community-wide trauma-informed initiatives have also begun to transform communities' approaches to civic services, community support structures, and public education.¹⁶ These efforts counter two of the strongest forces locking stress and trauma in place—isolation and lack of resources—by fostering collaboration and resource sharing.

Traditional Human Service Approaches

Most behavioral health providers and organizations have evolved beyond the institutionalization of people with mental health challenges and the “break ‘em down so you can build ‘em back up” approach to substance use disorders, but those old traditions have left their mark on the field and associated communities of recovery. Many related health, human service, and criminal justice systems may have even more to learn.

The traditional human service paradigm can be ineffective and even harmful for people with histories of trauma. A quick synthesis of some of the literature on trauma-informed care reveals a number of potentially counterproductive elements in the old paradigm, e.g.:

- A hierarchical structure and reliance on rule, control, and consequences, with efforts to control and manage participants (e.g., seclusion, restraint) often resulting in destabilization, retraumatization, and triggering of traumatic memories
- Attributing to the individual too much responsibility (e.g., blaming the victim) or too little responsibility (e.g., considering people helpless and “doing for them”)
- An overall focus on problems and deficits, with strengths considered as afterthoughts, marginalized

16. 16 Blanch, A. (2011). Peace4Tarpon knows it takes a village. National Council Magazine, 2011, Issue 2.

within assessment processes, and neglected in planning processes

- Interpretation of behaviors as symptoms, though they may have started as necessary, adaptive ways of surviving traumatic circumstances—and might still provide protection
- Over-medication and inappropriate medication for conditions and crises that would be better addressed through skill building and more effective responses by staff members
- Interpretation of problems as individual problems, rather than seeing them in the context of relationships, systems, communities, cultures, and history—and failure to consider this larger environment’s potential to instill resilience, healing, and recovery
- Separate service systems, each with its own view of the individual and approaches that may run counter to those of other systems, resulting in, at best a sense of confusion or cognitive dissonance, and at worst the undermining of one system’s efforts by another
- Emphasis on individual diagnoses, considered and treated separately from one another

Current knowledge of trauma-informed care comes from the bitter experience of many trauma survivors, and from the creativity and courage of service participants, families, staff, and administrators who have forged safer, more respectful, and more effective approaches. The momentum toward this model is increasing as the research community gathers more and more evidence of the reach and consequences of trauma and the benefits of trauma-informed care.

Essential Elements of Trauma-informed Care

Trauma-informed care is rooted in an understanding of the three stages of trauma recovery documented by Judith Herman, MD in her foundational book, *Trauma and Recovery*.¹⁷ In Stage 1, “Safety and Stabilization,” one of the survivor’s primary responsibilities is to learn to identify and manage post-trauma effects and the triggers that might activate them, and—wherever possible—to avoid dangerous and destabilizing circumstances, including treatment processes that trigger post-trauma symptoms (e.g., by invoking strong emotions or memories). Trauma-informed care is essential at each stage, but its first critical task is to protect people in Stage 1.

When people are stable enough to progress to Stage 2, “Remembrance and Mourning,” safe trauma-focused services that address traumatic memories may become important facets of the healing process. And in Stage 3, “Reconnection,” recovery support also takes on special importance, as people reconnect with others and with their own sense of meaning and purpose.

Many implementation and practice models have been developed to capture and communicate the essential elements of trauma-informed care—and, with some variation, they emphasize many of the same

17. 17 Herman, J. (1992). *Trauma and recovery: The aftermath of violence—From domestic abuse to political terror*. New York: Basic Books.

characteristics. In its working definition of trauma-informed care,¹⁸ the Substance Abuse and Mental Health Services Administration (SAMHSA) identifies ten guiding principles for trauma-informed care, principles that reflect many of the predominant TIC models. They are reprinted here verbatim:

1. **Safety:** Throughout the organization, staff and the people they serve feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety.
2. **Trustworthiness and transparency:** Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among staff, clients, and family members of people being served by the organization.
3. **Collaboration and mutuality:** There is true partnering and leveling of power differences between staff and clients and among organizational staff from direct care staff to administrators; there is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making.
4. **Empowerment:** Throughout the organization and among the clients served, individuals' strengths are recognized, built on, and validated and new skills developed as necessary.
5. **Voice and choice:** The organization aims to strengthen the staff's, clients', and family members' experience of choice and recognize that every person's experience is unique and requires an individualized approach.
6. **Peer support and mutual self-help:** are integral to the organizational and service delivery approach and are understood as a key vehicle for building trust, establishing safety, and empowerment.
7. **Resilience and strengths based:** a belief in resilience and in the ability of individuals, organizations, and communities to heal and promote recovery from trauma builds on what clients, staff and communities have to offer rather than responding to their perceived deficits.
8. **Inclusiveness and shared purpose:** The organization recognizes that everyone has a role to play in a trauma-informed approach; one does not have to be a therapist to be therapeutic.
9. **Cultural, historical, and gender issues:** The organization addresses cultural, historical, and gender issues; the organization actively moves past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, geography, etc.), offers gender responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma.
10. **Change process:** is conscious, intentional and ongoing; the organization strives to become a learning community, constantly responding to new knowledge and developments.¹⁹

Along with its leadership in trauma-informed care, SAMHSA has also spearheaded a nationwide movement toward recovery-oriented systems of care (ROSC) and explored a number of other conceptual models and their implications for behavioral health and recovery support services. The next chapter looks at the way trauma-

18. 18 SAMHSA. Retrieved 9/15/13 from <http://www.samhsa.gov/traumajustice/traumadefinition/approach.aspx>

19. 19 Ibid

informed care fits into a ROSC, and at the relationships among these constructs a few of the many related conceptual models.

Action Notes for Section 4

This Action Note invites you to spearhead an effort to take inventory of the ways in which trauma-informed approaches are already in place in your organization, system, or community, and elements of trauma-informed approaches that should be added. Who else should be involved in gathering this information?

Off the top of your head, write a few words about some trauma-informed approaches that are already in place in terms of:

- Mission and vision
- Collaboration with other systems
- TIC Initiatives
- Policies
- Procedures
- Safety measures
- Atmosphere
- Composition of leadership
- Management/supervision styles
- Roles for service recipients
- Staff understanding of TIC
- Service provision styles

Section 5: Trauma-informed Care in Context

My paradigms are tired of shifting! My paradigms need stability!

—Anonymous²⁰

Like the Executive Director quoted above, many leaders cannot help perceiving each new conceptual model as one more “flavor of the month” and each new page of guidelines as yet another set of demands competing for scarce resources. Trauma-informed care, which plays such an essential role in so many aspects of human services, is still marginalized at times, or assumed to be covered in other models. This section offers a more productive alternative, an exploration of the ways in which TIC and these other models complete and enhance one another, beginning with recovery-oriented systems of care.

ROSC and the Recovery Paradigm

In recent years, concepts and practices of recovery-oriented systems of care (ROSC) have gained steady ascendance in the behavioral health field, because they make human and financial sense: ROSC implementation can improve immediate and long-term outcomes and save money.

Many readers of this document will be familiar with the ROSC conceptual model, which is working to replace traditional “acute-care” approaches, instead addressing the complex and chronic nature of substance use disorders and mental health challenges by:

- Taking a whole-system, multi-system approach and using recovery as the central guiding principle in service planning and implementation
- Not replacing treatment, but integrating recovery concepts and peer-based recovery support services into all aspects of pre-treatment, treatment, and post-treatment services
- Empowering service participants, people in recovery, and families to wield true influence on policy, assessment, service planning and delivery, and evaluation
- Preparing and compensating providers of ongoing peer-based recovery support, often rooted in the community, and integrating their efforts with those of treatment providers

For any who are less familiar with the ROSC model, a brief description of it—including the recovery paradigm and collections of principles identified by diverse groups of SAMHSA stakeholders—will show why it has been chosen as the primary context for this exploration of trauma-informed care. Perhaps the best description of the recovery paradigm and definitions of “recovery-oriented systems of care” and “recovery management”

20. 20 From an elevator conversation with the Executive Director of a statewide human service organization.

appear in William L. White's classic monograph, *Recovery Management and Recovery-oriented Systems of Care: Scientific Rationale and Promising Practices*.²¹ Three excerpts from this document are reprinted below.

Toward a Recovery Paradigm

Calls for a “chronic care” model of addiction treatment grew out of and in turn intensified a shift in the organizing paradigm of the addictions field from one of pathology (focus on the etiology and patterns of AOD problems) and intervention (focus on professional-directed addiction treatment) to a focus on the lived solution (focus on long-term addiction recovery). This emerging recovery paradigm is evident in calls to reconnect addiction treatment to the larger and more enduring process of addiction treatment, and to growing scientific interest in AA, other Twelve Step programs, and secular and religious alternatives to Twelve Step programs. At the treatment system level, it is also evident in:

- the emergence of recovery as an organizing fulcrum for national, state, and urban addiction treatment policy;
- efforts to define recovery;
- calls for a fully developed recovery research agenda;
- federal programs promoting peer-based recovery support services such as CSAT's Access to Recovery and Recovery Community Services Program; and
- calls to use recovery as an integrating bridge for the addiction and mental health fields.

The field seems to be shifting its historical focus toward the processes of recovery initiation to pathways, patterns, stages, and styles of long-term recovery. That transition has opened the door for the concepts of recovery management and recovery-oriented systems of care, which are heard with increasing frequency but are often ill-defined or used interchangeably (p. 17).

Recovery-oriented Systems of Care as a Macrosystem Organizing Philosophy

The phrase recovery-oriented systems of care...refers to the complete network of indigenous and professional services and relationships that can support the long-term recovery of individuals and families and the creation of values and policies in the larger cultural and policy environment that are supportive of these recovery processes. The “system” in this phrase is not a federal, state, or local agency, but a macro-level organization of the larger cultural and community environment in which long-term recovery is nested.

Recovery Management as a Microsystem Organizing Philosophy

Recovery management...is a philosophy of organizing addiction treatment and recovery support services to enhance pre-recovery engagement, recovery initiation, long-term recovery maintenance, and the quality of personal/family life in long-term recovery....

21. 21 White, W.L. (2008). *Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices*. Pittsburgh, PA: Northeast Addiction Technology Transfer Center, the Great Lakes Addiction Technology Transfer Center, and the Philadelphia Department of Behavioral Health and Mental Retardation Services.

As we shall see, achieving both a recovery-oriented system of care and implementing a recovery management philosophy requires substantial changes in treatment philosophies, purchase of care strategies, regulatory policies and monitoring protocols, clinical and support service menus, service relationships, the roles of the service professional and service consumer, the training and supervision of staff and volunteers, and intra- and inter-organizational relationships (p. 18).²²

SAMHSA's Principles, Components, and Elements of Recovery and ROSC

In 2005 and 2006, the Substance Abuse and Mental Health Services Administration convened two large and diverse stakeholder groups and invited them to craft definitions and principles related to recovery and recovery-oriented systems of care. The first group defined recovery as: “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential”²³ and developed 12 Principles of Recovery and 17 Essential Elements of Recovery-oriented Systems. The group convened the following year developed 10 Fundamental Components of Recovery from a mental health perspective.²⁴

12 Principles of Recovery

1. There are many pathways to recovery.
2. Recovery is self-directed and empowering.
3. Recovery involves a personal recognition of the need for change and transformation.
4. Recovery is holistic.
5. Recovery has cultural dimensions.
6. Recovery exists on a continuum of improved health and wellness.
7. Recovery emerges from hope and gratitude.
8. Recovery involves a process of healing and self-redefinition.
9. Recovery involves addressing discrimination and transcending shame and stigma.
10. Recovery is supported by peers and allies.
11. Recovery involves (re)joining and (re)building a life in the community.
12. Recovery is a reality.

22. 22 Ibid.

23. 23 SAMHSA. (2011). SAMHSA News Release: SAMHSA announces a working definition of “recovery” from Mental disorders and substance use disorders. Retrieved September, 2012 from <http://www.samhsa.gov/newsroom/advisories/1112223420.aspx>.

24. 24 Stengel, K., Schwartz, E., and Mathai, C. (2012). Operationalizing recovery-oriented systems: Expert panel meeting report, May 22-23, 2012. Rockville, MD: Substance Abuse and Mental Health Services Administration.

10 Fundamental Components of Recovery

1. Self directed
2. Individualized and person-centered
3. Empowerment
4. Holistic
5. Non-linear
6. Strength-based

17 Essential Elements of Recovery-oriented Systems of Care

1. Person-centered
2. Family and other ally involvement
3. Individualized and comprehensive services across the lifespan
4. Systems anchored in the community
5. Continuity of care (pretreatment, treatment, continuing care, and recovery support)
6. Partnership/consultant relationship, focusing more on collaboration and less on hierarchy
7. Strength-based (emphasis on individual strengths, assets, and resilience)
8. Culturally responsive
9. Responsive to personal belief systems
10. Commitment to peer recovery support services
11. Inclusion of the voices of individuals in recovery and their families
12. Integrated services
13. System-wide education and training
14. Ongoing monitoring and outreach

Recovery-oriented, Trauma-informed Systems of Care

Recovery-oriented systems of care (ROSC) and trauma-informed care (TIC) are related, interwoven, and interdependent. And yet many organizations and systems have addressed these two models in separate initiatives, with little or no communication, coordination, or collaboration—or have addressed one model and not the other. However:

- Effects of toxic stress and trauma are major contributors to the complexity and intransigence of many disorders and symptoms, circumstances that often necessitate significant recovery support. A thorough grounding of treatment and recovery support leaders, staff, and volunteers in TIC can deepen and enhance their understanding of challenges to recovery and strengthen their responses to those

challenges.

- Essential components of TIC (including many of its guiding principles) are also essential components of ROSC. Integrating TIC and ROSC efforts makes it possible to share resources, eliminate duplication of efforts, forge more effective ways of implementing both models, and assume leadership roles in national TIC and ROSC efforts.
- Recovery support services conducted without sufficient grounding in TIC can be ineffective, even harmful. Old traditions within some treatment and recovery cultures embrace or tolerate harsh confrontation and/or shaming—practices that can destabilize vulnerable service participants—as ways of motivating people to change their behaviors.
- Services that are called trauma-informed care but are based on an acute-care model, or conducted without the benefit of long-term peer support, have limited value in the treatment of complex and chronic conditions. Thus far the realms of trauma treatment/research and TIC still experience some challenges in integrating peer support.²⁵

ROSC is an essential framework in which trauma-informed care is more likely to take place, and a medium for integrating TIC within multiple systems and in the community as a whole.

Related Models and Frameworks

Trauma-informed care and recovery-oriented systems of care are also integral to the success of many other models. Consider a few examples, introduced here.

Public Health/Environmental Approaches

As discussed in earlier Sections, environmental factors (e.g., physical, socioeconomic, policy) often interact with genetic/epigenetic, psychological, social, and spiritual factors to lock toxic stress and trauma in place—and to transmit their effects widely—within a family, a community, or a culture. Clearly an understanding of trauma and recovery is incomplete without consideration of the full range of environmental factors, and services for trauma and its sequelae may have only temporary positive effects—in this generation, and certainly in the next—if these environmental factors continue to promote toxic and traumagenic experiences.

TIC and ROSC considerations also play essential roles in public health and prevention— particularly

25. 25 For example, the theme of the 2013 Annual Meeting of the International Society for Traumatic Stress Studies was “Resilience After Trauma: From Surviving to Thriving.” Out of hundreds of symposia, there were only three presentations on peer-based services. Two of these were 12-minute talks within four-presentation symposia, and the third was the case study of a program in Rwanda.

in prevention concerns for children (e.g., fostering long-term recovery among parents, for the safety, development, and physical/behavioral health of their children), but also in the full spectrum of public health concerns. And prevention efforts—particularly those that might disturb the denial and lack of trust that many children need to maintain for their own protection in troubled families—should be conducted in safe and trauma-informed ways.²⁶

Models of Cultural Competence

Conceptual and implementation models of cultural competence share much with models of trauma-informed and recovery-oriented services, providers, organizations, systems, and communities. The *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards)* call for “effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.”²⁷

SAMHSA’s guidelines for trauma-informed care exceed those standards, specifying that “The organization addresses cultural, historical, and gender issues; the organization actively moves past cultural stereotypes and biases (e.g. based on race, ethnicity, sexual orientation, age, geography, etc.), offers gender responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma.” And one of the principal elements that proponents of culturally competent services have consistently advocated—empowerment of individuals, families, cultures, and communities—is both an essential requirement and a natural result of trauma-informed and recovery-oriented organizations, services, systems, and communities.

Healthcare Integration

Defined as “the systematic coordination of general and behavioral healthcare,”²⁸ healthcare integration is (at the time of this writing) a major topic of thought, discussion, and effort within behavioral health and primary care. Although trauma-informed care and recovery-oriented systems and services are not yet featured

26. 26 Illinois Prevention Resource Center (1994). *Breaking the Chain: Making prevention programs work for children of addicted families*. Springfield, IL: Illinois Prevention Resource Center.

27. 27 U.S. Department of Health and Human Services (2001). *The national standards for culturally and linguistically appropriate services in health and health care: Final report*. Washington, DC: U.S. Department of Health and Human Services, Office of Minority Health.

28. 28 SAMHSA-HRSA Center for Integrated Health Services. What is integrated care? Retrieved January, 2014 from <http://www.integration.samhsa.gov/about-us/what-is-integrated-care>.

prominently in those discussions, it is only a matter of time until necessity places them center stage, for a number of reasons. For example:

- Effects of toxic stress and trauma are major contributors to the existence and complexity of many chronic physical and behavioral health conditions, as evidenced by higher levels of trauma history among people with these conditions. Medical teams often miss opportunities to ask the questions that might help them intervene early in the process.
- Symptoms of, and treatment for, many behavioral health conditions and post-trauma effects can raise vulnerability to many physical illnesses. For example, both the eating disorders that are common among trauma survivors and the use of most psychotropic medications can increase food consumption, blood sugar levels, and weight gain, raising the risk of diabetes, cardiovascular disease, and gastrointestinal problems.²⁹ And smoking, use of street drugs, and overuse of alcohol or prescription medications—also more common among trauma survivors—all raise a variety of serious health risks.
- Primary medical care is often driven by a sense of urgency—little time to build trusting relationships—and many tests and procedures are painful and invasive. This can raise the risk of triggering traumatic memories and emotions, de-stabilizing behavioral health and trauma recovery, and jeopardizing patients’ ability to cooperate with medical staff. Few fields need a strong focus on trauma-informed care more than the medical field.
- Like treatment for post-trauma effects and behavioral health conditions, treatment of chronic physical illness is often followed by neglect of medical regimens and return to behavioral excesses that contributed to the illnesses. Many patients are also bewildered by medical terms and instructions, so they “get lost” in referral and follow-up processes. The long-term perspective and integrated peer support services that have become staples of ROSC are desperately needed within primary care systems.

Armed with these and many other relevant considerations, formal and informal leadership can play critical roles in promoting shared ideas, shared resources, and truly integrated approaches.

Action Notes for Section 5

For a picture of where your organization, system, or community is in terms of your use and integration of related conceptual models and initiatives, you might:

29. 29 Newcomer, J.W. (2007). Metabolic syndrome and mental illness. *American Journal of Managed Care*, 13, S170-S177.

1. Convene a multidisciplinary group of people who would know what kinds of initiatives and processes are taking place.
2. Together, draw a chart with a square for each initiative, and write inside that square the major tasks of the initiative.
3. Draw arrows among them, showing collaborative projects, relationships, resource sharing, etc., and dotted arrows showing potential projects, relationships, and resource sharing.

Section 6: Implementing Trauma-informed Care

There are a hundred stages of change, the first 96 being precontemplation.

—Stuart Duckworth³⁰

Broad conceptual models such as trauma-informed care and ROSC resonate deeply with individuals' and organizations' experiences and inspire commitment and creativity. But large-scale change processes require concrete, step-by-step approaches, taken with care and respect for the existing organizational culture, the values that drive it, and the people who depend on it.

Several implementation models have been developed to guide organizations and systems toward trauma-informed policies, practices, and personnel. This section very briefly introduces three of the best-known national models. Developers of these and other approaches provide information on their web sites, offer written materials, and can provide training and technical assistance to organizations and systems that choose to implement them.

After a look at 12 priorities defined for trauma-informed mental health service systems, the final portions of this Section offer a brief description of Technology Transfer, the study of diffusion of innovative practice, and a few thoughts on effective, human-centered implementation of new models in organizations and systems.

30. 30 This quote is attributed to Stuart Duckworth. The 2009 document in which it is supposed to have appeared remains elusive, but the quote is too good not to include.

Risking Connection®

Risking Connection® (RC), a model for understanding and responding to the needs of people who have been wounded in interpersonal relationships, was developed in 1999 out of a partnership between the Sidran Institute (www.sidran.org) and the Trauma Research, Education and Training Institute (TREATI), under a commission from the state mental health authorities of Maine and New York.

As described at www.sidran.org, “Risking Connection® teaches a relational framework and skills for working with survivors of traumatic experiences. The focus is on relationship as healing, and on self-care for service providers.” A few points about this model:

- Risking Connection® identifies four primary components of the therapeutic relationship: Respect, Information, Connection, and Hope (RICH).
- This model is based on a clinical theory called Constructivist Self Development Theory (CSDT, developed by Lisa McCann, PhD and Laurie Anne Pearlman, PhD), which looks at individuals’ responses to trauma as meaningful adaptations to their experience.
- The 20-hour training curriculum based on this model emphasizes the role of therapeutic relationship, empowerment of service participants and providers, collaboration, psychoeducation, understanding symptoms as adaptation, and meaning making. The model also addresses the effects of this work on service providers.

The Sanctuary Model®

Another model that is receiving growing recognition is The Sanctuary Model®, developed by Sandra Bloom, MD, Joseph Foderaro, LCSW, Ruth Ann Ryan, MSN, CS, Brian Farragher, LCSW, MBA, Sarah Yanosky, LCSW and Linda Harrison, MEd, LPC. The Sanctuary Model® (www.sanctuaryweb.com) provides a framework for understanding the universal impact of toxic stress and trauma and engaging members of an organization, a system, or a community, including ways of keeping people active and interested and tools for working through conflicts.

One central theme of The Sanctuary Model® is that the process of change and healing is essentially the same whether it is taking place in someone receiving services, the service provider, the organization, the family, or the community. Like recovery, The Sanctuary Model® begins the healing process at the center, in this case, the service provider. Healthy individuals, organizations, and systems are far more likely to heal—and far less likely to wound—and people who have benefitted from a process are better prepared to bring that process to others.

This model relies on four key domains of healing: Safety (in self, relationships, environment), Emotions (identifying/modulating emotions), Loss (feeling grief and recognizing that change includes loss) and Future (new roles, ways of relating, identity as a “survivor”). The model is passed on through the S.E.L.F Curriculum and the group training program by the same name. Its guiding principles are the Seven Sanctuary

Commitments, to be embraced at all levels of the organization: 1) commitment to nonviolence, 2) emotional intelligence, 3) social learning, 4) open communication, 5) democracy, 6) social responsibility, and 7) growth and change.

Creating Cultures of Trauma Informed Care

Maxine Harris, PhD and Roger D. Fallot, PhD of Community Connections (www.communityconnectionsdc.org) have written extensively of cultures of trauma-informed care, and address implementation of trauma-informed care as a process of culture change. They outline the four-stage system-change process that they use to guide TIC implementation:³¹

1. *Initial planning:* This stage involves considering the importance of, and weighing commitment to, a trauma-informed change process. Important elements include administrative support and commitment, a trauma initiative workgroup, representation of each stakeholder group, identification of “champions,” and an understanding that this shift will take one to two years and will involve the entire agency and its culture.
2. *Two-day kickoff training:* This stage includes all workgroup members, as many staff as possible, and significant representation of service participants. There are at least three presentations: 1) Central ideas of trauma-informed cultures, 2) Importance of staff support and care, and 3) Importance of trauma in the work of the agency.
3. *Short-term follow-up:* This stage involves application of ideas from the training, using a Self-Assessment and Planning Protocol that addresses both service-level and administrative or systems-level changes, assisted by outside consultants with implementation experience. Stage 3 also includes development and review (by administration, staff, service participants, consultants) of an Implementation Plan, followed by educational events (e.g., “Understanding Trauma 101” and “Staff Support and Care”).
4. *Longer-term follow-up:* The final stage includes progress review meetings with consultants, the workgroup, and selected others, followed by ongoing processes to sustain the initiative to its conclusion and to maintain the momentum until culture change has spread throughout the agency.

Priorities for Trauma-informed Mental Health Service Systems

Treatment organizations do not operate in a vacuum, and support at the service system level is necessary, not

31. 31 Fallot, R.D. and Harris, M. (2009). Creating cultures of trauma informed care. Washington, DC: Community Connections.

just for the organizations within the system, but also for the integration of these services in a multi-system, whole community approach. The National Association of State Mental Health Program Directors and the National Technical Assistance Center for State Mental Health Planning have identified twelve priorities for trauma-informed mental health systems:

1. Designated trauma function and focus in the department
2. State trauma policy or position paper
3. Workforce orientation, training, support, competencies, job standards
4. Linkages with higher education to promote education of professionals in trauma
5. Consumer/survivor/recovering person involvement and trauma-informed rights
6. Trauma policies/services that respect culture, race, ethnicity, gender, age, sexual orientation, disability, and socioeconomic status
7. Integration/coordination among systems serving persons with trauma histories
8. Trauma-informed disaster planning and terrorism response
9. Financing criteria and mechanisms to pay for best practice treatment models/services
10. Clinical practice guidelines for working with people with trauma histories
11. Procedures to avoid retraumatization and reduce the impact of trauma
12. Rules, regulations, and standards to support access to evidence-based/best practices³²

The ATTC Model of Technology Transfer

As a field, and as a larger society, we have no shortage of innovative models and practices, but we do sometimes have a hard time persuading individuals, organizations, and systems to adopt new approaches. Meeting these challenges is one of the major missions of the National Addiction Technology Transfer Center (ATTC) Network.

With 10 Regional Centers, four National Focus Centers, and a Network Coordinating Office, the ATTC Network is a nationwide, multidisciplinary resource for professionals in the addictions treatment and recovery services field, dedicated to raising awareness of evidence-based and promising treatment and recovery practices, building workforce skills for state-of-the-art service delivery, and changing practice and improving outcomes by helping people incorporate these skills into everyday use.

One of the ATTC Network's most fundamental tools is Technology Transfer, a conceptual model and system of strategies designed to make it more likely that a particular model or practice will be adopted and its practices implemented. In adapting the basic concept of technology transfer to its work in the substance

32. 32 Jennings, A. (2004). *Blueprint for action: Building trauma-informed mental health service systems*. Alexandria, VA: National Association of State Mental Health Program Directors and National Technical Assistance Center for State Mental Health Planning.

use disorder field, the Network has blended a number of relevant models, including stages-of-change and motivational theories, to overcome the many challenges to the adoption of new ideas and practices.

The following excerpt from “ATTC Network Model of Technology Transfer in the Innovation Process” gives a basic introduction to these stages and the processes they foster and assist:

The conceptual model in the figure below, developed by the Addiction Technology Transfer Center Network, illustrates the continuum of diffusion of an innovation (an idea, technology, treatment or method) from creation through implementation.

Highlighted within the conceptual model is technology transfer, a multidimensional process that intentionally promotes the use of an innovation. Technology transfer begins during development, continues through dissemination, and extends into early implementation. This process requires multiple stakeholders and resources, and involves activities related to translation and adoption. Technology transfer is designed to accelerate the diffusion of an innovation.

First, during development, the innovation is designed and initially evaluated. Next, during translation, the essential elements and relevance of the innovation are explained and the innovation is packaged to facilitate its spread. In dissemination, awareness about the innovation is promoted with the goal of encouraging its adoption. Adoption is not a single decision but a process of deciding to use the innovation. Finally, during implementation, the innovation is incorporated into routine practice in “real world” settings. Across the continuum, bidirectional communication is a critical component and is represented by a continuous feedback loop.

An organization, system, or community interested in adopting an innovation such as ROSC or trauma-informed care—or any new practice or approach—might find the ATTC technology transfer model a useful tool. It can help change agents:

- Provide a standard language that stakeholders can use to describe their tasks and the process as a whole
- Place the stages of diffusion in context, so key partners can prepare for a multi-tiered change process
- Promote adoption of evidence-based practices with high fidelity
- Create a common understanding that increases partners’ satisfaction with the process
- Focus the organization’s, system’s, or community’s purchasing power by providing a realistic look at what activities in the various stages are likely to accomplish

The Human Side of Innovation

Like the individuals they are made of, organizations often balk at the prospect of change, accept it in stages, and find ways of undoing approaches that seem to have been forced on them.

People who have made the process of change their life’s work have much to offer systems and organizations

about to engage in this process. Few of these experts offer better suggestions for this than Michael A. Diamond, PhD, in his seminal 1996 article on the human side of innovation. A few examples:³³

- No matter how much they admire expertise, members of an organization, system, or community tend to resent experts who “descend from on high” to tell them what their problems are and offer solutions. Rather than taking an “expert authority” stance, it is better to approach stakeholders in an attitude of openness and humility and let them, not only help solve the challenges at hand, but first help define the challenges and plan the solutions. Much of the success of a change process depends on whether or not the people who are supposed to implement the solution buy into the definition of the problem and the nature of the solution.
- Understand that the “resistance” that change processes often inspire is a natural expression of the anxiety people feel when they perceive that change is being imposed on them. No matter how much they want to learn and improve, people tend to feel powerless, uncertain, and inferior if they get the impression that the way they have been doing things is now considered wrong or inadequate. However, if they have been part of the planning process from the beginning, participating in empowered and meaningful ways, they can become the ones who have chosen change, a position of dignity.
- Understand and respect the fact that adoption of the new also means the loss of the old, including the sense of certainty that long-time routines and rituals carry, and all the ways in which traditional responses have been woven into the organizational culture. It is helpful to give each individual opportunities for, and support in, identifying and grieving these losses and building a new vision that works for both the individual and the process as a whole.
- Diamond presents the concept of a “transitional space,” not so much a physical but a psychological space in which people can work through their thoughts and feelings about the change process, explore the implications of change, make mistakes without dire consequences, and work toward taking responsibility for changing.
- He also emphasizes the fundamental importance of building and maintaining organizational resilience. If leaders promote collaboration and trust through their own respectful and collaborative approaches, the organization is more likely to respond effectively to change.³⁴

With all these options and resources in mind, it is time to think—at least in hypothetical terms— about the human, conceptual, material, and financial resources you might use to foster and sustain the change process. Whether your goal is trauma-informed care, a recovery-oriented system of care, or an integrated combination

33. 33 Diamond, M. (1996). Innovation and diffusion of technology: A human process. *Consulting Psychology Journal: Practice and Research*, 48(4), 221-229.

34. 34 Ibid.

of the two, the Action Notes below give you a space to begin listing some of the resources you have, and some of the resources you need.

The next Section will hone in on one important aspect of implementation: staff training in trauma-informed care and the support that staff and volunteers will need—and no doubt already need—to work safely and effectively with people who have been deeply affected by toxic stress and trauma.

Action Notes for Section 6

An important early step in a major implementation process is an inventory of resources that can be mobilized in that effort, including:

- The human, conceptual, and material resources already in place that might aid in the implementation of trauma-informed care
- The resources that are not yet in place but would be free, or be within your organization's, community's, or system's means to engage or acquire
- The resources that are beyond your current means but would be worth engaging, acquiring (alone or shared with allied initiatives), or borrowing if that became possible.

Who might be the key people to involve in taking this inventory?

At a minimum, your inventory should consider each of these categories and types of resources:

- *Human:* These might include leadership, management, line staff, consultants, volunteers, community members, members of allied systems, representatives of funding bodies, and other stakeholders.
- *Conceptual:* These might include models (conceptual, implementation, or practice), policies, procedures or protocols related to any facets of your implementation process.
- *Material:* This category might include financial assets, funding opportunities, collateral, written documents, audiovisuals, work space, furniture, office products, etc.

Section 7: Trauma Training and Staff Support

Working with trauma survivors can be stressful, and sometimes even vicariously traumatizing. It often exposes us to the pain and suffering that comes from observing the worst that human beings can do to each other.

—John Briere and Catherine Scott³⁵

One of the most challenging tasks of human service leadership is to foster in staff, colleagues, and partners an understanding of deep and complex subjects—and to do this as quickly and as economically as possible. When it comes to toxic stress, trauma, and trauma-informed care:

- The depth and complexity of the subject—and the lure of simplistic approaches—can both be significant. In this balancing act, financial realities can tip the scale, and this can be risky. People who understand the complexities should help make these decisions.
- It is clear that all staff and volunteers have the potential to harm people who are experiencing vulnerabilities, but the prospect of training all personnel can be daunting.
- Common misconceptions about trauma, its effects, and stage-appropriate responses can make it difficult for providers to hear and apply accurate information on these subjects.
- The learner’s own experience of toxic stress and trauma can deepen understanding, but it can also complicate the learning process and the application of lessons learned.
- If this information is not integrated with the other conceptual models embraced by the system (e.g., recovery-oriented services, cultural competence, integrated healthcare), it might be—at best—implemented in costlier and less effective ways and—at worst—dismissed as just another flavor of the month, to be endured and then ignored.

Most models for implementing trauma-informed care (including those described briefly in the previous Section) include staff and leadership training and technical assistance components. However, when a comprehensive approach is not an option—and a half-hearted approach would be ineffective and even

35. 35 Briere, J. and Scott, C. (2006). *Principles of trauma therapy: A guide to symptoms, evaluations, education, and treatment*. Thousand Oaks, CA: Sage Publications, Inc.

dangerous—it comes down to finding the best compromise. This section presents some suggestions for training and staff support.

When it is time to map out a training program for staff in trauma and trauma-informed care, many leaders choose a tiered approach—for example, providing:

- *First Tier: For all staff, volunteers, and/or community members, at all levels of the organization or system—with significant participation by service participants in both planning and delivery:*
 - General, accessible, de-stigmatizing information about toxic stress and trauma
 - Basic tips for safe, respectful, and effective responses to all service participants and people in recovery, given the high prevalence of trauma history and the ever-present possibility that a tough veneer might hide significant vulnerabilities
 - Ways of identifying and eliminating safety issues and triggers for post-trauma reactions within the organization, family, community, or service system
- *Second Tier: For recovery support, clinical, case management, and other service-provision staff:*
 - More in-depth discussion of the nature of toxic stress and trauma, their effects, and their implications for therapeutic and support relationships, with special emphasis on the prevalence and implications of complex and developmental trauma in treatment and recovery support service participant
 - The relationship between toxic stress/trauma and co- occurring conditions (e.g., substance use disorders, mental health challenges, chronic physical illnesses)
 - Basic principles and practices of trauma-informed care
 - Brief screening and supported referral to assessment processes
 - The stages of trauma recovery, their implications for service provision, and appropriate treatment and recovery support approaches at each stage—with an emphasis on present-focused safety/stabilization-stage approaches, and careful clarification of any misunderstanding that might arise from that discussion (e.g., when trainers warn not to draw traumatic memories out of people in Stage 1, emphasize that this does not mean they should discourage people from talking about or seeking help for the memories that are triggered or arise unsolicited)
 - Strength-based, normalizing, non-stigmatizing, non-“pathologizing” ways of discussing trauma and its effects
 - Ways of modeling and describing basic skills in self-care, modulation of emotions and stress responses, and management of post-trauma effects
 - Safe and effective ways of responding to and de-escalating post-trauma reactions (e.g., collaborating with service participants in developing individualized plans for safe de-escalation), and seeking assistance from other staff in proactive, non- triggering forms of de-escalation, whenever assistance is need
 - The importance of and opportunities for self-care, ongoing growth, mutual support, supervision,

- and appropriate help-seeking among service providers
- Basic information about recognizing and addressing stress and vicarious traumatization among service providers, family members, and support networks
- *Third Tier: For all clinical staff:*
 - More in-depth coverage of the nature and effects of trauma, including the physiology and neurobiology; psychological, social, and spiritual implications; and medical, behavioral, psychiatric, cognitive, parenting, and legal sequelae
 - More in-depth information about trauma-informed care and its implementation within the organization, system, and community
 - The use of assessment tools/techniques and referral to stage-appropriate trauma- focused care
 - Conducting effective, normalizing, strength-based psychoeducation on the nature and effects of toxic stress and trauma (including its physiological roots) and the power of resilience and recovery
 - Training service participants in safety skills and considerations and ways of recognizing and managing the effects of toxic stress and trauma in everyday life
 - More in-depth information about secondary and vicarious traumatization, provision of careful ongoing supervision and mentorship, and development of individual and service provider group plans for self-care and mutual support
- *Fourth Tier: For providers of trauma-focused services:*
 - In-depth training, role-play, and skill rehearsal in the trauma-focused service models to be adopted
 - Wherever available, certification or licensure of staff who will deliver services
 - Ongoing technical assistance, supervision (including videotaping/analysis of sessions), mentorship, and continuing education in these practice models
 - Ongoing learning communities, discussion groups, and peer support groups or dyads among staff delivering these services.

Helping Staff Stay Afloat

“Compassion fatigue” has become a popular catch-all phrase for a range of natural reactions to the sometimes overwhelming burden of exposure to others’ extremely painful and frightening experiences. Compassion is a significant strength, and identifying it as part of the problem leaves many human service providers wondering just how to work the magic spigot and have *just the right amount* of compassion. It may be more helpful to break “compassion fatigue” down into its component elements and address each element as it arises. For example:

- Immersion in deficit-based models, with their primary focus on problems, symptoms, and diagnoses, can erode important resources for weathering traumatic material. Implementing strength-based approaches can improve outcomes and fortify hope, optimism, empowerment, and faith in one’s ability

to make a difference.

- Human service providers are notorious for neglecting self-care in order to meet others' needs. Never underestimate the power of stress and fatigue, with all their physical and neurochemical effects on mood, perspective, and energy levels. Policy, supervision, and mentorship can address these challenges effectively, but only if leadership is willing and able to discourage overwork; refrain from making overtaxing demands; and provide training and support in time management, stress modulation, and stress reduction.
- Some post-trauma effects—particularly the effects of complex or developmental trauma—can add layers of confusion and turbulence to relationships, including service relationships. In these cases, providers' sense of interpersonal stress and frustration might add to any challenges related to the traumatic material itself.
- Some of what is thought of as “secondary trauma” may actually be unresolved primary trauma, grief, guilt, shame, and/or anger triggered by exposure to others' traumatic material and ensuing emotions. Service providers are responsible for monitoring and pursuing their own growth and healing—and abstaining from any roles that take them beyond their levels of recovery. Supervisors and managers are responsible for knowing their staff well enough to recognize the signs and intervene within the boundaries of their professional roles—and for creating environments that make it safe to ask for help.
- Sometimes what seems like compassion fatigue might be an old fashioned case of countertransference, overidentification, or seeing the people they serve through the lens of their own needs and challenges. Ongoing employee development must work to instill a sense of responsibility for maintaining clear delineation and boundaries.
- And there is such a thing as “vicarious traumatization,” the effect of taking in so much traumatic material—often on a chronic basis—that it overwhelms one's coping abilities and alters one's world view. The leader's job is to ensure that there are many accessible options for guidance and support, and to create an atmosphere in which it is understood that sometimes there simply is too much pain, and people need the grace and the space to rest, reset, recover, and reconnect with their many sources of strength and spirit.

After this brief look at several aspects of trauma, trauma-informed care, recovery-oriented systems, allied models, and considerations for implementation, it is time to step back and look at the implications of all these thoughts and suggestions. The next and final Section reviews the tasks suggested in the Action Notes at the end of each Section and offers some thoughts on hope.

Action Notes for Section 7

It might be helpful to have a picture of where your staff and stakeholders are in terms of their need for training and support in trauma and trauma-informed care. To conduct a survey in your organization, system, or community—one that allows respondents to remain anonymous—to find out:

- How much staff and volunteers at all levels seem to know and understand about toxic stress, trauma, and trauma-informed care
- How staff, volunteers, service participants, and community members are being affected by exposure to other individuals' traumatic material and reactions
- What levels of resources (e.g., peer support, supervision, mentorship, social networks, employee assistance programs, counseling or therapy) people in each of these groups have for coping with and resolving these effects
- What additional resources they would be willing to use if those resources were available

Section 8: Accepting the Challenge

Three frogs are sitting on a log. One of them decides to jump. Now how many frogs are sitting on the log?

(Answer: Three. Just making a decision doesn't get the frog off the log!)

—Popular Riddle in Recovery Circles

Like the frog in the old riddle, most of us have learned over and over again that not even inspiration, vision, conviction, motivation, resolution, determination—not even all those qualities put together—will be enough to make things happen. It takes action. But unlike that contemplative frog, change leaders often find that it takes, not one leap, but a series of leaps, plus the persistence to lure the other two frogs off the log.

If you have read through this document, and perhaps begun to address the Action Notes at the end of each section, you might have something close to the bare bones of a place to start.

The most important tasks are the ones that involve reaching out to potential collaborators: people with answers, people with more questions, people whose input will make things easier, people whose input will make things harder—but better—people who can help you do the things you cannot do alone.

To sum up those Action Notes, here are some interesting projects for leaders who know that the growing impact of toxic stress and trauma is a serious threat that requires careful effort, integrated with recovery-oriented systems and the full spectrum of related efforts.

From Section 1: The Role of Leadership

- Identify one or more teams in your organization, system, or community that are studying the kinds of issues and possibilities addressed in this manual—or start a new team. Consider sharing this manual with them, and think about the role you should play in these efforts and the challenges and resources you expect to find in the process.

From Section 2: Transforming the Vision

- Clarify (or update) your own vision regarding trauma-informed responses, and look for opportunities to participate in any collective vision- and mission-building processes within your organization, system, or community.

From Section 3: Toxic Stress and Trauma

- Catalyze a collaborative effort to compile a “ballpark” estimate of the total—and inclusive—human, social, and financial cost of toxic stress and trauma on your organization, your community, your system, and the people you serve.

From Section 4: Trauma-informed Care

- Spearhead a collaborative effort to take inventory of the ways in which trauma-informed approaches are already in place in your organization, system, or community, and the elements of trauma-informed approaches that should be added.

From Section 5: Trauma-informed Care in Context

- Gather a multidisciplinary group that can take inventory, within your organization, system, or community, of ways in which efforts toward trauma-informed care, recovery-oriented systems of care, and any other conceptual models are working together, and the extent to which information, resources, and collaborative efforts are being shared among these efforts.

From Section 6: Implementing Trauma-informed Care

- With help, make lists of the human, conceptual, and material resources that are being, might be, or

should be mobilized for these efforts in your organization, system, or community

From Section 7: Trauma Training and Staff Support

- Conduct a survey in your organization, system, or community—one that allows respondents to remain anonymous—to find out:
 - How much staff and volunteers at all levels seem to know and understand about toxic stress, trauma, and trauma-informed care
 - How staff, volunteers, and service participants are being affected by exposure to other individuals' traumatic material and reactions
 - What levels of resources each of these groups has for coping with and resolving those effects
 - What additional resources they would be willing to use if those resources were available

Evidence of Hope

When people have lived with the effects of toxic stress and trauma for a long time—a year, a lifetime, many generations—the capacity to trust may be the first casualty, with hope and determination falling not far behind.

As a society, we have watched our human and financial resources erode as the progressive effects of toxic stress and trauma have compromised our collective physical, psychological, behavioral, social, cultural, financial, spiritual, and moral health. All this has increased the senses of isolation and scarcity that wear at the fabric of human health, resilience, and recovery. Given all the ideas in this and thousands of other documents, it might not be too hard to envision collaborative solutions, but believing those solutions can happen is another matter.

Remember: Resilience is real. Most people not only survive but thrive, in spite of pain or poverty or grinding stress.

Recovery is real. Overwhelming numbers of people with chronic, once-debilitating substance use disorders and/or mental health challenges are living full lives, transformed lives. Most did not do it alone, though, and many have become that strength for others.

And for anyone who doubts that trauma-informed care can overcome the silos and the scarcity and expand to the scale we need, there is the best possible precedent: recovery-oriented systems of care. In a growing number of organizations, systems, and communities—even large cities and states—diverse groups of

stakeholders have pooled their ideas and resources in service of recovery.³⁶ This movement is a sign of hope; a source of ideas; and a sound partner in efforts to empower individuals, families, and communities.

The architects and advocates of trauma-informed care and recovery-oriented systems of care need one another. One nourishes and protects the roots, and the other tends the branches, but it is the same tree. It is all of us, and each one of us is responsible. This is our challenge, and our hope.

Citation

Woll, P. (2017). *Addressing stress and trauma in recovery-oriented systems and communities: A challenge to leadership*. Kansas City, MO: Addiction Technology Transfer Center Network Coordinating Office.

This work resides in the public domain, unless otherwise indicated.

Bibliography

Achara, I., Ali, O., Davidson, L., Evans, A.C., King, J.K., Poplawski, P., and White, W.L. (2011). *Philadelphia Behavioral Health Services Transformation Practice Guidelines for recovery and resilience oriented treatment*.

Philadelphia, PA: Philadelphia Department of Behavioral Health and Intellectual disAbility Services. Aimee, J. Midei, A.J., Karen A. Matthews, K.A., Chang, Y-F, and Bromberger J.T. (2012). Childhood physical abuse is associated with incident metabolic syndrome in mid-life women. *Health Psychology*, 32(2).

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders, Fourth Edition, Text Revision (DSM-IV-TR)*. Arlington, VA: American Psychiatric Association.

Anthony, W., Cohen, M., Farkas, M., & Gagne, C. (2002). *Psychiatric Rehabilitation*, 2nd Edition. Boston, MA: Center for Psychiatric Rehabilitation.

Baker, R.A., Andrew, M.J., Schrader, G., Knight, J.L. (2001). Preoperative depression and mortality in coronary artery bypass surgery: Preliminary findings. *ANZ Journal of Surgery*, 71(3), 139-142.

Barrera, P., Espey, B., Fishbein, R., Moran, D., & Flannery, R. B. (2000). Linking substance abuse and serious mental service

Bellack, A. S. (2006). Scientific and consumer models of recovery in schizophrenia: Concordance, contrasts, and implications.

36. 36 White, W.L., Clark, H.W., Kirk, T.A., Evans, A.C., Boyle, M., Valentine, P., and Albright, L. (2007). Perspectives on systems transformation: How visionary leaders are shifting addiction treatment toward a recovery-oriented system of care. Chicago, IL: Great Lakes Addiction Technology Transfer Center. Lambert, C. (2008). Trails of tears, and hope. *Harvard Magazine*, March-April, 2008. White (2008), loc. cit. Achara, I., Ali, O., Davidson, L., Evans, A.C., King, J.K., Poplawski, P., and White, W.L. (2011). *Philadelphia Behavioral Health Services Transformation Practice Guidelines for recovery and resilience oriented treatment*. Philadelphia, PA: Philadelphia Department of Behavioral Health and Intellectual disAbility Services. Blanch, A. (2011), loc. cit.

- Belleau, C., DuPont, R., Erickson, C., Flaherty, M., Galanter, M., Gold, M., Kaskutas, L., Laudet, A., McDaid, C., McLellan, A.
- Betty Ford Institute. *Journal of Substance Abuse Treatment*, 33(3), 221-228.
- Blanch, A. (2011). Peace4Tarpon knows it takes a village. *National Council Magazine*, 2011, Issue 2.
- Blanch, A. (2012). SAMHSA's National Center for Trauma-Informed Care: Changing communities, changing lives. Rockville, MD: National Center for Trauma-Informed Care, Substance Abuse and Mental Health Services Administration.
- Blanch, A.K. and Shern, D.L. (2011). Implementing the new "germ" theory for the public's health: A call to action. Alexandria, VA: Mental Health America
- Bonanno, G.A. (2004). Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events? *American Psychologist*, 59(1), 20-28.
- Boston Public Health Commission (2007). *The Disparities Project: Year one report*. Boston, MA: Boston Public Health Commission.
- Brave Heart, M.Y.H. (2003). The historical trauma response among Natives and its relationship with substance abuse: A Lakota illustration. *Journal of Psychoactive Drugs*, 35, 7-13. Danieli, Y., Ed. (1998). *International handbook of multigenerational legacies of trauma*. New York: Plenum Press.
- Briere, J. and Scott, C. (2006). *Principles of trauma therapy: A guide to symptoms, evaluations, education, and treatment*. Thousand Oaks, CA: Sage Publications, Inc.
- Bukberg, J., Penman, D., and Holland, J.C. (1984). Depression in hospitalized cancer patients. *Psychosomatic Medicine*, 46(3), 199-212
- CalMend (2011). Integration of mental health, substance use, and primary care services: Embracing our values from a client and family member perspective. Sacramento, CA: California Institute for Mental Health, CalMEND.
- Carlson, B.E. and Shafer, M.S. (2010). Traumatic histories and stressful life events of incarcerated parents: Childhood and adult trauma histories.
- Center for Substance Abuse Treatment. (2005). National Summit on Recovery: Conference Report (HHS Publication No. SMA
- Center for the Developing Child, Harvard University. Three core concepts in early development. Retrieved January, 2014 from http://developingchild.harvard.edu/resources/multimedia/videos/three_core_concepts/toxic_stress/.
- Collins, C., Hewson, D.L., Munger, R. and Wade, T. (2010). *Evolving models of behavioral health integration in primary care*. New York: Millbank Memorial Fund.
- Collins, J.W. Jr., Wambach, J., David, R.K. and Rankin, K.M. (2009). Women's lifelong exposure to neighborhood poverty and low birth weight: A population-based study. *Maternal and Child Health Journal*, 13(3), 326-333.
- Connerney, I., Shapiro, P.A., McLaughlin, J.S., Bagiella, E., and Sloan, R.P. (2001). Relation between

depression after coronary artery bypass surgery and 12-month outcome: A prospective study. *The Lancet*, 358(9295), 1766-1771.

Corrigan, P. W., & Watson, A. C. (2004). At Issue: Stop the stigma: Call mental illness a brain disease. *Schizophrenia Bulletin*,

Coyhis, D., & White, W. (2006). *Alcohol problems in Native America: The untold story of resistance and recovery*. Colorado Springs, CO: White Bison, Inc.

Crews, D. E. (2010). Strategies for implementing sustainability: Five leadership challenges. *SAM Advanced Management Journal*,

Derogatis, L.R., Morrow, G.R., Fetting, J., Penman, D., Piasetsky, S., Schmale, A.M., Henrichs, M., and Carnicke, C.L.M. (1983). The prevalence of psychiatric disorders among cancer patients. *Journal of the American Medical Association*, 249(6), 751-757.

Diamond, M. (1996). Innovation and diffusion of technology: A human process. *Consulting Psychology Journal: Practice and Research*, 48(4), 221-229.

Dixon, J. (2000). Social determinants of health. *Health Promotion International*, 15(1), 87-89. Kilpatrick, D.G., Koenen, K.C., Ruggiero, K.J., Acierno, R., Galea, S., Resnick, H.S., Roitzsch, J., Boyle, J. and Gelernter, J. (2007). The serotonin transporter genotype and social support and moderation of posttraumatic stress disorder and depression in hurricane-exposed adults. *The American Journal of Psychiatry*, 164(11), 1693-1699.

Elliott, D.E., Bjelajac, P., Fallot, R.D., Markoff, L.S., and Reed, B.G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology*, 33(4), 461-477.

Evans, A.C. and White, W.L. (2013). "Recovery-oriented systems of care": Reflections on the meaning of a widely used phrase. Posted at multiple recovery advocacy web sites and at www.williamwhitepapers.com.

Fallot, R.D. and Harris, M. (2009). *Creating cultures of trauma informed care*. Washington, DC: Community Connections.

Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P., and Marks, J.S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, 14(4), 245-258.

Funk, M. and Ivbijaro, G. (Eds.) (2008). *Integrating mental health into primary care: A global perspective*. Geneva, Switzerland: World Health Organization and World Organization of Family Doctors.

Gagne, C., White, W., & Anthony, W. (2007). *Recovery: A common vision for the fields of mental health and addictions*.

Gates, L. B., Mandiberg, J. M., & Akabas, S. H. (2010). Building capacity in social service agencies to employ peer providers.

Geronimus, A.T., Hicken, M., Keene, D. and Bound, J. (2006). *American Journal of Public Health*, 96(5), 826- 833.

Golomb, B.A. (1998). Cholesterol and violence: Is there a connection? *Annals of Internal Medicine*, 128(6), 478-87.

González-Salvador, M.T., Arango, C., Lyketsos, C.G., and Barba, A.C. (1999). The stress and psychological morbidity of the Alzheimer patient caregiver. *International Journal of Geriatric Psychiatry*, 14(9), 701-710.

Great Lakes Addiction Technology Transfer Center. (2007). Perspectives on systems transformation: How visionary leaders are shifting

Halvorson, A. & Whitter, M. (2009). Approaches to Recovery-Oriented Systems of Care at the State and Local Levels: Three Cases

Heim, C. and Nemeroff, C.B. (2001). The role of childhood trauma in the neurobiology of mood and anxiety disorders: preclinical and clinical studies. *Biological Psychiatry*, 49(12), 1023-1039.

Herman, J. (1992). *Trauma and recovery: The aftermath of violence—From domestic abuse to political terror*. New York: Basic Books.

Hughes, D.A. and Baylin, J. (2010). Brain-based parenting: The neuroscience of caregiving for healthy attachment. *Neuroscience Letters*, 47(1), 15-18

Jennings, A. (2004). *Blueprint for action: Building trauma-informed mental health service systems*. Alexandria, VA: National Association of State Mental Health Program Directors and National Technical Assistance Center for State Mental Health Planning.

Jennings, A. (2004). *The damaging consequences of violence and trauma: Facts, discussion points, and recommendations for the behavioral health system*. Alexandria, VA: National Technical Assistance Center for State Mental Health Planning, National Association of State Mental Health Program Directors.

Joint Principles of the Patient-Centered Medical Home (2007). Washington, DC: American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and American Osteopathic Association (AOA).

Kaplan, L. (2008). The role of recovery support services in recovery-oriented systems of care (DHHS Publication No. SMA 08-4315).

Kelly, J. & White, W. (Eds., 2011). *Addiction recovery management: Theory, research and practice*. New York: Springer Science.

Kendall-Tackett, K. (2009). Psychological trauma and physical health: A psychoneuroimmunology approach to etiology of negative health effects and possible interventions. *Psychological Trauma: Theory, Research, Practice, and Policy*, 1(1), 35-48

Kessler, R.C., Sonnega, A., Bromet, E., Hughes, M., and Nelson, C.B. (1995). Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry*, 52(12), 1048-1060.

Kirk, T. A., Evans, A. C., & Dailey, W. F. (2005). Implementing a statewide recovery-oriented system of care: From concept to reality

Ko, S.J., Ford, J.D., Kassam-Adams, N., Berkowitz, S.J., Wilson, C., Wong, M., Brymer, M.J. and Layne, C.M.

(2008). Creating trauma-informed systems: Child welfare, education, first responders, health care, juvenile justice. *Professional Psychology: Research and Practice*, 39(4), 396-404.

Kotter, J. P. (1995). Leading change: Why transformation efforts fail. *Harvard Business Review*, 73(2), 59-67.

Kurtz, M.E., Kurtz, J.C., Given, C.C., and Given, B. (1996). Concordance of cancer patient and caregiver symptom reports. *Cancer Practice*, 4(4), 185-90.

Lamb, R., Evans, A. C, & White, W. (2009). The role of partnership in recovery-oriented systems of care: The Philadelphia experience.

Lambert, C. (2008). Trails of tears, and hope. *Harvard Magazine*, March-April, 2008.

Laudet, A. (2009). Environmental scan of measures of recovery. Rockville, MD: Center for Substance Abuse Treatment, Substance

Marans, S., Berkowitz, S.J. and Cohen, D.J. (1998). Police and mental health professionals. Collaborative responses to the impact of violence on children and families. *Child and Adolescent Psychiatric Clinics of North America*, 7(3), 635-651

Marmot, M. and Wilkinson, R. (2009). *Social determinants of health*. New York: Oxford University Press.
Koenen, K.C., Aiello, A.E., Bakshis, E., Amstadter, A.B., Ruggerio, K.J., Acierno, R., Kilpatrick, D.G., Galea, S. and Galea, S. (2009).

MATEC/GLATTC (2002). The triple challenge: Optimizing HIV treatment for patients with co-occurring mental illness and substance use disorders. Chicago, IL: Midwest AIDS Training and Education Center and Great Lakes Addiction Technology Transfer Center.

Mauer (2009). *Behavioral Health/Primary Care Integration and the Person-centered Healthcare Home*. Washington, DC: National Council for Community Behavioral Healthcare.

McEwen B.S. (2000). Allostasis and allostatic load: Implications for neuropsychopharmacology". *Neuropsychopharmacology*, 22(2), 108-24.

McFarlane, A.C. (2010). The long-term costs of traumatic stress: Intertwined physical and psychological consequences. *World Psychiatry*, 9(1), 3-10.

Mills, P.J., Ziegler, M.G., Patterson, T., Dimsdale, J.E., Hauger, R., Irwin, M. and Grant, I. (1997). Plasma catecholamine and lymphocyte beta 2-adrenergic receptor alterations in elderly Alzheimer caregivers under stress. *Psychosomatic Medicine*, 59(3), 251-6.

Modai, I., Valevski, A., Dror, S., and Weizman, A. (1994). Serum cholesterol levels and suicidal tendencies in psychiatric inpatients. *Journal of Clinical Psychiatry*, 55(6), 252-254.

Najavits, L.M. (2002). *Seeking Safety: A treatment manual for PTSD and substance abuse*. New York: The Guilford Press.

National Center for PTSD (2007). Effects of traumatic stress after mass violence, terror, or disaster: Normal reactions to an abnormal situation. (Retrieved April 25, 2013 from <http://www.ptsd.va.gov/professional/pages/stress-mv-t-dhtml.asp>)

- National Center for Trauma-Informed Care. Trauma-informed care and trauma services. Retrieved January, 2014 from <http://www.samhsa.gov/nctic/trauma.asp>
- National Council for Behavioral Healthcare (2011). *National Council Magazine*, Trauma-informed Care Edition, Issue 2.
- National Crittenton Foundation (2012). Summary of results: Crittenton Adverse Childhood Experiences (ACE) Pilot. Portland, OR: National Crittenton Foundation.
- NCTIC/SAMHSA. Trauma-informed care and trauma services. Retrieved March, 2014 from <http://www.samhsa.gov/nctic/trauma.asp>.
- Neumesiter A., Normandin, M.D., Pietrzak, R.H., Piomelli, D., Zheng, M.Q., Gujarrro-Anton, A., Potenza, M.N., Bailey, C.R., Lin, S.F., Najafzadeh, S., Ropchan, J., Henry, S., Corsi-Travali, S., Carson, R.E., and Huang, Y. (2013). Elevated brain cannabinoid CB1 receptor availability in post-traumatic stress disorder: A positron emission tomography study. *Molecular Psychiatry* May 14; [e-pub ahead of print], retrieved from <http://www.nature.com/mp/journal/vaop/ncurrent/full/mp201361a.html>
- Newcomer, J.W. (2007). Metabolic syndrome and mental illness. *American Journal of Managed Care*, 13, S170-S177.
- Norman, S.B., Means-Christensen, A.J., Craske, M.G., Sherbourne, C.D., Roy-Byrne, P.P., and Stein, M.B. (2006). Associations between psychological trauma and physical illness in primary care. *Journal of Traumatic Stress*, 19(4), 461-470.
- Norris, F.H., Stevens, S.P., Pfefferbaum, B. and Wyche, K.F. (2008). Community resilience as a metaphor, theory, set of capacities, and strategy for disaster readiness. *American Journal of Community Psychology*, 41(1-2), 127-150.
- O'Connell, M., Tondora, J., Croog, G., Evans, A., & Davidson, L. (2005). From rhetoric to routine: Assessing perceptions of
- Parks J., Svendsen, D., Singer, P., Foti, M.E., and Mauer, B. (2006). Morbidity and mortality in people with serious mental illness. Alexandria, VA: National Association of State Mental Health Program Directors.
- Mueser, K.T., Goodman, L.B., Trumbetta, S.L., Rosenberg, S.D., Osher, F.C., Vidaver, R., Auciello, P., and Foy, D.W. (1998). Trauma and posttraumatic stress disorder in severe mental illness. *Journal of Consulting and Clinical Psychology*, 66(3), Jun 1998, 493-499.
- Paton, D. and Johnston, D. (2001). Disasters and communities: Vulnerability, resilience and preparedness. *Disaster Prevention and Management*, 10(4), 270-277.
- Patrick, T.E. and Bryan, Y. (2005). Research strategies for optimizing pregnancy outcomes in minority populations. *American Journal of Obstetrics and Gynecology*, 192(5), S64-S70.
- Perry, B.D. (2001). Bonding and attachment in maltreated children: Consequences of emotional neglect in childhood. Houston, TX: The ChildTrauma Academy.
- Perry, B.D., Pollard, R.A., Blakley, T.L., Baker, W.L. and Vigilante, D. (1996). Childhood trauma, the

neurobiology of adaptation, and use-dependent development of the brain: How states become traits. *Infant Mental Health Journal*, 16(4), 271-291.

Robinson, K. (2009). *The element: How finding your passion changes everything*. New York: Penguin Group USA.

Salisan, S. (2011). Sine qua non for public health. *National Council Magazine*, 2011, Issue 2.

SAMHSA (2010). *Recovery oriented systems of care resource guide*. Rockville, MD: Substance Abuse and Mental Health Services Administration, Partners for Recovery.

SAMHSA (2012). Trauma definition. Retrieved January, 2013 from <http://www.samhsa.gov/traumajustice/traumadefinition/definition.aspx>.

SAMHSA-HRSA Center for Integrated Health Services. What is integrated care? Retrieved January, 2014 from <http://www.integration.samhsa.gov/about-us/what-is-integrated-care>.

SAMHSA. (2006). National consensus statement on mental health recovery. Rockville, MD: Center of Mental Health Services,

SAMHSA. (2009). Access to recovery (ATR) approaches to recovery-oriented systems of care: Three case studies. Rockville, MD: Center

SAMHSA. (2010). National summit on recovery from substance use disorders. Rockville, MD: Center for Substance Abuse

SAMHSA. (2010). Recovery-oriented systems of care (ROSC) resource guide. Rockville, MD: Center for Substance Abuse Treatment,

SAMHSA. (2011). SAMHSA News Release: SAMHSA Announces a Working Definition of “Recovery” From Mental Disorders

SAMHSA/CSAT (2000). Substance abuse treatment for persons with child abuse and neglect issues: TIP Series 36. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Scaer, R. (2005). *The trauma spectrum: Hidden wounds and human resiliency*. New York: W.W. Norton & Company.

Sheedy C. K., and Whitter M. (2009). *Guiding principles and elements of recovery-oriented systems of care: What do we know from the research?* HHS Publication No. (SMA) 09-4439. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

Sheedy, C. (2009). Guiding principles and elements of recovery-oriented systems of care: What do we know from the research? Rockville,

Siegel, D.J. (1999). *The developing mind: How relationships and the brain interact to shape who we are*. New York: The Guilford Press.

Siegel, D.L. (2007). *The mindful brain: Reflection and attunement in the cultivation of well being*. New York: W.W. Norton & Company.

Silow-Carroll, S. and Alteras, T. (2004). *Stretching state health care dollars: Care management to enhance cost-effectiveness*. New York: The Commonwealth Fund.

Substance Abuse and Mental Health Services Administration (SAMHSA) (2009). *Results from the 2008 National Survey on Drug Use and Health: National findings*. Rockville, MD: SAMHSA.

Substance Abuse and Mental Health Services Administration (SAMHSA) (2009). *Substance abuse treatment: Addressing the specific needs of women*. Rockville, MD: SAMHSA.

Substance Abuse and Mental Health Services Administration (SAMHSA) (2009). *Substance abuse treatment for persons with co-occurring disorders*. Rockville, MD: SAMHSA.

Substance Abuse and Mental Health Services Administration (SAMHSA) (2009). *Results from the 2008 National Survey on Drug Use and Health: National findings*. Rockville, MD: SAMHSA.

Substance Abuse and Mental Health Services Administration (SAMHSA) (2009). *Substance abuse treatment: Addressing the specific needs of women*. Rockville, MD: SAMHSA.

Substance Abuse and Mental Health Services Administration (SAMHSA) (2009). *Substance abuse treatment for persons with co-occurring disorders*. Rockville, MD: SAMHSA.

Tanielian, T. and Jaycox, L.H., Eds. (2008). *Invisible wounds of war: Psychological and cognitive injuries, their consequences, and services to assist recovery*. Santa Monica, CA: The Rand Corporation.

Tough, P. (2011). The poverty clinic: Can a stressful childhood make you a sick adult? *The New Yorker*, March 21, 2011.

U.S. Department of Health and Human Services (2001). *The national standards for culturally and linguistically appropriate services in health and health care: Final report*. Washington, DC: U.S. Department of Health and Human Services, Office of Minority Health.

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2010). *Child maltreatment 2008*.

van der Kolk, B.A. (1994). The body keeps the score: Memory and the evolving psychobiology of post traumatic stress. *Harvard Review of Psychiatry*, 1(5), 253-265. Ledoux, J. (1996). *The emotional brain: The mysterious underpinnings of emotional life*. New York: Simon and Schuster.

van der Kolk, B.A., McFarlane, A.C., and Weisaeth, L. (1996). *Traumatic stress: The effects of overwhelming experience on mind, body, and society*. New York: The Guilford Press.

van der Kolk, Bessel A. (1996). The complexity of adaptation to trauma: Self-regulation, stimulus discrimination, and characterological development. In van der Kolk, Bessel A. (Ed); McFarlane, Alexander C. (Ed); Weisaeth, Lars (Ed). *Traumatic stress: The effects of overwhelming experience on mind, body, and society* (pp. 182-213). New York: Guilford Press.

Virkkunen, M. (1979). Serum cholesterol in antisocial personality. *Neuropsychobiology*, 5(1), 27-30.

White, W. (1996). *Pathways from the culture of addiction to the culture of recovery: A travel guide for addiction professionals* (2nd ed.). Center City, MN: Hazelden.

White, W. (1997). *The incestuous workplace: Stress and distress in the organizational family* (2nd ed.). Center City, MN: Hazelden.

White, W. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Bloomington, IL: Chestnut Health Systems/Lighthouse Institute.

White, W. (2000). Addiction as a disease: Birth of a concept. *Counselor*, 1(1), 46-51, 73.

White, W. (2006). Let's go make some history: Chronicles of the new addiction recovery advocacy movement (Papers of William L. White). Washington, D.C.: Johnson Institute and Faces and Voices of Recovery.

White, W. (2007). Perspectives on Systems Transformation: How Visionary Leaders are Shifting Addiction Treatment Toward a Recovery-Oriented System of Care. (Interviews with H. Westley Clark, Thomas A. Kirk, Jr., Arthur C. Evans, Michael Boyle, Phillip Valentine and Lonnetta Albright). Chicago, IL: Great Lakes Addiction Technology Transfer Center.

White, W. (2008). Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices. Pittsburgh, PA: Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health & Mental Retardation Services.

White, W. (2009). Peer-based addiction recovery support: History, theory, practice and scientific evaluation. Chicago, IL: Great Lakes

White, W. (2009). Peer-based Addiction Recovery Support: History, Theory, Practice, and Scientific Evaluation. Chicago, IL: Great Lakes Addiction Technology Transfer Center and Philadelphia Department of Behavioral Health and Mental Retardation Services.

White, W. (2011). The Recovery-focused transformation of addiction treatment: An interview with Arthur C. Evans, Jr., PhD. Posted at www.williamwhitepapers.com; published in abridged form in *Counselor*

White, W. & Kurtz, E. (2006). Linking Addiction Treatment and Communities of Recovery: A Primer for Addiction Counselors and Recovery Coaches. Pittsburgh, PA: IRETA/NeATTC.

White, W. and Tuohy, C.M. (2013). Recovery-oriented practice and the addictions professional: A systems perspective. *Advances in Addiction and Recovery (NAADAC)*, Summer Issue, pp. 22-23.

White, W., & Popovits, R. (2000). Critical incidents: Ethical issues in the prevention and treatment of addiction (2nd ed.). Bloomington, IL: Chestnut Health Systems/Lighthouse Institute.

White, W., Hennessey, M., Oberg, D., and Sonnevile, D. (1990. Ed. 2002). Project SAFE: A developmental model of recovery. Bloomington, IL: Chestnut Health Systems.

White, W., Kurtz, E. & Sanders, M. (2006). Recovery Management. Chicago, IL: Great Lakes Addiction Technology Transfer Center.

White, W.L. (2008). *Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices*. Pittsburgh, PA: Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, and Philadelphia Department of Behavioral Health and Mental Retardation Services.

White, W.L. (2012). Recovery/Remission from Substance Use Disorders: An Analysis of Reported Outcomes in 415 Scientific Studies, 1868-2011. Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health and Intellectual Disability Services and Northeast Addiction Technology Transfer Center.

- White, W.L., Clark, H.W., Kirk, T.A., Evans, A.C., Boyle, M., Valentine, P., and Albright, L. (2007). *Perspectives on systems transformation: How visionary leaders are shifting addiction treatment toward a recovery-oriented system of care*. Chicago, IL: Great Lakes Addiction Technology Transfer Center.
- Woll, P. (2009). *The power and price of survival: Understanding resilience, stress, and trauma*. Chicago, IL: Human Priorities.
- Woll, P. (2013). Trauma-informed healthcare integration: Using the science to shape the conversation.
- Woll, P., Evans, A.C., Ali, S., Ashley, A.M., Berkowitz, S., Bloom, S.L., Cohen, J., Foa, E., Hurford, M.O., Jackson, K., Valdes, A., White, K.K., and Zinny, A. (2013). Seeding a system's response to trauma: Philadelphia's integrated network of trauma-informed and trauma-focused behavioral health care. Philadelphia, PA: Department of Behavioral Health and Intellectual disAbility Services.
- Woll, P., Evans, A.C., Ali, S., Ashley, A.M., Berkowitz, S., Bloom, S.L., Cohen, J., Foa, E., Hurford, M.O., Jackson, K., Valdes, A., White, K.K., and Zinny, A. (2013). Meeting trauma with transformation: The evolution of Philadelphia's behavioral health response. Philadelphia, PA: Department of Behavioral Health and Intellectual disAbility Services.
- Woll, P., Evans, A.C., Berkowitz, S., Jackson, K., and Achara-Abrahams, I. (2013). Safety, strength, resilience, and recovery: Trauma-informed systems and communities. Philadelphia, PA: Department of Behavioral Health and Intellectual disAbility Services.
- Yehuda, R. and Bierer, L.M. (2007). Transgenerational transmission of cortisol and PTSD risk. *Progress in Brain Research*, 167, 121-135.
- Yehuda, R., Ed. (2002). *Treating trauma survivors with PTSD*. Washington, DC: American Psychiatric Publishing, Inc.

PART VI

UNIT 6: SUPPORTED EMPLOYMENT, EDUCATION, AND PEER DELIVERED SUPPORT

This unit looks at the principles of supported employment and education and how this added support helps clients achieve their goals. Knowledge of these principles helps Peer Support Specialists understand how to best assist clients in addressing their employment and educational goals.

Unit 6 includes the NAMI pamphlet “Road to Recovery: Employment and Mental Illness.” Certified Recovery Support Specialists need to understand some of the logistical problems that are a result of an entitlement system whose payout is based on a formula impacted by hours worked and the time frame in which this occurs. Models of employment support are covered along with employment data analysis, trends and policy recommendations.

The video in Unit 6 provides perspectives on how education is best supported in the various systems of education from traditional to non-traditional. This is where theory meets the reality of the system.

The unit concludes with an overview of Peer Recovery Support services to be able to put the supported education and employment models in the context of peer support services.

Unit Objective:

- Identify resources that support employment and education

CORE PRINCIPLES OF SUPPORTED EMPLOYMENT/INDIVIDUAL PLACEMENT & SUPPORT: THE EVIDENCE-BASED PRACTICE

Core Principles

ZERO EXCLUSION

All people who want to work are eligible for employment services and receive help even if they

- Have experienced job loss(es) in the past
- Lose a job(s) while enrolled in SE/IPS
- Are still experiencing symptoms of mental illness
- Experience cognitive impairments (e.g., memory, problem-solving difficulties)
- *Are still using alcohol or other drugs
- Have a criminal history
- Do not know how to fill out an application or talk to employers
- Do not have previous job training or work experience
- Are afraid they might not learn the job fast enough
- Are afraid they might not fit in with others

*The use of alcohol and other drugs may limit job choices because many employers test for drug use. If job applicants can pass a drug test, their choices of jobs typically increase.

INTEGRATED EMPLOYMENT & TREATMENT

SE/IPS is integrated with (embedded in) mental health services. Employment specialists attend team meetings and work closely with case managers, psychiatrists, and other professionals to help people achieve their employment goals. Team members openly discuss and find solutions for issues that affect work and recovery, such as the following:

- Medication side effects (e.g., drowsiness)
- Persistent symptoms (e.g., hallucinations)
- Cognitive difficulties (e.g., problem-solving skills)
- Other rehabilitation needs (e.g., social skills, transportation, childcare)

COMPETITIVE JOBS

Competitive employment is the goal of SE/IPS services. Competitive jobs are regular jobs that anyone in the community can apply for. They are not jobs set aside for people with disabilities. Employment specialists help consumers of mental health services find regular part-time or full-time jobs that pay a minimum wage or more. Consumers are paid the same as other people who perform similar work. SE/IPS endorses competitive jobs for several reasons:

- Consumers like them more than sheltered work.
- They reduce stigma and discrimination by enabling consumers to work side-by-side with people who do not have psychiatric disabilities.
- They promote self-sufficiency, financial stability, and career development over time.
- They support positive self-worth.

RAPID JOB-SEARCH

As soon as people express an interest in employment, service team members connect them with employment specialists. In two to three weeks, specialists are helping consumers explore the job market, fill out applications, and interview with potential employers. Specialists do not require individuals to complete pre-employment assessments, training, workshops, and intermediate work experiences. A rapid job-search honors each person's desire to work.

SYSTEMATIC JOB DEVELOPMENT

Getting to know employers helps people find jobs that meet their strengths, needs, abilities, and preferences. Employment specialists build relationships with employers through planned in-person contacts over time. The face-to-face time enables specialists and employers to work together to find the right fit (or match). Employment specialists keep in mind the job preferences of the people they represent and ask about and listen for many different opportunities at each worksite. Specialists keep themselves attuned to the quality of work environments, the potential for flexible hours, and the potential for workplace adjustments that will accommodate individual strengths, skills, symptoms, and coping skills.

TIME-UNLIMITED SUPPORT

Follow-along services help people through their work and recovery journeys for as long as they want or need them. These supports are provided by employment specialists, case managers, other service providers, and by natural supports, including family members, friends, co-workers, and other peers. Examples of follow-along services include:

- On-the-job supports (e.g., job coaching)
- Job transitions (e.g., to new roles within a business, to new jobs at different businesses)

The goal of time-unlimited support is to help individuals become as independent as possible.

CONSUMER PREFERENCES

Service providers keep their attention focused upon the employment goals of people they serve and do not impose their ideas or plans. Service providers utilize motivational approaches to help individuals identify their personal strengths, skills, and job interests. People who find jobs that they want tend to experience a higher level of satisfaction and tend to keep their jobs longer. Individual preferences guide all aspects of the employment process, such as:

- Job searches
- Decisions to disclose personal issues to employers or not (e.g., disabilities, symptoms)
- Level of ongoing support from service providers

BENEFITS PLANNING

It is important for individuals to know how their jobs (earned income) might impact benefits such as Medicaid, Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), and housing subsidies. To help people make informed choices about their financial futures, employment specialists and other service providers learn the basics of benefits information. They also

- Help individuals understand benefits requirements (rules) and other regulations related to benefits & employment
- Help find benefits planners, who calculate the impact that income from employment will have upon various benefits
- Assist with reporting of income to different benefits providers

- Assist with identifying and documenting available work incentives

Citation

The Ohio Supported Employment Coordinating Center of Excellence. Core Principles of Supported Employment/Individual Placement & Support: The Evidence-Based Practice. 2012.

SUPPORTED EMPLOYMENT: HELPING PEOPLE WITH MENTAL ILLNESSES FIND AND KEEP JOBS

What is Supported Employment?

Supported Employment helps people with mental illnesses find and keep meaningful jobs in the community.

Why participate in Supported Employment?

When people feel good about having a job, they often see themselves in a more positive way. Work gives people structure and routines. Having an income gives them more choices about what to buy and where to live.

How does Supported Employment work?

Consumer choice

No one is excluded from participating.

Integrated services

Employment specialists closely coordinate with other rehabilitation and clinical treatment practitioners, creating a comprehensive treatment program.

Competitive jobs

Employment specialists help people find jobs in the open labor market that pay at least minimum wage and that anyone could have, regardless of their disability status.

Benefits counseling

Employment specialists help people understand how benefits (such as Social Security or Medicaid) are affected by working. Most people are able to work and continue to receive some benefits.

Timely support

Employment specialists help people look for jobs soon after they enter the program.

Continuous supports

Once a job is found, employment specialists provide ongoing support, as needed.

Consumer preferences

Choices about work are based on a person's preferences, strengths, and experiences.

Citation

Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (HHS). Supported Employment: Helping people with mental illnesses find and keep jobs. 2012.

This work resides in the public domain, unless otherwise indicated.

ROAD TO RECOVERY: EMPLOYMENT AND MENTAL ILLNESS

Road to Recovery: Employment and Mental Illness by NAMI, the National Alliance on Mental Illness, can be found on the organization's website. This 2014 report can be read online or you can download the PDF.

<https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/>

RoadtoRecovery

SUPPORTING PEOPLE IN RECOVERY TO ACCESS AND ENGAGE IN EDUCATION



One or more interactive elements has been excluded from this version of the text. You can view them online here: <https://cod.pressbooks.pub/therecoveryprocess/?p=356#oembed-1>

WHAT ARE PEER RECOVERY SUPPORT SERVICES?

Aisha says she knows many people who tried treatment for a substance use disorder; they also tried 12- Step meetings. Neither worked. Her friends are back on the street, still using. Anyway, Aisha doesn't have time to attend treatment sessions or go to meetings; she has a full-time job and is busy raising her two grandchildren because their mother is in prison.

Roger has just been released from jail. He has been clean for the 90 days of his incarceration, and he thinks he can stay clean if he can just find a job and a place to live with other people in recovery.

Elizabeth tells her treatment counselor that payday is her trigger, and that she needs an alcohol- and drug-free place to go and socialize on Friday evenings. She adds that it would be helpful if she could bring her children.

Luis says he understands that his AA meeting is not the place to discuss the complications he is encountering with his hepatitis C medications. But he needs someone to talk to because managing his response to the medications and his recovery at the same time is just too much for him to handle.

Bodie has been in recovery for a year. He is looking for an opportunity to be of service and to strengthen his recovery by giving back to the community. He loves gospel music and sings in his church choir.

Introduction

What do all these people have in common? Although they are at different points in the process of recovering from a substance use disorder, each is expressing a need for some form of social support to help them through the process. Equally important, each is also a potential source of social support for others.

In this paper on *What Are Peer Recovery Support Services*, you will be introduced to a new kind of social support services designed to fill the needs of people in or seeking recovery. The services are called peer recovery support services and, as the word peer implies, they are designed and delivered by people who have experienced both substance use disorder and recovery. Through the Recovery Community Services Program (RCSP), the Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment (SAMHSA/CSAT) funds grant projects across the country to develop and deliver these services.

The peer recovery support services developed by the RCSP projects help people become and stay engaged in the recovery process and reduce the likelihood of relapse. Because they are designed and delivered by peers who have been successful in the recovery process, they embody a powerful message of hope, as well as a wealth of experiential knowledge. The services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking to achieve or sustain recovery.

Social Support for Recovery

Research has shown that recovery is facilitated by social support (McLellan et al., 1998), and four types of social support have been identified in the literature (Cobb, 1976; Salzer, 2002): emotional, informational, instrumental, and affiliational support. RCSP projects have found these four types of social support useful in organizing the community-based peer-to-peer services they provide to recovering people. (Some typical examples are shown in Figure 1 below.) These four categories refer to types of social support, not discrete services or service models.

For example, a project that is planning social support services to address recovering people’s employment needs might consider whether a job referral (informational support) by itself is adequate, or whether emotional support (such as supportive coaching to prepare for an interview), and/or instrumental support (such as help cleaning up a criminal record) might also be needed. In general, the more robust the types of social support available to address any given recovery concern, the more likely that a person seeking help will walk away with useful information, a new insight or skill, or more confidence to help with the tasks ahead.

Peer Leaders and the Peer Service Alliance

RCSP projects use the term peer to refer to all individuals who share the experiences of addiction and recovery, either directly or as family members or significant others. In a peer-helping-peer service alliance, a peer leader in stable recovery provides social support services to a peer who is seeking help in establishing or maintaining his or her recovery. Both parties are helped by the interaction as the recovery of each is strengthened.

Figure 1 – Type of Social Support and Associated Peer Recovery Support Services

Type of Support	Description	Peer Support Service Examples
Emotional	Demonstrate empathy, caring, or concern to bolster person’s self-esteem and confidence.	Peer mentoring, Peer-led support groups
Informational	Share knowledge and information and/or provide life or vocational skills training	Parenting class, Job readiness training, Wellness seminar
Instrumental	Provide concrete assistance to help others accomplish tasks.	Child care, Transportation, Help accessing community health and social services
Affiliational	Facilitate contacts with other people to promote learning of social and recreational skills, create community, and acquire a sense of belonging.	Recovery centers, Sports league participation, Alcohol- and drug-free socialization opportunities

RCSP projects use many other titles besides peer leader and peer to describe the parties to the peer service

alliance. On the peer leader side of the equation, titles include recovery (or peer) mentor, guide, or coach; peer services interventionist; firestarter; and peer resource specialist. (Firestarters are peer leaders responsible for building local recovery communities in Native American communities.) The peer who seeks help also is given different titles in different RCSP projects, such as member (of the peer services organization), mentee, or simply peer. Most project leaders have consciously sought to find and use identifying terms that distinguish their peer services and service providers from those in formal, 3 professional treatment programs or in mutual aid groups conducted by lay persons. For this reason, terms such as counselor, case manager, or sponsor, as well as client, consumer, or patient, are avoided.

The RCSP projects' attention to language reflects the need to clearly distinguish the role of the peer leader from the role of the treatment counselor or other professional and the 12-Step sponsor (White, 2006). RCSP projects are intended by CSAT to enhance—not duplicate, replace, or compete with—valuable services already available in a community. Thus, in addition to using language which is not associated with treatment or mutual aid programs, axioms such as the following are commonly heard: “Peers do not diagnose;” “Peers do not provide therapy;” “Peers do not give advice.” Similarly, it is common to hear, “You need to ask your sponsor, not me, for help working the 12-Steps,” or “That’s a question for the doctor or nurse.”

Peer Recovery Support Service Activities

The RCSP peer recovery support service projects have developed a variety of peer services. Not all programs provide all services, and some peer leaders may provide more than one service. The following is a useful overview of the four major types of recovery support services emerging in RCSP projects: (1) peer mentoring or coaching, (2) recovery resource connecting, (3) facilitating and leading recovery groups, and (4) building community.

Peer Mentoring or Coaching

Although the name given to this service activity varies from project to project, the terms mentoring or coaching refer to a one-on-one relationship in which a peer leader with more recovery experience than the person served encourages, motivates, and supports a peer who is seeking to establish or strengthen his or her recovery.

The nature and functions of mentoring or coaching vary from one RCSP project to another. Generally, mentors or coaches assist peers with tasks such as setting recovery goals, developing recovery action plans, and solving problems directly related to recovery, including finding sober housing, making new friends, finding new uses of spare time, and improving one’s job skills. They may also provide assistance with issues that arise in connection with collateral problems such as having a criminal justice record or coexisting physical or mental challenges.

The relationship of the peer leader to the peer receiving help is highly supportive, rather than directive. The duration of the relationship between the two depends on a number of factors such as how much recovery time

the peer has, how much other support the peer is receiving, or how quickly the peer's most pressing problems can be addressed.

RCSP projects distinguish the role of the peer mentor or coach from that of a 12-Step sponsor in several ways. For example, the sponsor works within the 12-Step framework and is expected to help the person in early recovery understand and follow the specific guidance of the 12-Step program. The typical RCSP recovery mentor or coach, on the other hand, is often described as helping peers in early recovery make choices about which recovery pathway(s) will work for them, rather than urging them to adopt the mentor's or coach's own program or any specific program of recovery. The mentor or coach is often described as devoting a greater amount of time than the typical 12-Step sponsor to connecting the person in early recovery to community health, employment, housing, educational, and social services and resources and often has more specific knowledge about a larger range of available services and resources.

Peer Recovery Resource Connecting

The service activities of peer leaders in connecting peers to recovery resources might be likened to case management in substance use disorder treatment. The purpose of resource connecting services is to connect the peer with professional and nonprofessional services and resources available in the community that can help meet his or her individual needs on the road to recovery. The peer leader working in a peer setting to provide recovery resource connecting services often has had personal experience navigating the service systems and accessing the resources to which referral is being made, and can bring those personal experiences to bear.

Peer recovery support services provided in RCSP projects typically can help peers with their most pressing early recovery needs—finding a safe place to live and a job. Thus, peer leaders are likely to refer peers to safe housing or to sources of information about housing and to a wide variety of resources and services that provide assistance in developing job readiness or finding jobs. Peer leaders also help peers navigate the formal treatment system, advocating for their access and gaining admittance, as well as facilitating discharge planning, typically in collaboration with treatment staff.

Peer leaders also encourage and support participation in mutual aid groups and provide specific information about the various groups that exist in the community. They encourage and facilitate participation in educational opportunities. Depending on the particular needs of the population they serve, they also may focus on developing linkages to resources that address specialized needs, such as agencies providing services related to HIV infection or AIDS, mental health disorders, chronic and acute health problems, parenting young children, and problems stemming from involvement with the criminal justice system.

Self-disclosure and using one's own story as means of enhancing the value of the service is an

important dimension of the recovery mentoring or coaching role. In addition, a peer mentor or coach implicitly holds himself or herself out as a recovery role model. As described by William White, this core competency entails “modeling of core recovery values (e.g., tolerance, acceptance, gratitude); the capacity for self-observation, self-expression, sober problem-solving; recovery-based reconstruction of personal identity and interpersonal relationships; freedom from coercive institutions; economic self-sufficiency; positive citizenship and public service.” (White, 2006)

Facilitating and Leading Recovery Groups

In addition to conducting one-on-one coaching or mentoring and resource connecting activities, many peer leaders facilitate or lead recovery-oriented group activities. Some of these activities are structured as support groups, while others have educational purposes. Many have components of both.

The group activities that are structured as support groups typically involve the sharing of personal stories and some degree of collective problem-solving. Many of these groups are formed around shared identity, such as belonging to a common cultural or religious group, or shared experience related to the substance use disorder, such as the need to re-enter the community following incarceration, being HIV positive, or facing challenges in parenting. Many, but not all, group activities conducted by peer leaders have a spiritual component.

The group educational activities tend to focus on a specific subject or skill set, and may involve the participation of an expert as well as peer leaders. Typical topics and activities include training in job skills, budgeting and managing credit, and preventing relapse, as well as courses particularly targeted to people in recovery, such as conflict resolution grounded in recovery skills.

A number of RCSP projects have expanded beyond just linking people to existing resources and services to creating new recovery support services in the community. These efforts have ranged from active recruitment of recovery-friendly employers to the organization of a recovery-friendly network of dentists who offer free or deeply-discounted services to people whose early recovery is jeopardized by dental problems developed during their addiction. One project has increased the statewide stock of recovery housing through a technical assistance initiative that

helps peer leaders establish and operate recovery homes that adhere to an agreed-upon set of standards.

Building Community

A person in early recovery is often faced with the need to abandon friends and/or social networks that promote and help sustain a substance use disorder, but has no alternatives to put in their place that support recovery. Peer recovery support service providers can help such peers make new friends and begin to build alternative social networks. Peer leaders in RCSP projects often organize recovery-oriented activities that range from opportunities to participate in team sports to family-centered holiday celebrations and to payday get-togethers that are alcohol- and drug-free. These activities provide a sense of acceptance and belonging to a group, as well as the opportunity to practice new social skills.

A number of RCSP grantees have created recovery community centers as “places where recovery happens.” Many types of peer service activities—such as mentoring and coaching, connecting to resources, support and educational groups—take place at these centers. At the core of the effort is the nurturing of a caring recovery community, with shared norms and values, which is dedicated to supporting the recovery of all who seek it. These centers “bring recovery to Main Street” and, by making recovery visible, carry a message of hope to the larger community.

Volunteer and Staff Peer Leaders

Peer recovery support services capitalize on the often recognized desire among many in recovery to “give back” to their communities by providing services to others. Most of the RCSP peer leaders who give back by providing peer recovery support services have done so as volunteers. In some projects, however, peer leaders are paid for their services as staff. In a few projects, peer leaders are not staff, but receive stipends for their work.

All recovery support programs require effective management and all peer leaders, irrespective of their status as paid staff, volunteers, or recipients of stipends, require effective supervision. The range of supervisory

tasks may vary, however, depending on the status of the peer leaders as paid or unpaid volunteers or staff. Recruiting and retaining effective volunteers, for example, requires somewhat different techniques than hiring and keeping effective paid staff. The tenure of volunteers may be shorter than that of paid staff, requiring constant recruiting and training of volunteers. A project that relies on volunteers may use community organizing strategies to develop a strong volunteer base, while a project that relies solely on paid staff will be more likely to use standard employee recruitment processes. Moreover, staff time is typically allocated differently in a volunteer-oriented organization. Little staff time is devoted to direct service; staff effort is primarily directed at recruiting, training, and supervising peer leaders; developing and maintaining an organizational culture that incorporates principles of selfcare; and various other tasks related to organizational development, stakeholder development, and sustainability.

Whether the project uses paid or volunteer peer leaders also may affect how the project translates the range of peer leader direct service roles and functions into specific job or volunteer position descriptions. The project that relies primarily on volunteers who can dedicate 20 hours of service each month may distribute peer service roles and functions into volunteer positions that are narrower in scope than the roles and functions included in job descriptions developed by a project that relies primarily on peer leaders in fulltime staff positions. A paid peer leader, for example, might be expected to provide one-on-one mentoring and facilitate groups; a volunteer position might include mentoring or facilitation, but not both.

The Adaptability of Peer Recovery Support Services

One strength of peer recovery support services has been their adaptability to many stages and modalities of recovery, as well as to different service settings and organizational contexts. This adaptability makes them an effective vehicle for extending support for recovery beyond the treatment system and into the communities where people live and to people following different pathways to recovery. On the other hand, because of the variations in settings, organizational contexts, and recovery stages and pathways, identifying commonalities in peer recovery support services can be challenging.

Different Recovery Stages and Approaches

Peer leaders can provide social support services to individuals at all stages on the continuum of change that constitutes the recovery process. The Prochaska, Norcross, and DiClementi (1995) stages of change model has identified the stages of precontemplation, contemplation, determination/preparation, action, maintenance, and relapse. Whether peers are familiar with these stages of change or not, most can relate to the idea that recovery takes place in stages. RCSP projects have developed peer recovery support services that meet needs of people at different stages of the recovery process. The services may:

- Precede formal treatment, strengthening a peer's motivation for change

- Accompany treatment, providing a community connection during treatment
- Follow treatment, supporting relapse prevention
- Be delivered apart from treatment to someone who cannot enter the formal treatment system or chooses not to do so.

Furthermore, peer services can provide social support within the context of many different pathways to recovery, including pathways that are predominantly religious, spiritual, or secular; involve medication assistance; or focus on cultural survival and renewal as avenues to recovery.

Varied Service Settings

RCSP grant projects deliver peer services in a variety of settings including recovery community organizations, recovery centers, churches, child welfare organizations, recovery homes, drug courts, prerelease jail and prison programs, parole and probation programs, behavioral health agencies, and HIV/AIDS and other medical or social service centers. Peer leaders work in urban and rural communities with many different populations, including those defined by age (e.g., adolescents, elders), race or ethnicity (e.g., Asian/Pacific Islander American, Latino or Hispanic American, Native American, Caucasian), gender (e.g., women) or by co-existing conditions (e.g., HIV/AIDS and other infectious diseases, mental health disorders, homelessness, or a criminal record).

Variations in Organizational Contexts

Some RCSP projects are free-standing nonprofit recovery community organizations operated by members of the recovery community. Others reside within a host agency. These host agencies include those involved in the field of substance use disorders, including treatment providers; agencies that focus on the continuum of social service needs of specific populations, including those related to substance use; and agencies with a primary focus on challenges such as HIV/AIDS, post incarceration re-entry to the community, or children at risk of abuse or neglect. Each type of organizational context has its own culture and perspective on substance use disorders and recovery and presents its own opportunities and challenges in the establishment and operation of a peer recovery support service program.

These stages of recovery, pathways to recovery, service settings, and organizational contexts can present very different challenges to the peer recovery support services program. One project, for example, may be a new free-standing recovery community organization that is faced not only with the task of designing and delivering peer recovery support services, but also with the tasks of building a board of directors and developing the fiscal infrastructure to handle a Federal grant. Another may be housed in a host agency that is a seasoned nonprofit that has been handling Federal grants successfully for years, but is rooted in a service system that is inexperienced with working with people in or seeking recovery. One may work almost exclusively with peers

who have completed formal treatment, while another may work with peers who have not yet acknowledged that their substance use is a problem.

Some Important Cross-Project Principles

Notwithstanding important differences among RCSP projects, certain core principles cut across projects. One key principle is having shared values. In the RCSP experience, shared values have, in turn, given rise to other key principles, including a preference for strength-based approaches and a service philosophy that nurtures self-direction, empowerment, and choice.

Shared Values

RCSP project participants have identified core values that inform the task of organizing the recovery community to provide peer recovery support services. These include:

- **Keeping recovery first**—Placing recovery at the center of the effort, grounding peer services in the strengths and inherent resiliency of recovery rather than in the pathology of substance use disorders.
- **Cultural diversity and inclusion**—Developing a recovery community peer support services program that honors different routes to recovery and has leaders and members from many groups at all levels within the organization.
- **Participatory process**—Making sure the recovery community directs or is actively involved in project design and implementation, so that recovery community members can identify their own strengths and needs, and design and deliver peer services that address them.
- **Authenticity of peers helping peers**—Drawing on the power of example, as well as the hope and motivation, that one person in recovery can offer to another; providing opportunities to give back to the community; and embracing the notion that both people in a relationship based on mutuality can be helped and empowered in the process.
- **Leadership development**—Building leadership abilities among members of the recovery community so that they are able to guide and direct the service program and deliver support services to their peers.

Many projects have identified additional core values, but virtually all subscribe to at least these five. RCSP projects have used these core values as a platform on which to build codes of ethics and as a guide to their development of practice guidelines for peer leaders.

Focus on Strengths and Resiliencies

A peer recovery support services program that incorporates a strengths perspective builds on people's

resiliencies and capacities rather than providing services focused primarily on correcting their deficits, disabilities, or problems. Emphasis is on uncovering, reaffirming, and enhancing the abilities, interests, knowledge, resources, aspirations, and hopes of individuals, families, groups, and communities. This approach assumes that the ability to recognize one's own strengths and identify internal and external resources enhances a person's chances of success in setting and achieving goals and in realizing his or her aspirations.

RCSP peer recovery support service programs have adopted the strengths perspective in multiple contexts. In the relationship between a peer leader and a peer seeking help, for example, recovery planning does not start with a process that identifies deficits and disabilities, but rather with a conversation intended to uncover the peer's interests, abilities, and goals. One of the peer's goals is likely to be a sustained change in substance use behavior. Goals are likely to address other life domains as well, such as housing, employment, education, family and social relationships, recreational opportunities, and physical, mental, or spiritual health.

As the individual's goals become clear, the peer leader can help the peer identify the resources and skills that need to be marshaled to attain the goals. The peer may already possess some of these resources, skills, and talents and may even have demonstrated them during the active stages of a substance abuse disorder; he or she may need help in developing others, in some cases seeking an external source for help in developing new capacities. These ingredients—the articulation of the peer's own goals and desires, in his or her own words, and an enumeration and affirmation of his or her specific capacities to marshal resources to achieve them—form the foundation of an empowering recovery plan.

RCSP projects also have adopted strengths-based approaches to the recovery community, as well as to the larger community. By engaging the recovery community in all aspects of the identification, planning, and delivery of peer recovery support services, projects have expressly built upon the strengths and insights of those who are working to achieve and sustain their own recovery goals and are willing to give back to the community through the peer recovery support effort. Similarly, they actively work within the larger community to identify and strengthen existing services and resources that can support recovery. Peer services function as a bridge to a larger network of community support. As one project director noted, “We are building our community's capacity to care.”

Many RCSP projects have benefited from conducting comprehensive community strengths and needs assessments. This type of assessment—which may be ongoing throughout the life of the project—identifies services and resources available both in the recovery community and in the community at large that can support recovery. The assessment creates multiple opportunities for people in and seeking recovery, as well as family members, significant others, and stakeholders, to identify, in their own words, what has worked for them, what they think is needed, and what they can contribute to the peer effort. In addition to helping ensure that a project develops services that fill gaps, rather than competing with services and resources already available in the community, the strengths and needs assessment identifies important resources within the recovery community and the larger community that can contribute to the development of strong peer services and/or provide assistance that recovering people need. The assessment also facilitates the building of important

stakeholder relationships and serves as a foundation for effectively connecting people to resources in the community that support recovery.

Many peer recovery support service programs have developed peer leader training programs to help peer leaders build skills in strengths-based recovery planning. These include training in the use of motivational interviewing techniques, adapted for peer leaders. In addition, many programs have found it important to continually reinforce their commitment to strength-based services through program procedures and guidelines and ongoing supervision. Both peer leaders and peers seeking help may be more familiar with service systems that are focused more on naming and reducing deficits and pathologies than on naming and nurturing strengths. Moreover, the stigmas associated with substance use disorders encourage patterns of shame and blame. Training and positive reinforcement can help prevent peer leaders from slipping back into deficit-based ways of thinking.

Self-Direction, Empowerment, and Choice

Embedded in the shared values of RCSP peer recovery support services is a philosophy of self-direction, choice, and empowerment. The many pathways to recovery are acknowledged, the person seeking recovery is assumed to be fully capable of making informed choices, and his or her preferences are respected.

In practice, carrying out the principles of self-direction, empowerment, and choice has sometimes been challenging to peer leaders. In the first place, they have often needed to become well-informed about pathways to recovery different from their own. In some cases, project leaders have had to combat their own misconceptions about, and prejudices against, certain recovery modalities, such as recovery assisted by medication or grounded in religious belief.

Furthermore, the assumption that the person seeking recovery is fully capable of making informed choices may not always fit the circumstances, particularly when neurological impairment is significant or when acute or severe psychiatric symptoms are associated with an active substance use disorder or early recovery. This can require a peer leader to know when to strike a delicate balance between respect for the peer's rights of choice and a need to keep the recovery process simple for the time being.

Several RCSP projects use asset mapping to uncover the community's natural assets (people, organizations, places, and things) that support recovery and to build stronger connections between these assets and people who are seeking recovery. In addition, these projects seek to foster mutually beneficial relationships with the individuals and organizations that are responsible for these assets. These asset-mapping strategies, and the asset-based community development theory (Kretzmann & McKnight, 1993) on which they are based, are a comfortable fit with the strength-based philosophy of most RCSP peer recovery support services.

The Many Values of Peer Recovery Support Services

Historically, the substance use disorder and recovery field led the way in recognizing the importance of peer support services for a person seeking to come to terms with a life-changing condition. Utilization of peer support is, by now, a common practice in many fields. In the medical world of today, for example, there is scarcely a specialty where peer support is not recognized as a valuable adjunct to professional medical and social interventions. Improved outcomes are particularly notable when peer support services are provided to people with chronic conditions that require long-term self-management. Thus, the peer recovery support services offered by RCSP grant projects and others stand in a long, well-documented, and copied evidence-based tradition.

Peer recovery support services can fill a need long recognized by treatment providers for services to support recovery after an individual leaves a treatment program. In addition, peer recovery support services hold promise as a vital link between systems that treat substance use disorders in a clinical setting and the larger communities in which people seeking to achieve and sustain recovery live. Using a nonmedical model in which social support services are provided by peer leaders who have experienced a substance use disorder and recovery, these services extend the continuum of care by facilitating entry into treatment, providing social support services during treatment, and providing a post-treatment safety net to those who are seeking to sustain treatment gains.

These services are proving to be very adaptable, operating within diverse populations, stages of recovery, pathways to recovery, service settings, and organizational contexts. Notably, they build on resources that already exist in the community, including diverse communities of recovering people who wish to be of service. By serving as role models for recovery, providing mentoring and coaching, connecting people to needed services and community supports, and helping in the process of establishing new social networks supportive of recovery, peer leaders make recovery a presence in their communities and send a message of hope fulfilled.

Citation

Center for Substance Abuse Treatment, What are Peer Recovery Support Services? HHS Publication No. (SMA) 09-4454. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009.

This work resides in the public domain, unless otherwise indicated.

References and Additional Resources

Kretzmann, J.P. and McKnight, J.L. (1993) Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets, Evanston, IL: Institute for Policy Research.

Loveland, D., and Boyle, M. (2005). Manual for Recovery Coaching and Personal Recovery Plan Development. Peoria, IL: Fayette Companies.

McLellan, A.T., Hagan, T.A., Levine, M., Gould, F., Meyers, K. and Bencivengo, M., et al. (1998). Research report: Supplemental social services improve outcomes in public addiction treatment. *Addiction*, 93(10), 1489-1499.

Prochaska, J., Norcross, J., and DiClemente, C. (1995). *Changing for Good*. New York: HarperCollins Books.

Rapp, R.C. (2002) Strength-Based Case Management: Enhancing Treatment for Persons with Substance Abuse Problems, in Saleebey, D., ed., *The Strengths Perspective in Social Work Practice*, 3rd ed., Allyn & Bacon, Boston, MA.

Salzer, M. (2002). Best practice guidelines for consumer-delivered services. Unpublished paper developed for Behavioral Health Recovery Management Project. An initiative of Fayette Companies, Peoria, IL; Chestnut Health Systems, Bloomington, IL; and the University of Chicago Center for Psychiatric Rehabilitation. Web site: <http://bhrm.org/guidelines.htm>

Salzer, M. (2002). Consumer-delivered services as a best practice in mental health care delivery and the development of practice guidelines. *Psychiatric Rehabilitation Skills*, 6(3), 355-383.

Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment Recovery Community Services Program. (In press.) *Emerging Approaches Conference Report*. Rockville, MD.

White, W.L. (2006) Sponsor, Recovery Coach, Addiction Counselor: The Importance of Role Clarity and Role Integrity. Philadelphia Department of Mental Health and Mental Retardation Services, Philadelphia, PA.

White, W.L., Kurtz, E., and Sanders, M. (2006) *Recovery Management*. Great Lakes Addiction Technology Transfer Center, Chicago, IL.

White, W.L. (2009) *Peer-based Addiction Recovery Support: History, Theory, Practice, and Scientific Evaluation*. Great Lakes Addiction Technology Transfer Center, Chicago, IL.

PART VII

UNIT 7: THE ROLE OF FAMILY IN RECOVERY

This unit looks at the role of “family” (of origin or choice) as an important force in a client’s life. Many clients have come from a family history of substance abuse and this legacy needs to be addressed as part of their recovery. We will look at family involvement in Intensive Outpatient Treatment (IOT) with the goal of engaging the family for the benefit of the client. We will also look at services that support the efforts of family members as the client moves through the recovery process.

Substance Misuse and its influence on families is also discussed. General guidelines for providing services that are culturally responsive and reflect cultural humility are explained.

Unit Objectives:

- Describe the role of family in recovery
- Discuss how to support families of clients in recovery

FAMILY-BASED SERVICES

Family-Based Services

Substance use disorders exist within several social contexts, one of which is the family. Family members, whether they are from the family of origin or family of choice, are important forces in a client's life. Each client has a family, a family history, and a family story that play important roles in recovery. Many clients come from substance using families and have been raised with alcohol abuse or drug use as part of their lives. Addressing this legacy is part of their recovery. In addition, a client's family members often have significant substance use and other psychiatric problems of their own. Intensive outpatient treatment (IOT) programs that take a comprehensive approach to evaluating the family are likely to identify other individuals who would benefit from being admitted to a substance abuse or mental health treatment program. Some family members may be in treatment already. For these reasons, many IOT programs incorporate a family systems approach. Family education, family therapy, and other services are necessary in an IOT program's process so that the contributions and influence of family members support recovery.

A complete discussion of family therapy for substance use disorders in IOT programs is not within the scope of this TIP. This chapter introduces features of family involvement in IOT programs and briefly discusses family therapy as an enhanced service that IOT programs may offer or, more frequently, to which they may refer clients and their families. The Center for Substance Abuse Treatment has developed TIP 39, *Substance Abuse Treatment and Family Therapy* (CSAT 2004c), that addresses how a substance use disorder affects the family, how family therapy works to change the interactions among family members, and the integration of family therapy into substance abuse treatment.

Families of people who abuse substances live in a world shaped by substance use. This world may include inconsistent behaviors and few or very rigid rules. Family members may have difficulty expressing their emotions, achieving intimacy, and solving problems. They frequently may experience but may not express anger, shame, guilt, sadness, and hopelessness. To function, families often subscribe to the following: don't trust, don't feel, and don't talk. The result can be an unhealthy environment in which individuals may be isolated, engage in destructive alliances, be overly involved with other family members, or develop significant medical and stress-related problems.

Increasingly, treatment professionals view substance use disorders from a family systems perspective (Crnkovic and DelCampo 1998). Research findings document a relationship between family involvement in treatment and positive outcomes and attest to the need for family-based services (Rowe and Liddle 2003). Family involvement in treatment seems to work equally well for adults and adolescents (Stanton and Shadish 1997). When the family is ready and able to shift from old, negative behaviors to new, healthier ones, family

members become collaborators in the treatment process (Edwards and Steinglass 1995). Most IOT programs do not offer couples- or family-based therapies (Fals-Stewart and Birchler 2001). However, potential benefits of family therapy are such that IOT programs should have well-established links with organizations that provide these services.

No matter how alienated family members may be, they are critical to the strength and duration of the client's recovery. Family members are the individuals who were part of the client's life before treatment and will be part of his or her life after treatment. Family-based services that are part of IOT help ensure that family functioning adjusts to and positively influences the recovery of the client.

Planning for Family Involvement

IOT planning for family-based services involves defining the client's family in broad and flexible terms, setting essential goals, and determining the desired outcomes.

Defining the Family

In recent years, the concept and definition of family have broadened significantly to include people who are important to the client. These people can include a spouse, a boyfriend or girlfriend, a same-sex partner, parents, siblings, children, extended family members, friends, co-workers, employers, members of the clergy, and others. The term "family of origin" commonly is used to describe individuals related by blood, such as parents, grandparents, and siblings. The term "family of choice" is used to describe a family created by marriage, partnership, or friendships and other associations.

When determining the client's concept of family, the key is to identify who will be supportive of recovery and who might seek to undermine it. The treatment provider can begin this process by creating a genogram (see appendix 6-A, page 107) to assess the family of origin or choice. Similarly, a social network map (see appendix 6-B, page 109) can help the counselor identify and understand the family of origin and family of choice.

- **Creating a family genogram.** This technique renders the client's family relationships schematically and helps the counselor identify trends or patterns in the family history and understand the client's current situation. As treatment progresses, the genogram is revised to reflect new knowledge and changes in the family (CSAT 2004c).
- **Assessing the client's social supports with a social network map.** A social network map displays the links among individuals who have a common bond, shared social status, similar or shared functions, or geographic or cultural connection. Highly flexible, social networks form and disband on an ad hoc basis depending on specific need and interest. A social network assessment is used in social service arenas, including substance abuse treatment. When the assessment is used in IOT, individuals are identified who can support the client or participate in the treatment process (Barker 1999).

Goals and Outcomes of Family Services

One main goal of involving families in treatment is to increase family members' understanding of the client's substance use disorder as a chronic disease with related psychosocial components. Edwards (1990) states that family-based services can have the following effects:

- **Increase family support for the client's recovery.** Family sessions can increase a client's motivation for recovery, especially as the family realizes that the client's substance use disorder is intertwined with problems in the family.
- **Identify and support change of family patterns that work against recovery.** Relationship patterns among family members can work against recovery by supporting the client's substance use, family conflicts, and inappropriate coalitions.
- **Prepare family members for what to expect in early recovery.** Family members unrealistically may expect all problems to dissipate quickly, increasing the likelihood of disappointment and decreasing the likelihood of helpful support for the client's recovery.
- **Educate the family about relapse warning signs.** Family members who understand warning signs can help prevent the client's relapses.
- **Help family members understand the causes and effects of substance use disorders from a family perspective.** Most family members do not understand how substance use disorders develop or that patterns of behavior and interaction have developed in response to the substance-related behavior of the family member who is in treatment. It is valuable for individuals in the family to gain insight into how they may be maintaining the family's dysfunction. Counselors should help family members address feelings of anger, shame, and guilt and resolve issues relating to trust and intimacy.
- **Take advantage of family strengths.** Family members who demonstrate positive attitudes and supportive behaviors encourage the client's recovery. It is important to identify and build on strengths to support positive change.
- **Encourage family members to obtain long-term support.** As the client begins to recover, family members need to take responsibility for their own emotional, physical, and spiritual recovery.

A comprehensive IOT program views the client as part of a family system. When the family is involved in treatment, the following treatment outcomes are possible:

- The client is encouraged to enter treatment.
- The client is motivated to remain in treatment.
- Relapses are minimized.
- A supportive and healthy environment for recovery is provided.
- Other family members who may need treatment or other services are identified and treated.

- Changes in the family's longstanding dysfunctional patterns of communication, behavior, and emotional expression may protect other family members from abusing substances.

Engaging the Family in Treatment

Difficulties with engaging the family in treatment often are cited as reasons for not using a family systems approach and, in many cases, substantial obstacles exist. Family members may be resistant, or the client may be ambivalent or object to the family's involvement in treatment. But given the potential benefits associated with taking a family approach to service delivery, engaging the family in treatment is worthwhile.

Strategies To Engage the Family

The following approaches have proved helpful in encouraging families to engage in the treatment of a family member:

- **Include family members in the intake session.** The counselor can involve family members in the treatment process from the beginning. If a family member makes the initial call to the program, the counselor can ask that person to come with the client. If the client calls, the client can be asked to bring a family member. If the client is reluctant at this point, the counselor can gently encourage the client to include family members but should not make it a condition of the person's entry into treatment. In another approach, the counselor can ask, "Who close to you is concerned about your substance use and might be willing to serve as a support to you during your recovery?" The client then might be asked to invite these supportive people to come to the initial intake interview. During the intake interview, family members can be asked to complete a brief written family assessment. A more comprehensive family systems approach can involve multiple private and family interviews. These interviews and other early meetings with the family develop support from a family that is empowered to address systemic issues. Similarly, the initial meeting helps family members learn about substance use disorders, their influence on a family, and the services the program can offer to the family (see below).
- **Use client-initiated engagement efforts.** The counselor and client collaborate on a plan to engage family members in treatment. The client can be given the opportunity to invite chosen family members to participate in the program. If this effort is unsuccessful, then, with the client's written permission, the counselor telephones, visits, or sends a personal note to the identified family members. Federal confidentiality rules require that client permission be documented (CSAT 2004b).
- **Offer a written invitation.** The IOT provider can give the client written invitations, with the clinic's contact information, to deliver to family members. Giving the client the invitations allows the provider to determine whether the client is willing to involve family members in treatment and which family members the client wants to involve in the process. The invitation briefly describes the treatment

program and identifies activities family members will be asked to participate in. For example, a family member may be asked to attend family education sessions, complete an assessment questionnaire, remove all substances from the home (if applicable), participate in family counseling sessions, or attend a celebration of the completion of a treatment phases.

Suggestions for Engaging Family Members at Intake

- Emphasize the need to gather information from family members.
- State the program's policy about family members' participation in treatment.
- Indicate the program's desire to hear family members' concerns about the client's substance abuse.
- Acknowledge family members' influence over the client and their desire to help.
- Make clear that family members' participation will help the client on the road to recovery.
- Emphasize how the program can help family members maintain a relationship with the client and manage their own feelings (anger, frustration, depression, and hopelessness).

- **Offer incentives.** Incentives may help address recruitment problems. Family members can be provided with coupons (e.g., for pizza, movies) for attending sessions or completing assignments. Refreshments also help family members feel welcome. In addition, providers can facilitate transportation (e.g., arrange carpools) and childcare services and remove other obstacles to family members' participation.
- **Plan picnics or dinners for families.** Multifamily picnics and dinners are a part of some IOT programs and can be scheduled for holidays or weekends. These events can be held on the program's grounds or in nearby parks or community centers and provide a supportive and non-threatening environment where individuals can have fun and learn about substance use disorders, recovery, and the IOT program. The client and family members are asked to bring a dish, but all are welcome. Immediately after the meal, a counselor conducts an hour-long educational session covering topics such as recovery support groups, family-oriented services, and characteristics of substance use disorders. Participants are told of the educational nature of the sessions when invited.
- **Use community reinforcement training (CRT) interventions.** CRT interventions have improved the retention of family members in treatment and induced people who abuse substances to enter treatment (Meyers et al. 1998, 2002). Among other strategies, the CRT approach teaches family members that substance abuse is not a moral failing but a disease and that they are not the cause of and cannot be the cure of their loved one's substance use disorder. They also learn to identify and pursue their own interests, communicate in nonjudgmental ways, encourage drinking of nonalcoholic

beverages during social occasions, manage dangerous situations, and discuss treatment entry with the family member who abuses substances when the consequences of abuse are severe (Kirby et al. 1999b).

- **Use the resources of the program.** To create a family-friendly environment, IOT staff at all program levels need to work together toward the goal of engaging families. For example, flexible program hours and large offices or meeting rooms may be needed to accommodate family schedules and large families. Safe toys should be made available for children so that they are less likely to disrupt a session. Front office staff should be trained to encourage and reinforce the efforts of family members who call or come in with the client for the initial visit. Programs can organize their client record systems and procedures so that staff members have easier access to family-related information for each client.
- **Provide a safe, welcoming environment.** Family members may be anxious or reluctant to participate in the treatment process. A welcoming environment encourages them to participate despite their concerns. A safe, clean, and cheerful meeting space is important. Good lighting, a well-marked and well-maintained exterior, culturally appropriate décor, comfortable furniture, and amusements for children convey the message that family members are welcome, valued by the treatment team, and essential to the recovery of the client. Ice-breaking activities, simple games, and role-play activities can make the group meeting inviting.

Overcoming Barriers to Engaging Family Members in Treatment

Not all family members participate in the treatment process. Sometimes individuals are reluctant to become involved with treatment, even though they care about the client. Women are more likely to be involved in their male partners' treatment; men are less likely to participate in their female partners' treatment (Laudet et al. 1999). Also, the client may not want family members to be involved because of threats of domestic violence or past abuse by a family member, guilt about the substance abuse, fear that family secrets may be revealed, concern about adding to the family burden, or other reasons. All family members who *do* participate must feel free to raise pertinent issues, even if another family member objects. Because of the risk of domestic abuse that comes with raising difficult issues, providers must assess carefully the potential for violence within the family (CSAT 2004c).

Despite these barriers, the IOT provider is encouraged to take every possible action to engage families of clients in the treatment process. Better client retention, fewer relapses, improved family functioning, and family healing are all possible outcomes (O'Farrell and Fals-Stewart 2001).

Supportive supervision of the counselors providing these family services

- Gives staff members confidence that they are providing appropriate levels of service while addressing clinical issues that inevitably arise
- Ensures that counselors and staff members understand their limitations in working with family members

- Guards against counselors and staff members attempting to provide therapy for which they have not been trained

When working with families, programs can make use of existing partnerships with agencies and groups that provide enhanced family services, individual counseling for other family members, health care, and financial and legal services to support clients' families.

Family Services

Family members

- May need guidance on how to address many issues that can arise during early recovery
- May have questions or misconceptions about substance use disorders
- May need to find healthy ways to handle their justifiable feelings of anger, frustration, shame, helplessness, guilt, and sadness that stem from attempts to fix the client's substance use disorder
- May need the counselor's intervention to understand and avoid behaviors that contribute to the client's continued use of alcohol and drugs

The types of services described in this section can support the efforts of family members as the client moves through the course of treatment. Although every family is different, and the pace of recovery varies from family to family, a sample treatment calendar is provided in exhibit 6-2. IOT services can assist family members in accomplishing the tasks described in the calendar.

Family Education Groups

Family education groups provide information about the nature of a substance use disorder; its effects on the client, the family, and others; the nature of relapse and recovery; and family dynamics. These groups often motivate families to become more involved in treatment.

The family education group typically meets weekly for 2 to 3 hours, often in the evening or on weekends, and includes between 10 and 40 individuals. The group is facilitated by a counselor and usually covers these topics:

- Medical aspects of addiction and dependence
- Relapse and relapse prevention
- Addiction as a family disease
- Subconscious refusal to admit that the client has a substance use disorder (i.e., denial)
- Enabling behaviors

- Communication
- Reasons for testing and monitoring of the client
- Leisure time planning
- Parenting skills

Group members listen to lectures, discuss topics, and engage in exercises that help them become knowledgeable about substance use disorders and their effects on the family.

Multifamily Groups

Multifamily groups can be thought of as microcosms of the larger community. They offer more opportunities for learning, adaptation, and growth than do groups of one client and family members. These groups provide family members with a sense of normalcy and a support network. Individuals learn that other families face similar difficulties. This discovery may reduce the stigma and shame commonly found among families struggling with substance use disorders.

Families often exhibit mutually supportive, spontaneous involvement with one another and reinforce one another's problem-solving approaches. Cross-learning—in which, for example, a man learns to understand his wife better by listening to other husbands and wives—is one of the most powerful effects of multifamily therapy. Incorporating multifamily groups into IOT has been shown to increase the length of treatment for female clients, increase completion rates for men, and improve family functioning and children's behavior (Boylin and Doucette 1997; Meezan and O'Keefe 1998). Treatment providers report that having more than one generation present in the group can help institute a family's commitment to abstinence and recovery (Conner et al. 1998).

Multifamily groups typically engage several clients and their family members in group exercises that teach them how to develop healthy communication techniques, avoid enabling behaviors, reduce codependence, and get help. Until a multifamily group coalesces, it may be helpful for members' participation to be structured (e.g., talking only about themselves, not about the person in IOT). IOT providers should foster an atmosphere of acceptance and emotional safety so that learning occurs in a relaxed setting. Group sessions generally are scheduled weekly and last for 2 to 4 hours with group size ranging from 12 to 30 members (6 to 8 families) (Crnkovic and DelCampo 1998). Clients' recovery may be aided by the inclusion of supportive individuals from outside the family (e.g., sponsors, friends, religious leaders, co-workers). The consensus panel recommends that multifamily groups be co-led by two therapists trained in this process. Membership may change frequently, and clients and their families join the group as others graduate from the treatment program.

Family Therapy Groups

In 1997, Stanton and Shadish conducted a meta-analysis that compared the effectiveness of family education, family therapy, and other forms of family intervention for people with substance use disorders. Their results suggested family therapy is more effective than family education groups and other family services. However, family therapy can be delivered only by specially trained therapists. Forty-two States require that people practicing as family therapists be licensed.

In most States, a family therapist must have a master's degree to practice independently (CSAT 2004c). Family therapy addresses the dynamics in the family that may encourage substance abuse and offers support for changing these dynamics. It emphasizes that the family as a dynamic system, not merely the inclusion of family members in treatment, is the hallmark of family therapy (CSAT 2004c). These sessions may include individual family, couples, and child-focused therapy. (Family therapy for adolescents is discussed in chapter 9.) Because not all IOT programs provide these types of therapy groups, providers should consider establishing referral agreements with other community service organizations that provide family therapy.

Individual family therapy

This type of therapy helps family members look at their interactions and identify the factors in the family that contribute to a substance use disorder. Family members are encouraged to restructure negative patterns of behavior and communication into interactions that are more conducive to recovery for everyone. Through family therapy, adults and children express to the client how behavior has affected them and how new coping skills now are affecting their lives. The client has the opportunity to use new skills learned in treatment and to receive constructive feedback from family members in a safe environment. During these sessions, families may address issues such as irresponsible behavior, indebtedness, substance use in the home by other family members, availability of alcohol on special occasions, and how to reveal treatment and recovery to others. The content of these sessions varies significantly, based on the needs and motivations of the family members. Family therapy may be scheduled monthly or more frequently.

Couples therapy

Couples counseling is useful in improving certain aspects of functioning in families with substance use disorders (O'Farrell and Fals-Stewart 2002). This therapy focuses on improving a couple's relationship and reducing problems related to substance abuse. The spouse or significant other is taught to reinforce abstinence, decrease behaviors that cue substance use, and avoid protecting the client from the adverse consequences of substance use. Both partners are taught to increase positive exchanges, improve communication, and work together to solve problems. The number of sessions can be six or more and can include sessions for one couple or groups of couples (Fals-Stewart et al. 1996).

Child-focused therapy

Play and structured recreational activities for children and parents can reduce conflict in families with substance use disorders. In groups with their children, parents are taught parenting and problem-solving skills and are given information about normal childhood development. Parents recovering from substance use disorders have a chance to experience pleasurable recreational activities with their children (e.g., volleyball, soccer) and learn to interact with them in a structured, therapeutic setting. Older children can be educated about substance use and how it can affect them and their families.

Family Retreats

Some IOT providers have found that family retreats can be effective in helping families harmed by substance use disorders, although research is unavailable on this topic. Participants can take important steps toward healing damaged relationships. Some participants have described family retreats as the most important aspect of their experience in treatment.

Most family retreats cover 2 days, usually over a weekend; participants spend nights at home. Retreats provide clients and their family members with the opportunity to work intensively with one another to address powerful emotions such as shame and guilt and to restore lost intimacy and trust. Participants take part in education sessions, exercises, and group activities. Day 1 activities can include family education on

- Communication skills
- Experiencing and working with feelings
- Developing trusting relationships within the family
- Creating healthy expectations
- Reestablishing roles

Participants receive an assignment the evening of day 1 to work on at home. Assignments may focus on developing relapse contracts, reading from journals, or sharing positive family memories. Day 2 can focus on a therapeutic event during which

- Participants discuss the assignments they completed the night before.
- Family members are encouraged to tell one another important things, which may never have been said or discussed before.
- Family sculpting exercises are conducted; this activity dramatically illustrates relationships and communication patterns that need to change. In family sculpting, each family member takes a turn positioning the other family members in relation to one another, posing them as he or she sees fit, and explaining the choices (CSAT 1999a).

Programs that conduct retreats find that executing a “contract for participation” with the client helps ensure that the retreats are well attended. Therapists may need to assist the client in recruiting family members to attend. Retreats should be staffed by therapists who are experienced in managing highly emotional events.

Support Groups for Families

Mutual-help groups provide the continuing emotional, educational, and interpersonal support that family members often need as clients complete their treatment. Attending support group meetings helps family members adjust to changes being made by the recovering member and begin new lives of their own. Family support groups may be sponsored on an ongoing basis by the IOT program or consist of community-based fellowships such as Al-Anon, Nar-Anon, Alateen, Adult Children of Alcoholics (www.adultchildren.org), Adult Children Anonymous (www.12stepforums.net/acoa.html), and Families Anonymous.

When a family support group is sponsored by the IOT program, it usually meets weekly. Family members can discuss problems and concerns that arise because of the client’s recovery and reconnection with the family. Such groups offer continuity for family members during the difficult treatment and recovery periods. Surrounded by familiar program staff members and other family participants, family members build on the momentum of their previous experiences in treatment. Examples of the issues discussed include parenting, decision-making, conflicts, sexual functioning, intimacy, anger management, mood swings, reestablishing trust, adjusting roles, learning what is “normal,” renegotiating relapse prevention contracts, and substance use by other family members.

Community-based 12-Step support groups such as Al-Anon, Nar-Anon, and Alateen are independent from the IOT program. Because family members may be reluctant to initiate contact with such groups, IOT providers can assist family members by providing information about meetings, such as what happens at these meetings, the rituals observed, who attends, how meetings are conducted, the purpose of the meetings, and where to find them. Members of mutual-help groups can be invited to give talks to the family members in the IOT program. Providers also should emphasize that the meetings are anonymous. By encouraging family members to attend at least three meetings before deciding whether to continue, the IOT provider increases the probability that family members have a positive experience and continue to attend. IOT staff can encourage members of multiple families from the program to attend meetings together so that they can reinforce and reassure one another.

Family Clinical Issues in IOT

Diverse questions, concerns, and behaviors are presented by family members during IOT sessions. The complexity of human relationships and interactions is revealed in treatment and can challenge both participants and counselors to use the opportunities and experiences therapeutically. Long suppressed anger,

family secrets, shame, and confusion may surface. Family members may harbor feelings and thoughts that can affect the client and the family adversely and that require resolution within a therapeutic environment.

Unrealistic Expectations About Treatment Outcomes

Family members often have unrealistic expectations about treatment and the client's recovery. Family members may not understand the nature of a substance use disorder or are unable to accept that it is a chronic, relapsing disease and recovery is a lifelong process. Some family members, for instance, can be so fatigued and emotionally depleted from the stress of living with the person who abuses substances that they have unrealistic hopes for treatment. Strategies and solutions to address unrealistic expectations and common fallacies about treatment and recovery include the following:

- **Informing the family early in treatment about common but unrealistic expectations.** By gently raising this issue early in treatment during individual family sessions, the IOT counselor can draw attention to and begin to dispel any fallacies. The counselor can probe for related family beliefs, answer family members' specific questions, and provide real-life examples before unrealistic expectations lead to an undermining of family and client functioning. This process also can identify specific educational needs.
- **Using a variety of formats to provide clear, understandable information about substance use disorders.** A family education group is a basic component of IOT programming that is effective in debunking many fallacies about substance use disorders. For instance, the group can be used to dispel the idea that once a client is in treatment, he or she will stop having the urge to use; that once use stops, everything will be "perfect"; or that doctors and counselors will teach how to get well. A counselor can obtain or develop written materials (fact sheets, brochures, posters) at appropriate reading levels and in relevant languages. These materials need to be available at the program facility and distributed to family members at intake and during treatment. A brief, informative video can be played during family sessions, in counselors' offices, or in the waiting room.
- **Reaching many family members.** It is important to educate as many family members as possible and to ensure that the most influential family members become knowledgeable about substance use disorders and then redirect other family members if necessary.

Family Responses to Relapse

Clients can relapse, and family members may be unwilling or unable to be compassionate or nonjudgmental about episodes of relapse. Typically, relapse is an unpopular topic with family members. If relapse occurs, counselors need to be prepared for a range of emotional responses from families, including anger, panic, blame, depression, spitefulness, and relief. Some families may abandon or withdraw from the client; others

may attempt to engage the client in substance-using activities; still other families may be caught in patterns of depression and resignation or panic and fear.

The following therapeutic options may help counselors in assisting families that may experience a family member's relapse:

- **Prepare the family members as well as the client for the possibility of relapse.** Family members are likely to be the first to know when a client relapses. IOT programs focus on strengthening the client's relapse prevention skills, but families also need assistance. IOT staff members can help families
 - Understand that relapse can happen and that each family reacts in unique ways.
 - Accept that their reactions to the relapse crisis do not necessarily indicate that the family is in deep trouble.
 - Prepare a plan that identifies steps the family will take if relapse occurs.
 - Identify ways that family members can support one another.
 - Seek help if the plan
- **Assist family members in engaging support services and resources.** Community-based support groups such as Al-Anon, Nar-Anon, Alateen, and Alatot (for children of parents who abuse alcohol) are available in most areas and are indispensable sources of help for many families. Family members should be encouraged to attend meetings regardless of the client's recovery status. In these groups, family members focus on their own needs, accept what they cannot change, and engage in healthy, satisfying activities. To facilitate attendance, some IOT programs offer these groups space at their facility. Others sponsor their own family support groups, led by alumni of the programs, that are open to all who wish to attend for as long as they desire.
- **Seek interventions for individual family members when their responses to relapse are unhealthy.** The IOT counselor needs to be alert to the possibility that relapse by a client may require additional family interventions and referrals to other service professionals. For example, another family member also may be in recovery and may need additional assistance from a support group. Another family member may become depressed as a result of the client's relapse, or an adolescent may act out. The client and other family members may benefit from psychological or psychiatric interventions.

Sabotage by Family Members

A family can sabotage the client's progress when one or more family members behave in ways that undermine the client's abstinence or treatment. For example, family members may continue to use or leave alcohol or drugs where the client is likely to see them.

They may state to the client or others that the client is likely to fail or may refuse to let the client use the family car to go to a support meeting or treatment session. Examples of successful clinical approaches to discourage sabotage and encourage positive participation are as follows:

- Schedule individual family sessions to discuss the specific behaviors that are sabotaging recovery efforts.
- Discuss alternative behaviors that support recovery, and offer support for making the behavioral changes.
- Determine whether individual therapy is needed, and support family members with a referral to a family therapist as appropriate.
- Work with family members to create a contract that specifies how their behavior is to change.
- Monitor progress.

Family Life Without Substance Abuse

As recovery begins, some family problems resolve with abstinence. Issues of trust and worries about how the family will be different are likely to emerge. Here are a few common questions and some suggested answers on how IOT counselors can help families:

- How do we reestablish trust?
 - Teach family members that a lack of trust is a normal and natural reaction in early recovery but, at the same time, the recovering person may sense this lack of trust and may become angry or sad.
 - Indicate that the newly abstinent member may suffer from a “time warp” in which a week seems more like a month. Such different perceptions of time can add to conflict around the trust issue because the client may expect the family’s trust after what is, in reality, only a short period of abstinence.
 - Discuss the idea that mistrust transforms into trust only as the client maintains abstinence and demonstrates positive changes in behavior. Ask the client to accept that family members may not trust him or her for a period.
 - Suggest that family members agree to extend their trust incrementally to the client. For example, an adolescent client may be given permission to use the family car for an outing if the adolescent’s school attendance is satisfactory for a specific period.
- How do we have fun again?
 - Suggest creating new family rituals to replace old ones that involved substance use.
 - Suggest establishing and celebrating “family” abstinence anniversaries.
 - Encourage participation in events sponsored by Al-Anon, Nar-Anon, and other family support groups.
 - Urge participation in multifamily groups sponsored by the treatment program.
 - Ask each member to identify a favorite “family fun” activity for the entire family to enjoy.
 - Ask members to consider separate couples and parent–child activities to create new relationships between family members.
 - Ask members to keep a family journal that includes ideas, feedback, and comments from family

members on various activities, rituals, and other family events.

- What do we say to friends, neighbors, and associates about treatment and recovery?
 - Assist family members in discussing and coming to decisions about what information they want to share with others and when. Write down this information, give it to all family members in the form of an agreement, and have each member sign the agreement.
 - Review the privacy and confidentiality provisions that govern treatment programs with family members to remind them that providers will not discuss these topics with others and that family members are in control of what others know. Use family support group sessions to discuss this issue so that members learn from the experiences and examples of other families.
 - Have family members “rehearse” situations they are likely to encounter to practice appropriate responses.
- First the bottle, now the meetings. Will it ever get better?
 - Acknowledge that the spouse or significant other is disappointed and frustrated.
 - Point out that recovery is the first and most important goal during this difficult period and that people in recovery often immerse themselves in recovery activities with the same intensity with which they used substances.
 - Assist the spouse or significant other in focusing instead on his or her own recovery and in attending Al-Anon, Nar-Anon, or other support groups.

Resources for Family-Based Services

Publications and Videos

A helpful reference is *Family Therapy: An Overview* (Goldenberg and Goldenberg 1985). This book presents a comparison of six theoretical models of family therapy, including the psychodynamic, experiential/humanistic, structural, communication, and behavioral models. Meyers and colleagues (2003) offer an overview of community reinforcement and family therapy (CRAFT) that emphasizes the approach’s empirical support. Using concerned family members and friends, CRAFT works to bring those who deny they have a substance use disorder into treatment.

American Outreach Association (AOA) (www.americanoutreach.org). AOA is a private, nonprofit organization that produces pamphlets to help families cope with alcohol and substance abuse. The pamphlets can

be downloaded from AOA’s Web site. Topics include strategies on confronting children who use substances, effective ways for parents to communicate with their children, and ways to help someone with alcohol and drug abuse problems.

Films for the Humanities and Sciences (www.films.com). This organization offers 150 educational films

on substance abuse, covering topics such as treatment issues and the effects of addiction on family members and including a series on young adults and substance abuse.

Gerald T. Rogers Productions (www.gtrvideo.com). This company produces films and videos on substance abuse for many audiences, from first graders to families with members who abuse substances.

Hazelden Foundation (www.hazeldenbookplace.org). Hazelden Bookplace is an online resource center and marketplace for products and services from Hazelden Publishing & Educational Services and provides resources to help individuals, families, and communities prevent and recover from substance use and related disorders.

Johnson Institute (johnsoninstitute.org). This organization offers books, booklets, and videos that are distributed through the Hazelden Bookplace Web site. Some family-related videotapes available are *Parenting Issues for Recovering Families*, *The Kid and Me: Parenting for Prevention*, *The Enabler*, *Intervention*, and *Intervention: How to Help Someone Who Doesn't Want Help*.

National Families in Action (NFIA) (www.nationalfamilies.org). NFIA is a national drug education, prevention, and policy center with the mission of helping families prevent substance abuse among children by promoting science-based policies. NFIA offers books, pamphlets, and afterschool programs to keep young people substance free. NFIA has collaborated with other organizations on several projects, including Allied Systems Strengthening Families Project and the Drug-Free America Foundation.

NIMCO, Inc. (www.nimcoinc.com). This organization offers videos on alcohol, tobacco, and drug education and prevention topics. Videos cover such issues as drinking and driving, steroid use, substance abuse in the workplace, and the effects of substance abuse on the mind and body.

Pyramid Media (www.pyramidmedia.com). This company offers films and videos about substance abuse that are appropriate for training, educational groups, and individual and family viewing.

Substance Abuse and Mental Health Services Administration's National Clearinghouse for Alcohol and Drug Information (NCADI) (www.ncadi.samhsa.gov). NCADI is a national resource center funded by the Federal Government that offers a large inventory of publications and videos for treatment professionals, clients, families, and the general public, including *Alcoholism Tends To Run in Families*. This fact sheet presents important information about the influence of parental alcoholism on children and families. It considers evidence that links alcoholism to dysfunctional marital relationships, child abuse, depression, physical problems, and impaired school performances, among other undesirable effects.

Moyers on Addiction: Close to Home (www.pbs.org/wnet/closetohome). This is the online companion to the PBS show. It features real-life stories of struggles with addiction, information on treatment and prevention, and downloadable resources such as family guides, viewer's guides, teacher's guides, and health professional's guides to the PBS series.

Family Support Groups

Adult Children of Alcoholics (ACOA) (www.adultchildren.org). ACOA is a 12-Step, 12-Tradition program that offers support for grown children of parents with alcohol or drug addiction.

Al-Anon family groups (www.al-anon.org). Al-Anon is a fellowship of relatives and friends of people who have alcohol problems who share their experiences, strengths, and hopes. Members believe that alcoholism is a family illness and that changed attitudes can aid recovery. The program is based on the 12 Steps and 12 Traditions of Alcoholics Anonymous.

Families Anonymous (FA) (www.familiesanonymous.org). FA is a 12-Step, mutual-help, recovery support group for relatives and friends of those who have alcohol, drug, or behavioral problems. FA pamphlets, booklets, newsletters, and daily inspirational thought book are written by the members.

Nar-Anon family groups (www.naranon.com). Similar to Al-Anon, Nar-Anon is a fellowship of relatives and friends of people who abuse substances and offers a constructive program for members to achieve peace of mind and to gain hope for the future.

National Asian Pacific American Families Against Substance Abuse (www.napafasa.org). This nonprofit organization is dedicated to addressing the alcohol, tobacco, and drug issues of Asian and Pacific Islander (API) populations in the continental United States, Hawaii, and the six Pacific Island jurisdictions, as well as elsewhere. Its nationwide network consists of approximately 200 API and human service organizations, and its Web site lists resources, services for public and professional audiences, and current activities.

Citation

Center for Substance Abuse Treatment. Substance Abuse: Clinical Issues in Intensive Outpatient Treatment. Treatment Improvement Protocol (TIP) Series 47. DHHS Publication No. (SMA) 06-4182. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2006.

This work resides in the public domain, unless otherwise indicated.

SUBSTANCE USE DISORDER TREATMENT AND FAMILY THERAPY: TREATMENT IMPROVEMENT PROTOCOL

Executive Summary

Introduction

This Treatment Improvement Protocol (TIP) update provides information and guidance on the latest science-informed, family-based interventions and family counseling approaches for substance use disorders (SUDs). Intended audiences include SUD treatment providers such as drug and alcohol counselors, licensed clinical social workers, licensed marriage and family therapists, psychologists and psychiatrists specializing in addiction, psychiatric and mental health nurses (specialty practice registered nurses), and peer recovery support specialists. The TIP's audience also includes SUD treatment program administrators, supervisors, and clinical/program directors.

SUDs are complex, lifelong conditions that affect not just people in recovery but their families as well. To give a person struggling with alcohol and drug addiction the greatest chance at lasting, successful recovery, families often need to be included in treatment and services. This TIP is designed to help providers and administrators better understand how to do this by describing the unique impacts of SUDs on families; how family functioning and dynamics can both support and interfere with recovery; and how treatments, services, and programs can best be tailored to families' needs.

An expert panel developed the TIP's content based on a review of the most up-to-date literature and on their extensive experience in the field of alcohol and drug addiction treatment and family counseling. Other professionals also generously contributed their time and commitment to this publication.

The TIP is divided into six chapters so readers can easily find material they need most. Below is a summary of the TIP's main messages, followed by a description of each chapter's key content areas.

Overall Key Messages

Families affect and are affected by SUDs. In most cases, including family members in a client's treatment or services for substance misuse is beneficial and makes achieving and sustaining long-term recovery more likely.

Family-based SUD interventions are supported by empirical evidence and have been shown to be

effective in promoting long-term behavior change, including recovery. A wide variety of family-based treatment models and approaches are available. You can select from these based in part on the family's makeup, needs, readiness for change, treatment setting, and level of care required.

No two families are identical, and as such, the ways in which family members function and interact with one another will vary from family to family. As a clinician, **you should be prepared to adapt SUD treatments and services to each family's unique background, structure, and situation.**

Each family has its own ways of behaving and relating to one another. Those dynamics influence substance misuse and recovery and should be considered when making shared treatment decisions with clients and their family members. **You should be able to identify common family structures and dynamics and understand how they influence substance misuse.** This will help you develop more targeted treatments that directly address a given family's dysfunctions and needs.

Most families are doing their best to adapt to the situation of a family member struggling with substance misuse. In general, families usually are just trying to maintain a steady state (or homeostasis). Sometimes that means engaging in behaviors that actually support the family member's substance misuse. **Avoid blaming, shaming, and using judgmental labels (e.g., referring to family members as "co-dependent" or "enablers") when working with families. Instead, offer them education, empathy, and support.**

There are several ways you can integrate family-based treatments and services into care. Motivational interviewing (MI), family-focused interviews and assessments, genograms, and family-based treatment goals are just a few options.

Families are diverse and may need treatments and services tailored to factors such as their racial/ethnic background, level of acculturation, immigration/nativity status, and history of military service.

It is not enough for clinicians to learn about and offer family-based treatments and services for substance misuse. **Administrators, directors, and clinical supervisors also play a role in delivering family-based SUD treatment and ensuring programs adopt and maintain a family-centered culture.** This means comprehensively addressing a wide range of program development and workforce factors, like hiring and retention, training, clinician and supervisor core competencies, and licensing and credentialing.

Programs that establish and foster close ties to the surrounding community can better help clients and families access resources that meet their needs. Administrators are vital to this process as well.

Content Overview

This TIP is divided into six chapters designed to thoroughly cover all relevant aspects of the ways in which families are touched by SUDs and how providers can offer treatment and services to help meet families' full range of needs.

Chapter 1: Substance Use Disorder Treatment: Working With Families

This chapter lays the groundwork for understanding the treatment concepts and theories of family-based SUD treatment discussed in later parts of this TIP. It is for providers and administrators.

Families are complex entities; no two are the same. To provide effective family-based services for SUDs, one must understand different types of families and the common characteristics families often possess (including their rules, roles, boundaries, and communication styles).

Family counseling can help families facing SUDs in many different ways, including by teaching them to better understand how their interactions and behaviors are contributing to a family member's substance misuse and learning how to adapt their behaviors to support a family member's recovery. Family-based interventions are often centered on helping families learn how to change their behaviors toward and interactions with one another, how they can be a positive influence on recovery, and how to prevent substance misuse in future generations. **There are numerous familybased treatment models, approaches, settings, and formats for SUDs, giving providers (and their client families) a wide range of tools and options from which to choose.**

In Chapter 1, you will learn about:

- The benefits and challenges of offering family counseling for SUDs, including why you should include families in SUD treatment and services and in goal setting for those treatments and services.
- The history of family-based SUD treatment and how the incorporation of families into traditional treatment approaches and settings has changed over time.
- The core objectives of current family-based treatment for SUDs, such as helping the family become a source of strength in their family member's recovery and helping them understand how they influence their family member's substance-related behaviors.
- Common characteristics present in nearly all families (e.g., roles, rules, communication patterns, degree of loyalty, culture) and how those characteristics vary—and subsequently affect a family member's recovery.
- The various pathways by which family-based SUD treatment and services are delivered, such as parallel, sequential, and integrated approaches. Different pathways may be more appropriate for certain families depending on their particular structure, way of functioning, and dynamics.
- The different degrees of family involvement that can occur in SUD treatment across different levels of care and settings (e.g., residential treatment, outpatient care).

Chapter 2: Influence of Substance Misuse on Families

This chapter summarizes the ways in which substance misuse affects family dynamics (the ways in which

families behave toward and relate to one another) and family systems and the ways in which those in turn influence substance misuse. This chapter is for providers.

Families operate in their own unique ways. Family dynamics play a large role in both sustaining and reducing/preventing substance misuse. Although all families are different, certain families affect and are affected by SUDs in similar ways. You should be aware of how the dynamics among specific family types—such as families with young or adolescent children, families with adult children, childless couples, and blended families—are affected by and contribute to the risk of substance misuse in the family. This will help you better determine which treatment/services are best suited to the family and their dynamics.

This chapter also presents the latest empirical evidence about common traits of families touched by drug and alcohol addiction. Again, although each family is different, this discussion will help you understand and identify possible targets of intervention, such as poor communication style, high levels of family conflict, ineffective parenting approaches, and lack of family connectedness.

In Chapter 2, you will learn the following:

- **Families with SUDs tend to share certain characteristics, which are often the focus of treatment and services.** These include problems with communication, conflict, parenting skills, family cohesion, and family attitudes about substance use.
- **Most families engage in behaviors to try to maintain homeostasis, or balance.** Family members often try to keep things as “normal” and consistent as possible, and in doing so may behave in ways that actually make substance misuse more likely. Sometimes this is called **enabling**. Rather than criticize or shame families for such behaviors (which are completely normal and, in a way, adaptive), instead work with families to help them learn how to develop healthier behaviors and dynamics.
- There may be gender-specific differences in how family dynamics affect and are affected by SUDs. **These gender differences may need to be taken into consideration when offering treatment and services.** For instance, women are often socialized to be caretakers and to not be confrontational. A mother or daughter may feel that it is not her place to criticize a family member’s substance misuse and may instead engage in caretaking or “enabling” behaviors. These gender beliefs may need to be addressed in treatment if they are contributing to family dysfunction and preventing recovery.
- In couples in which one partner has an SUD, research suggests there is a high risk of interpersonal violence and mistreatment. **Be sure to screen for all forms of abuse.**
- Parents struggling with SUDs may not be able to properly care for their young or adolescent children, possibly leading to negative physical, emotional, economic, and social outcomes for offspring. Neglect and other forms of abuse also may be present. This raises professional and legal issues related to safety, and means loss of child custody may become a factor at some point during treatment/services.
- Children of parents with SUDs may be forced to take on roles inappropriate for their developmental stage. For instance, a teenager may feel that he has to become the “father” of the household because his father has alcohol use disorder and cannot reliably earn a living and help support the family. This can be

a significant source of stress for the child.

- It is easy to sympathize with young children living with parents with drug and alcohol addiction, but **do not overlook the effects of SUDs on adult children**. Even when grown, children can be negatively affected by their parents' substance misuse, including being at risk for substance misuse themselves as well as other unhealthy outcomes (e.g., suicide attempts, higher mortality).
- Just by nature of their structure, blended families often struggle with certain difficult dynamics and situations (like loss of a biological parent or stepparents/stepchildren feeling like “outsiders”). When SUDs are thrown into the mix, this can raise the family stress level even higher. **Be particularly sensitive to the difficulties facing blended families with SUDs**, and understand how helping them strengthen their bonds with one another can be a powerful factor in supporting recovery and preventing substance misuse.
- Adolescent substance misuse can negatively affect parents and siblings and also place the youth at risk for dangerous or unhealthy outcomes (like car accidents, dropping out of school, or continued substance misuse into adulthood). **A family may need help identifying dynamics and functions that are supporting the teen's SUD and making recovery more difficult.**

Chapter 3: Family Counseling Approaches

This chapter reviews research-based family counseling approaches specifically developed for treating couples and families in which the primary issue facing the family system is an SUD. It describes the underlying concepts, goals, techniques, and research support for each approach. This chapter is for providers.

The numerous family-based SUD treatments that exist differ in the strategies and techniques used to address substance misuse. However, these treatments share certain features, such as an emphasis on treating the family as a whole rather than focusing only on the individual with an SUD; using a non-blaming, collaborative approach to care; and adapting to the culture and values embraced by each family. Specific family-based treatments that can be used effectively to help families improve their functioning and enhance recovery include psychoeducation, multidimensional family therapy (MDFT), behavioral couples and family therapy, brief strategic family therapy (BSFT), functional family therapy, and solution-focused brief therapy. This chapter discusses each in detail.

In Chapter 3, you will learn the following:

- Family-based treatment guides families in enhancing their thoughts about and reactions to substance misuse. This in turn typically leads to major changes within the family as a whole.
- Regardless of approach, all family-based treatment shares certain core aspects. Aspects include improving the health and well-being of the whole family, not just the person with substance misuse; respecting the value of family and other social relationships as a key part of recovery; and meeting harm-reduction goals other than abstinence, which can still benefit the family and the individual.

- Psychoeducation is a widely used approach to family-based SUD treatment, and many families can improve their functioning and dynamics simply by learning about drug and alcohol addiction and recovery. **Do not underestimate the power of this seemingly simple intervention.**
- MDFT has good empirical support for reducing SUDs, especially among adolescents. It addresses individual behaviors and family processes. It has improved functioning among adolescents, parents, families as a whole, and families' relationships within their communities.
- Behavioral couples and family counseling approaches help support recovery by teaching clients to improve the quality of their relationships, engage in healthier communication, and build positive relationships with one another.
- BSFT uses a problem-focused, practical approach to reduce or eliminate youth substance misuse and enhance family functioning.
- Functional family therapy also takes a problem-solving approach to engaging, motivating, and creating behavior change among clients. Families are also taught how to apply their newfound skills to future situations.
- Solution-focused brief therapy invites families to build a positive vision of their future and identify interpersonal changes and improvements in target behaviors needed to make that vision a reality.
- Network Therapy uses a combination of individual and group therapy approaches and involves members of the client's network of supportive family members and friends in sessions. The main goal is for members of the supportive network to learn how they can reinforce the client's efforts to achieve and maintain abstinence.
- **In addition to understanding specific treatment approaches, consider offering other family-based skills and services that can support recovery across the continuum of care.** These could include engaging the family in treatment, linking members to community and mutual-aid recovery supports, facilitating behavioral contracts between the person in recovery and his or her family members, and teaching relapse prevention techniques (e.g., family-based problem-solving).
- Case management services can help families address problems within larger systems of care, like healthcare-, education-, legal-, and childcare-related issues. **These commonly occur in individuals and families with SUDs and thus should be a standard part of family-based SUD treatment.**
- Family peer recovery support services offer families the valuable opportunity to learn from others who have walked in their shoes. This can be incredibly powerful and healing, as families touched by drug and alcohol addiction often feel isolated and struggle with stigma, shame, and confusion.

Chapter 4: Integrated Family Counseling To Address Substance Use Disorders

This chapter discusses the advantages and limitations of integrated treatment models and the degree of providers' involvement with families. It offers guidelines on how to deliver family counseling in combination

with specific SUD treatment and to match counseling approaches to each family's specific level of recovery. The intended audience is providers.

As a general rule, families should be incorporated into SUD treatment and services to give individuals the best chances at lasting recovery. **Be sure to let the individual in recovery decide who in the family should be invited to participate in treatment.** Barriers to participation may need to be problem solved, such as family members who live far away, have scheduling conflicts, or simply refuse to be a part of treatment. As in individual counseling, screening and assessment are critical components to information gathering, but in this context, both processes should be family based. For instance, discuss not only the individual's history of substance misuse but also how substance misuse has occurred historically, throughout the family. Rather than focusing entirely on problems within the family, be sure to also explore family members' strengths, including supportive qualities (e.g., warmth, compassion), talents, and goals. This will help you maintain a positive tone throughout treatment and can help keep families motivated and engaged in care.

In Chapter 4, you will learn that:

- In some instances, certain family members should not be included in SUD treatment and services. Such situations include when intimate partner violence has occurred, when child abuse or neglect has occurred, when individuals are currently withdrawing from substances, when clients with SUDs are also struggling with psychosis or are suicidal, and when clients have significant cognitive problems (like severe learning or memory problems).
- Mandated family treatment can be difficult because family members are not seeking care willingly. In such cases, MI can help you build rapport with clients and enhance their willingness and desire to participate in treatment.
- As with individual treatment, screening and assessments should be conducted to identify current and past problems in need of intervention. Use a family-based focus that explores the family history of SUDs, mental disorders, abuse, legal problems, work and school issues, and overall health. Family interviews can help you gather this information and also serve as an opportunity for you to build rapport with families, educate them about treatments and services, and get their “buy-in” to enter and stay engaged in treatment.
- Family-based assessments help you determine the history of the family's functioning and substance misuse. Do not forget to also explore the family's strengths and supports.
- A **genogram** can help you and your client families visualize their current and history of substance-related problems. It is also a way to depict their strengths and resources.
- Family members may each have different goals for treatment, and that's okay. Your job is to help them identify changes they would like to make, teach them how to make those changes, and guide them in becoming sources of support for one another. You can do this by educating families about SUDs and recovery, facilitating communication between family members, and linking them to community-based resources and support networks.

- It is common to encounter certain challenges in working with families with SUDs, but these can be overcome by helping families build healthier coping skills, educating them to correct myths and misconceptions about SUDs and recovery, offering case management services to help coordinate schedules and service needs, and addressing each family member's particular stage of change.

Chapter 5: Race/Ethnicity, Sexual Orientation, and Military Status

This chapter discusses family counseling for SUDs among families of diverse racial and ethnic backgrounds; lesbian, gay, bisexual, or transgender (LGBT) families; and military families (including active duty personnel and veterans). Each section discusses the latest empirical evidence for family-based SUD treatment with that population as well as suggestions for how you can tailor family-based interventions to improve outcomes. This chapter is for providers.

Family-based counseling is supported by empirical evidence as a safe and effective option for overcoming drug and alcohol addiction. However, no SUD treatment is “one size fits all” for all families. Certain families may benefit more from particular treatment approaches, formats, and settings than from others, based in part on their attitudes, beliefs, and dynamics. These attitudes, beliefs, and dynamics often differ based on a given family's culture or background. As such, it is critical that you as a clinician understand how diverse families may affect and are affected by substance misuse and tailor your treatments and services as needed. For instance, in families of certain racial or ethnic backgrounds, there may be language barriers or cultural beliefs that make treatment seeking less likely. In military families, there may be attitudes that normalize substance misuse and make recovery seem unnecessary. This chapter will guide you through some specific types of families and how their dynamics, functions, attitudes, and values could affect treatment.

In Chapter 5, you will learn that:

- Diversity among families is an important factor to consider when trying to understand how substance misuse fits into a particular family and which treatments and services may be best for them.
- It is not enough to just be culturally sensitive to such issues; rather, you should provide family-based treatment and services that are culturally responsive. This includes adopting cultural humility, in which you seek to learn from your client families rather than imposing onto them your own beliefs, ideas, and knowledge about a given culture.
- There are several factors to consider when working with diverse family cultures, including their family structure, role of extended family members, spiritual/religious beliefs, immigrant/ nativity status, family values, approach to communication, experience with racism or other discrimination, and history of extended separation (especially between parents and children).
- When working with African American families, you should consider tailoring treatments and services by using culturally relevant storytelling techniques, helping parents strengthen the bonds between each other, and addressing racial socialization (that is, the ways in which parents, directly and indirectly, teach

their children about race and society).

- Outcomes of family-based SUD treatment for Latino families may be best when you offer treatments and services in their native language, explore the family's history of migration and cultural transition, and understand how substance use is defined and discussed in their country of origin.
- For Asian American families, you can adapt family-based SUD treatment by discussing the concept of collectivism and how that might fit into the family's views, values, and customs; exploring the family's level of acculturation; and learning about help-seeking and coping behaviors common in their country of origin.
- For American Indian/Alaska Native families, a systemwide approach that involves the entire community, tribe, or clan is often needed. Helping families understand their interconnectedness, and how the behavior of one family member can have ripple effects on the rest of the family, is critical and may require clinicians to involve valued others who are outside the family (e.g., community elders, spiritual healers) in the treatment process.
- LGBT families have not been the subject of as much research as families of diverse racial and ethnic backgrounds. Nevertheless, evidence suggests that these families may benefit from strategies such as alliance building among family members, including nontraditional family members, in treatment and having separate counseling sessions with family members non-accepting of your client.
- If working with military families, you will benefit from learning about military culture, as it is very different from civilian life. This includes understanding power hierarchies, values and expectations for behavior, and attitudes about substance misuse. Military families may benefit from treatment and services that take into account their history of long periods of separation (e.g., deployment) and relocation, both of which are common in military culture and can be significant sources of strain that might make substance misuse by parents, adolescents, or both more likely.

Chapter 6: Administrative and Programmatic Considerations

This chapter outlines family-related aspects of substance misuse that programs should account for when providing alcohol and drug addiction treatment and recovery support services. This chapter is for administrators and clinical supervisors.

The key to developing and implementing family-based SUD treatment and services is to ensure treatment programs adopt a family-centered culture. This means administrators, directors, supervisors, and other leadership should work together to ensure existing treatment and services are family friendly, tailored to families' full range of needs, and based on empirical evidence. A family-centered culture means an organization includes family members and their needs throughout the treatment and service provision process, including as part of engagement and in shaping the physical program environment. Integrating family counseling and program elements requires education and buy-in among staff as well as the families you serve. Efforts to

enhance workforce development also must be present, such as the hiring and retention of clinicians competent and comfortable in working with families with SUDs.

In Chapter 6, you will learn that:

- Program policies and procedures should be implemented in ways that make treatment and services accessible and effective for families.
- Fully integrated family-based programs are those in which all staff understand the ways in which family can influence (and are influenced by) substance misuse. As a reflection of this, administrators, program managers, and clinical supervisors should help create, implement, and document policies that are family friendly. Clinicians should understand how to incorporate these policies into practice.
- Clinical staff, including supervisors, should possess family-centered counseling competencies. This includes recruiting and hiring clinicians, supervisors, and administrators who already have the training and knowledge to support a family-based culture in your program setting.
- Core skills for SUD treatment and service providers include having knowledge of family-based interventions and treatment models; diverse cultural factors that affect families with substance misuse; the ways in which family dynamics, relationships, and communication affect recovery; and system concepts, theories, and techniques.
- Administrators and supervisors need to ensure that clinicians engage family members as appropriate throughout all stages of care and that they show families respect, honor their strengths, and recognize their unique needs.
- One way in which programs demonstrate their commitment to building and maintaining a family-centered culture is by making certain that staff have the necessary training, licensing, and credentialing in family counseling.
- By providing ongoing opportunities for staff training and education, programs and administrators help ensure clinicians and supervisors possess the latest evidence-based knowledge and practical understanding of working with families with substance misuse.
- Administrators should develop and maintain ongoing supportive partnerships with community-based organizations to help family members stay integrated within their community and access a wide range of services for all needs (e.g., those related to child welfare, social services, the legal system, housing, spirituality/faith, education/vocation). Building and maintaining strong relationships with the surrounding community will also help a program stay up to date on available and effective local resources for client families.

Citation

Substance Abuse and Mental Health Services Administration. Substance Use Disorder Treatment and Family

Therapy. Treatment Improvement Protocol (TIP) Series, No. 39. SAMHSA Publication No. PEP20-02-02-012. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020.

This work resides in the public domain, unless otherwise indicated.

PART VIII

UNIT 8: SKILL BUILDING AND THE ROLE OF MENTAL HEALTH TREATMENT TEAM MEMBERS

This unit looks at building competencies and skills among service providers with an emphasis on evidence-based practices (EBP) and based on principles of adult learning. It is important to understand how to facilitate skill building to increase client functioning in the community. A brief overview is given of various evidence based and promising practices in a variety of settings including forensic.

Finally, the links between recovery-oriented care, integrated health care, and the dimensions of wellness are examined in detail. This shift from an orientation focused on symptoms, illness and medication is a more holistic (and trauma informed) approach to recovery. CRSS credentialed staff need to collaborate with their clients to promote their self-directed healthy behaviors and foster resilience.

Unit Objectives:

- Demonstrate skills-building techniques that support recovery
- Delineate the roles of members of a mental health treatment team
- Define the dimensions of wellness

EVIDENCE-BASED PRACTICE AND RECOVERY-ORIENTED CARE

<https://youtu.be/HQXKIZPnvQc>

WHOLE HEALTH AND RECOVERY

<https://youtu.be/yKkQFp-JOs4>

BUILDING COMPETENCIES AND SKILLS AMONG SERVICE PROVIDERS WORKING WITH YOUNG PEOPLE WHO EXPERIENCE SERIOUS MENTAL HEALTH CONDITIONS: STATE OF THE SCIENCE

This paper explores what is currently known about the most promising strategies for increasing providers' capacity to deliver effective behavioral health services and supports. The paper also describes how this information has been—or could be—applied to the design of cutting-edge approaches for building skills and competencies among providers that work with young people who experience serious mental health conditions.

Need for developmentally- appropriate service and support strategies

Evidence produced in recent years has drawn attention to the idea that the services and supports that are typically available for emerging adults with serious mental health conditions (SMHCs) tend to be neither engaging nor developmentally optimal (Kessler, Demler, & Frank, 2005; Pottick, Bilder, & Vander Stoep, 2008; U. S. Government Accountability Office, 2008). In fact, while young people in this age range experience the highest rates of SMHCs, they are also the population group least likely to engage in behavioral health services, and this is particularly true for young people from racial and ethnic minorities (Substance Abuse and Mental Health Services Administration, 2015, 2017).

Recognizing this gap between need and uptake, researchers and service providers have responded by describing and developing promising new approaches specifically designed to meet the unique needs of emerging adults with SMHCs, and a small number of these approaches have been tested to the extent that they can be described as “empirically supported” (i.e., supported by evidence; Walker & Gowen, 2011, 2012; Walker et al., 2013). Many of these approaches share a core of key practice principles that are intended to promote engagement, good working relationships, and the activation of change processes. Typically, the principles encourage practitioners to work with young people in ways that are strengths-based and driven by the young person's perspectives and priorities.

Additional shared principles stress the importance of helping the young person to acquire skills for increasing self-determination, as well as skills for building relationships and/or social capital, through

connections to supportive adults and peers, and through connections to development-enhancing contexts (Walker 2015; Walker & Flower, 2015).

As a complement to efforts to design new approaches specifically for young/emerging adults, the field has also seen initial efforts to adapt and test evidence-based practices (EBPs) that have been shown to be effective for children, adolescents, or adults generally. Discussions of the processes for adapting EBPs so that they are optimal for emerging adults focus on ensuring that the adapted versions are engaging and developmentally appropriate, and compatible with young people's cultures, values, and needs. A key theme in these discussions is that the adaptations should also include attention to enhancing young people's self-determination and relationship-building skills (e.g., Ellison et al., 2015; Institute of Medicine & National Research Council, 2015).

“Studies have shown that providers using “treatment as usual” very rarely used element of either evidence-based or best practices, despite frequently believing that they were doing so.”

The importance of developing and testing structured interventions and programs for young people is reinforced by studies examining what happens when, as is typical in usual care, practitioners use an unstructured, eclectic approach. Studies of service providers working with adults (Carroll & Martino, 2010) or children (Garland et al., 2010; Garland, Bickman, & Chorpita, 2010) have shown that providers using “treatment as usual” very rarely used elements of either evidence-based or best practices, despite frequently believing that they were doing so. In fact, Carroll and Martino found that clinicians in their control condition spent large amounts of time with clients involved in clinician-initiated “chat” that was not connected to treatment and that predicted lower levels of engagement. In contrast, clinicians receiving training in the active condition— Motivational Interviewing, a structured approach—had very low levels of chat.

Training best practices

If developmentally-appropriate programs and interventions are to be implemented more widely, there is an obvious need for cost-effective training to create a workforce that is prepared to provide services to emerging adults in effective, engaging, and developmentally-appropriate ways (Clark & Unruh, 2009; Haber, Karpur, Deschênes, & Clark, 2008; Hoffman, Heflinger, Athay, & Davis, 2009; Stein, Connors, Chambers, Thomas, & Stephan, 2014). The broader research on training strategies and components provides guidance on how this can be accomplished.

Adhere to principles of adult learning.

Best practices for training are based on principles of adult learning. Specifically, adults learn best when they are self-directed, internally motivated, and actively engaged in examining their own attitudes and increasing their

own knowledge and skills (Trotter, 2006). Ideally, training content builds upon what individual participants already know, is presented in meaningful ways, incorporates active learning processes, and includes a focus on how to apply learning to problems at hand (Kadushin & Harkness, 2002; Trotter, 2006).

Effective training that builds on past experiences takes account of stages of professional development (novice to expert), learning processes, individual learning modality preferences (auditory, visual, sensory, practical), and learning styles (Kolb & Kolb, 2005).

Promote understanding of service contexts and users.

For service providers to be effective, training initiatives need to prepare them to function in community settings and with the service users that they are likely to encounter in practice (Hoge, Huey, & O’Connell, 2004). Training content and strategies should therefore include a focus on having participants apply their learning to situations and problems they encounter as providers, with support and feedback provided when they implement new practices or techniques (Kadushin & Harkness, 2002; Trotter, 2006). Inclusion of community and service user voices in training initiatives can also help to increase providers’ understanding of service contexts and users. For example, communities of color and advocacy organizations such as Youth MOVE National and the Federation of Families for Children’s Mental Health have advocated for members of the focal community and service users to be involved in the development and implementation of training initiatives to provide “insider” perspectives. To be well prepared to serve youth, service providers are increasingly asking for young adults with service experiences to provide training, as reported in the recent Pathways Transition Training Partnership/ Youth MOVE training needs survey, *Supporting You in Supporting Youth* (Jivanjee, Brennan, Grover, & Thorpe, 2018).

Incorporate high-quality coaching.

Training providers to work with young people in new ways typically requires substantial time and investment. Less resource-intensive strategies such as training work-shops and self-paced online trainings have shown some effectiveness in increasing provider knowledge and changing their attitudes. When workshops are enhanced with opportunities to observe and practice new skills, practitioners are in some cases able to replicate these skills within the controlled context of the training (Lyon, Stirman, Kerns, & Bruns, 2011; Olmstead, Carroll, Canning-Ball, & Martino, 2011). While increased knowledge, favorable attitudes, and the ability to demonstrate key skills in a controlled environment are important precursors to practice change, these kinds of lower-resource strategies are generally acknowledged to be insufficient to create and sustain practice change in

real-world settings. (Beidas & Kendall, 2010; Carroll & Rounsaville, 2007; Lyon et al., 2011; Sholomskas et al., 2005).

For practitioners to become adept in new ways of working with clients, initial training needs to be followed by high-quality, practice-focused coaching over a period of at least several months.

There is a growing consensus that, in order for practitioners to become adept in new ways of working with clients, initial training needs to be followed by high-quality, practice-focused coaching over a period of at least several months (Edmunds, Beidas, & Kendall, 2013; Goense, Boendermaker, & van Yperen, 2016; Martino et al., 2016). Coaching is often understood to be a function of regular supervision,

but can also be provided by consultants, expert peers, or other individuals in a dedicated coaching role. High-quality coaching incorporates “gold standard” elements (Dorsey et al., 2013), including observation of practice (either live or via audio- or video recording) and provision of feedback in a manner that is connected to the intervention theory and based on objective criteria (Garland et al., 2013; Herschell, Kolko, Baumann, & Davis, 2010; Milne, Sheikh, Pattison, & Wilkinson, 2011). It is also important that ongoing coaching/supervision incorporate observation, since people generally (Kruger & Dunning, 1999), and clinicians specifically (Martino, Ball, Nich, Frankforter, & Carroll, 2009; Olmstead, Abraham, Martino, & Roman, 2012), tend to be very poor reporters on their own level of skill.

Ensure a supportive organizational context.

The organizational context is also important since organizational structures and systems, management practices, and supervisor, and peer support have been found to impact the extent to which new learning is applied in practice (Beidas & Kendall, 2010; Gray, Sharland, Heinsch, & Schubert, 2015). Team-based learning with others in supportive environments allows opportunities to receive coaching, feedback, and reinforcement (Gururaja, Yang, Paige, & Chauvin, 2008; Lick, 2005; Senge, 1990). In a recent qualitative study of social workers’ and social work students’ experiences and perspectives on lifelong learning (Jivanjee, Pendell, Nissen, & Goodluck, 2015), participants described examples of workplace cultures that either promoted or inhibited learning and the application of new learning on the job. For example, heavy caseloads, overwork, and fears of making a mistake were described as barriers to ongoing learning, while having a supervisor who supports learning was described as essential. For knowledge transfer to occur, training goals and content must be consistent with organizational goals and be reinforced on the job through management and supervisory support for practice changes, and training efforts must be accompanied by relevant changes in structures for accountability and reporting, as evidenced in a study of staff training to improve practice in child welfare organizations (van Zyl, Antle, & Barbee, 2011).

Training modalities

A range of training modalities is used to prepare service providers and to sustain and enhance their skills, each with strengths and limitations. Face-to-face training through workshops and presentations is widely used for continuing education and to support professional licensure (Nissen, Pendell, Jivanjee, & Goodluck, 2014). Face-to-face training has the advantage of being tailored to local conditions, and it tends to be popular with service providers (Jivanjee et al., 2018). Face-to-face training can be helpful for communicating new knowledge and for changing provider attitudes toward new ideas and practices. However, as noted previously there is little evidence that such training leads to knowledge transfer in the absence of follow-up coaching. Further, such trainings are expensive to provide and limited in the numbers of participants. While trainer characteristics and content delivery matter, the most frequently reported best practice strategies for supporting knowledge transfer have been supervisory support and reinforcement, coaching and opportunities to practice, use of inter-active activities, post-training evaluation, and correspondence of training content and job responsibilities (Burke & Hutchins, 2008; Lyon et al., 2011; Shapiro & Kazemi, 2017).

Web-based training has grown in popularity as a cost-effective training approach that can reach wide audiences.

In recent years, web-based training has grown in popularity as a cost-effective training approach that can reach wide audiences, with additional advantages of being self-paced, convenient, engaging, and transportable across locations (Khanna, Carper, Harris, & Kendall, 2017). Positive outcomes of online training programs for service providers in mental health services have also been reported (e.g., Westbrook, McManus, Clark, & Bennett-Levy, 2012), although participants voiced concerns about inadequate accountability for completion of self-paced online training (McMillen, Hawley, & Proctor, 2016). Other studies suggest that there are further benefits from adding components to online training programs, such as treatment manuals, workshops, consultation, taped review of practice sessions, supervisor training, booster sessions, and/or completion of case reviews (Harned et al., 2014; McCay et al., 2017; Morris & Stuart, 2002; Reeves et al., 2006; Ruzek et al., 2014).

Barriers to the use of training best practices

Despite the consensus that effective training is necessary to improve the practice of service providers working with young people with mental health difficulties, significant obstacles have been identified that stand in the way of the use of training best practices. In the Supporting You in Supporting Youth survey (Jivanjee et al., 2018), most transition service providers working with young people with mental health challenges endorsed five major barriers to receiving needed training: expense, heavy workload, shortage of travel funds, distance to training, and limited time off. Nearly half of participants also reported that lack of organizational support was at least moderately affecting their training access. About a quarter of respondents also noted that inadequate

access to technology for online training and lack of supervisor support had an impact on their ability to get the training they needed. Each of the obstacles endorsed by service providers in the Supporting You in Supporting Youth survey will be discussed.

Cost, distance, and time.

The costs of providing the type of “gold standard” training that will lead to practice change can be a major barrier to the implementation of new programs or interventions. For example, the training that is required as part of EBP implementation is typically consistent with most aspects of the gold standard. Recent studies of implementation of various types of cognitive-behavioral therapy (CBT), one of the most frequently implemented EBPs, provide estimates of these costs. A

recent investigation by Lang and Connell (2017) found that, across ten clinics, initial 10-month implementation costs averaged USD \$89,575 per agency, \$11,659 per participating staff member, and \$2,745 per child treated with trauma-focused CBT.

Roundfield and Lang (2017) studied ongoing costs to sustain the same intervention across 14 clinics, and

found yearly costs of \$65,192 per clinic, \$4,461 per staff member trained, and \$1,896 per child treated. EBP implementation costs are seen as one of the top barriers to implementation (Aarons, Wells, Zagursky, Fettes, & Palinkas, 2009) and were cited as the top reason for discontinuation of an EBP in a study that found that fewer than half of community agencies sustained an EBP over six years (Bond et al., 2014). A likely contributor to the lack of EBP sustainment is that while agencies bear the costs of the training, they typically do not reap the benefits, as payment for services is rarely predicated on client outcomes and other types of benefits (e.g., fewer out-of-home placements or emergency room visits) accrue to other system entities (Roundfield & Lang, 2017).

When funding is limited, organizations may have to balance the need for training against the requirement to have staff provide billable services during working hours (Sigel, Benton, Lynch, & Kramer, 2013). The logistics of training may include traveling considerable distances for live face-to-face training opportunities, which involve both travel costs and lost time from work, resulting in reduced revenue (Roundfield & Lang, 2017). Organizations must also insure that supervisory duties are covered, when supervisors attend trainings (Martino et al., 2016). In agencies requiring staff to carry heavy workloads, service providers may have to engage in training opportunities outside of regular working hours, adding to already demanding schedules and workplace stress (Reding et al, in press).

EBP implementation costs are seen as one of the top barriers to implementation and were cited as the top reason for discontinuation of an EBP.

Organizational factors.

Issues arising in organizations that can delay or derail training efforts include resistance to change in the face of

limited resources, and the absence of champions in the organization who promote the presentation of new approaches based on evidence, and support their eventual adoption by service providers (Gray & Schubert, 2012). Turnover within organizations, as key staff members take on new roles, or leave altogether and are replaced, can also interfere with the process of planning and executing training programs associated with the adoption of promising, empirically-supported, and evidence-based practices (Beidas et al., 2016).

Technology barriers.

With the development of online training resources for transition service providers, such as self-paced modules and webinar presentations and archives, potential trainees have encountered obstacles to their participation. Their organization may have specific policies that limit access to their preferred technological devices or channels, or the technology-based training programs may not be accessible on the devices that they use most, including mobile phones (Storey, 2017). They may also have difficulty adapting to training delivered through technology, or lack the time and motivation to complete self-paced, or self-directed online training programs (Brennan, Sellmaier, Jivanjee & Grover, 2018; Harned et al., 2014; McMillen et al., 2016).

Providing “live” trainings partially or fully via web conference can eliminate the often substantial costs associated with travel for both trainees and trainers.

Lack of supervisor support.

Although some attention has been paid to the importance of reducing supervisor stress and its associated turnover (Tebes et al., 2011), the lack of a consistent and supportive supervisor who fosters the implementation of knowledge and skills derived from training is a key organizational problem (Martino et al., 2016). Supervisors can also experience challenges working with service providers on training issues if they themselves are unfamiliar with the new practice and/or the theory base for the change they are promoting (Regan et al., 2017; Walker & Matarese, 2011).

Emerging approaches to managing barriers

Creative use of training modalities.

One set of strategies for addressing barriers to the use of training best practices involves creatively combining training modalities and/or incorporating technology to reduce costs and to allow for training experiences that are more in tune with principles of adult learning. For example, providing “live” trainings partially or fully via web conference can eliminate the often substantial costs associated with travel for both trainees and trainers. What is more, when travel costs are eliminated through online delivery of content, training can be spread out

over time and skills introduced sequentially, starting with more basic skills and moving to more advanced skills, with time to practice and consolidate gains in between.

Similarly, allowing trainees to “observe” real practice by accessing a library of video recordings online can eliminate the costs related to bringing in experts to demonstrate good practice and the costs related to time and travel to observation of real sessions with service users. When trainees can access library material as needed, training can be more self-paced and better matched to individual needs. Another example is the use of audio or video recordings as the basis for consultation on trainees’ practice, which can eliminate costs related to having experts shadow trainees in the field.

Specialization.

One of the drivers of costs for implementation of new practices is the fact that most providers in community settings see clients that are diverse in terms of needs and, often, age, culture, or other treatment-relevant characteristics. So, for example, per-client costs for an empirically-supported practice are driven up when the treatment—such as a treatment designed for emerging adults or a treatment focused on trauma—is only relevant for a subset of a providers’ clients. Strategies involving technology can be helpful in this situation as well, through the use of tele-mental health strategies that allow providers to specialize and provide a single type of service to more homogeneous clients across a wider geographic area (Hilty et al., 2013). Costs are reduced since fewer total providers would need training in order to serve the client population. This strategy would also address the “jack of all trades, master of none” problem, i.e., the need for providers to be trained in multiple interventions or practices in order to meet the needs of diverse clients. Even if agencies have the funding to comprehensively support multiple practices, it is not clear that providers can fully master a sufficient number of relevant practices such that at least one of those will be relevant to meeting the needs of any given client.

Specialization for the role of trainer and practice consultant/coach can also be facilitated technologically to improve cost-effectiveness. For example, significant expense is often incurred training local supervisors and practice coaches to support a new intervention or program. Typically, these staff will not have knowledge or experience using the new practice themselves (and often they do not carry a caseload anyway), so training them to a sufficient level of expertise requires substantial investment of both time and funds. And of course, this investment is lost if the supervisor/coach leaves the job. Many training efforts rely on train-the-trainer models to develop local expertise, but available research indicates that trainer competence drops off with each step of remove from the purveyor (Olmstead et al., 2011). Additionally, on-site coaches and supervisors typically experience competition for their time, which makes it difficult for them to provide ongoing training support that matches best practice. However, if it is not necessary to be on site (i.e., training takes place using tele- and web-based strategies) training and coaching can be provided indefinitely by specialists with expert knowledge, resulting in higher quality at reduced cost.

Modularization.

A third set of strategies capitalizes on the fact that evidence-based and empirically-supported interventions often share core elements, components or modules with one another (e.g., Weisz et al., 2012; Walker, 2015). One specific strategy proposes that providers can be trained in the elements that appear frequently as constituents of larger evidence-based and empirically-supported interventions. Once trained, the providers can then apply these elements flexibly to meet individual client needs. This approach has been explored for component elements of psychotherapy for children (e.g., behavioral contracting, goal setting, guided imagery; Chorpita & Daleiden, 2009) and holds promise for reducing the costs of training providers to work effectively with children. A slightly different strategy involves creating and testing structured enhancements—e.g., engagement or communication enhancements—that can be used to improve practice elements that are shared across interventions (e.g., Walker, Seibel, & Jackson, 2017).

Current work at Pathways RTC

As noted previously, in collaboration with Youth MOVE National, Pathways Research and Training Center has undertaken the Supporting You in Supporting Youth survey as a means of better understanding providers' perceptions of training needs and their preferences regarding training modalities (Jivanjee et al., 2017). This information can help move the field forward in responding to the needs, opportunities and challenges described here. Additionally, Pathways RTC is developing and testing several competency-building approaches that incorporate a variety of cutting edge strategies, described in this document. Further details about each of these training projects can be found in the linked documents.

- Achieve My Plan (AMP; Walker et al., 2017), is an enhancement for existing interventions and programs that build providers' competence in working with young people in ways that promote their acquisition of self-determination skills, ensure that care/treatment is based on their perspectives and priorities, and promote strengths in meaningful ways. Current AMP training is completely delivered via “remote” training and coaching (i.e., via webconference and the internet) in a way that conforms to best practices outlined here.
- AMP+ is an adaptation of “original AMP,” and is also an enhancement to existing interventions or programs (Walker, Baird, & Welch, 2018). AMP+ aims to build skills for young adult peer support providers who work in a peer role that is focused on supporting young people to carry out activities and plans in the community. AMP+ training is also delivered remotely in a manner that is similar to the

Pathways RTC is developing and testing several competency-building approaches that incorporate a variety of cutting edge strategies.

training for “original” AMP.

- *Promoting Positive Pathways to Adulthood* (PPPA; Brennan, Jivanjee, Sellmaier, & Grover, 2018) is a 10-module online training program with an accompanying toolkit of practice activities based on core competencies identified through literature searches and stakeholder consultation. A recent study tested the outcomes of PPPA and found that participants receiving either online training only or online training plus team-based practice exercises made significant gains in transition-related knowledge and self-rated transition competencies, with those participating in team-based exercises achieving greater knowledge gains.
- *Technology-Enhanced Coaching* focuses on helping supervisors to perform more effectively in the role of coaching their providers in skills for working more effectively using TIP (the Transition to Independence Program, a widely implemented intervention for working with older youth and young adults who experience serious mental health conditions). Supervisors are coached by Pathways staff in the efficient use of a reliable feedback system that incorporates video of providers’ work.

Conclusion

This review of research and conceptual literature and lessons learned from Pathways training initiatives provides support for training and workforce development strategies that build on principles of adult learning, take advantage of new technologies, and reinforce the application of new learning through on-the-job consultation and coaching. To improve outcomes for youth and young adults with mental health needs, service providers must be well-prepared and supported to offer services that are engaging, evidence-based, developmentally appropriate, and compatible with young people’s cultures, values and needs. The research examined here reveals that creative uses of a variety of training methods are needed, with ongoing studies to identify the most effective combinations of training and coaching strategies for service providers at different stages of professional development and with different learning styles. Further research is needed to understand and disseminate the most effective methods for preparing service providers to offer developmentally appropriate and evidence-based supports to enhance young people’s self-determination and relationship-building skills in order to achieve their self-identified goals.

Citation

Walker, J., Jivanjee, P., Brennan, E., & Grover, L. (2018). *Building Competencies and Skills among Service Providers Working with Young People who Experience Serious Mental Health Conditions: State of the Science*. Portland, OR: Research and Training Center for Pathways to Positive Futures, Portland State University.

References

- Aarons, G.A., Wells, R.S., Zagursky, K., Fettes, D.L., & Palinkas, L.A. (2009). Implementing evidence-based practice in community mental health agencies: A multiple stakeholder analysis. *American Journal of Public Health, 99*(11), 2087–2095.
- Beidas, R.S., & Kendall, P.C. (2010). Training therapists in evidence-based practice: A critical review of studies from a systems-contextual perspective. *Clinical Psychology: Science and Practice, 17*(1), 1-30.
- Beidas, R.S., Marcus, S., Wolk, C.B., Powell, B., Aarons, G.A., Evans, A.C., ... Mandell, D.S. (2016). A prospective examination of clinician and supervisor turnover within the context of implementation of evidence-based practices in a publicly-funded mental health system. *Administration and Policy in Mental Health and Mental Health Services Research, 43*, 640-649.
- Bond, G.R., Drake, R.E., McHugo, G.J., Peterson, A.E., Jones, A.M., & Williams, J. (2014). Long-term sustainability of evidence-based practices in community mental health agencies. *Administration and Policy in Mental Health and Mental Health Services Research, 41*(2), 228–236.
- Brennan, E.M., Jivanjee, P., Sellmaier, C., & Grover, L. (2018). *Promoting Positive Pathways to Adulthood: Outcomes of an online training program for transition service providers*. Portland, OR: Pathways Transition Training Partnership, Research and Training Center on Pathways to Positive Futures, Portland State University.
- Brennan, E.M., Sellmaier, C., Jivanjee, P., & Grover, L. (2018). *Is online training an effective workforce development strategy for transition service providers? A comparative study*. Manuscript submitted for publication.
- Burke, L.A., & Hutchins, H.M. (2008). A study of best practices in training transfer and proposed model of transfer. *Human Resource Development Quarterly, 19*(2), 107-128.
- Carroll, K.M., & Martino, S. (2010). No train, no gain? *Clinical Psychology: Science and Practice, 17*, 36–40.
- Carroll, K.M., & Rounsaville, B.J. (2007). A vision of the next generation of behavioral therapies research in the addictions. *Addiction, 102*, 850-862.
- Chorpita, B.F., & Daleiden, E.L. (2009). Mapping evidence-based treatments for children and adolescents: Application of the distillation and matching model to 615 treatments from 322 randomized trials. *Journal of Consulting and Clinical Psychology, 77*(3), 566-579.
- Clark, H.B., & Unruh, D.K. (2009). Understanding and addressing the needs of transition-age youth and young adults and their families. In H. B. Clark, & D. K. Unruh (Eds.), *Transition of youth and young adults with emotional or behavioral difficulties: An evidence-supported handbook* (pp. 3-24). Baltimore, MD: Brookes Publishing.
- Dorsey S., Pullmann, M.D., Deblinger, E., Berliner, L., Kerns, S.E., Thompson, K., ... Garland, A.F. (2013). *Improving practice in community-based settings: A randomized trial of supervision-study protocol*. *Implementation Science, 8*(89), 1–11.

Edmunds, J.M., Beidas, R.S., & Kendall, P.C. (2013). Dissemination and implementation of evidence-based practices: Training and consultation as implementation strategies. *Clinical Psychology-Science and Practice*, 20(2), 152–165.

Ellison, M.L., Klodnick, V.V., Bond, G.R., Krzos, I.M., Kaiser, S.M., Fagan, M.A., & Davis, M. (2015). Adapting supported employment for emerging adults with serious mental health conditions. *The Journal of Behavioral Health Services & Research*, 42(2), 206–222.

Garland, A.F., Bickman, L., & Chorpita, B.F. (2010). Change what? Identifying quality improvement targets by investigating usual mental health care. *Administration and Policy in Mental Health*, 37(1–2), 15–26.

Garland, A.F., Brookman-Frazee, L., Hurlburt, M.S., Accurso, E.C., Zoffness, R.J., Haine-Schlagel, R., & Ganger, W. (2010). Mental health care for children with disruptive behavior problems: A view inside therapists' offices. *Psychiatric Services*, 61(8), 788–795.

Garland, A.F., Haine-Schlagel, R., Brookman-Frazee, L., Baker-Ericzen, M., Trask, E., & Fawley-King, K. (2013). Improving community-based mental health care for children: Translating knowledge into action. *Administration and Policy in Mental Health*, 40(1), 6–22.

Goense, P.B., Boendermaker, L., & van Yperen, T. (2016). Support systems for treatment integrity. *Research on Social Work Practice*, 26(1), 69–73.

Gray, M., & Schubert, L. (2012). Sustainable social work: Modelling knowledge production, transfer, and evidence-based practice. *International Journal of Social Welfare*, 21, 203–214.

Gray, M., Sharland, E., Heinsch, M., & Schubert, L. (2015).

Connecting research to action: Perspectives on research utilization. *British Journal of Social Work*, 45, 1952–1967.

Gururaja, R.P., Yang, T., Paige, J.T., & Chauvin, S.W. (2008). Examining the effectiveness of debriefing at the point of care in simulation-based operating room team training. In K. Henriksen, J.B. Battles, M.A. Keyes, & M.L. Grady, (Eds.), *Advances in patient safety: New directions and alternative approaches* (Vol. 3, Performance and Tools). Rockville, MD: Agency for Healthcare Research and Quality. Retrieved from: <https://www.ncbi.nlm.nih.gov/books/NBK43676>

Haber, M.G., Karpur, A., Deschênes, N., & Clark, H.B. (2008). Predicting improvement of transitioning young people in the partnerships for youth transition initiative: Findings from a multisite demonstration. *The Journal of Behavioral Health Services & Research*, 35(4), 488–513.

Harned, M.S., Dimeff, L.A., Woodcock, E.A., Kelly, T., Zaver-nik, J., Contreras, I., & Danner, S.M. (2014). Exposing clinicians to exposure: A randomized controlled dissemination trial of exposure therapy for anxiety disorders. *Behavior Therapy*, 45, 731–744.

Herschell, A.D., Kolko, D.J., Baumann, B.L., & Davis, A.C. (2010). The role of therapist training in the implementation of psychosocial treatments: A review and critique with recommendations. *Clinical Psychology Review*, 30(4), 448–66.

Hilty, D.M., Ferrer, D.C., Parish, M.B., Johnston, B., Callahan, E.J., & Yellowlees, P.M. (2013). The effectiveness of telemental health: A 2013 review. *Telemedicine Journal and e-Health*, 19(6), 444–454.

Hoffman, C., Heflinger, C.A., Athay, M., & Davis, M. (2009). Policy, funding, and sustainability: Issues and recommendations for promoting effective transition systems. In H.B. Clark & D.K. Unruh, (Eds.), *Transition of youth and young adults with emotional or behavioral difficulties: An evidence-based handbook* (pp. 263- 290). Baltimore, MD: Paul H. Brookes.

Hoge, M.A., Huey, L.Y., & O'Connell, M.J. (2004). Best practices in behavioral health workforce education and training. *Administration and Policy in Mental Health*, 32(2), 92-106.

Institute of Medicine and National Research Council. (2015). *Investing in the health and well-being of young adults*. Washington, DC: The National Academies Press.

Jivanjee, P., Brennan, E.M., Grover, L., & Thorp, K. (2018). *What do transition service providers need to know and be able to do? Results of a national survey of training needs and preferences*. Portland, OR: Pathways Transition Training Partnership, Research and Training Center on Pathways to Positive Futures, Portland State University.

Jivanjee, P., Pendell, K., Nissen, L.B., & Goodluck, C. (2015). Lifelong learning in social work: A qualitative exploration with social work practitioners and students. *Advances in Social Work*, 16(2) 260-275.

Kadushin, A., & Harkness, D. (2002). *Supervision in social work* (4th ed.). New York, NY: Columbia University Press.

Kessler, R., Demler, O., & Frank, R. (2005). Prevalence and treatment of mental disorders 1990 to 2003. *New England Journal of Medicine*, 352(24), 2515–2523.

Khanna, M.S., Carper, M.M., Harris, M.S., & Kendall, P.C. (2017). Web-based parent-training for parents of youth with impairment for anxiety. *Evidence-Based Practice in Child and Adolescent Mental Health*, 2(1), 43-53.

Kolb, A.Y., & Kolb, D.A. (2005). Learning styles and learning spaces: Enhancing experiential education in higher education. *Academy of Management Learning & Education*, 4(2), 193-212.

Kruger, J., & Dunning, D. (1999). Unskilled and unaware of it: How difficulties in recognizing one's own incompetence lead to inflated self-assessments. *Journal of Personality and Social Psychology*, 77(6), 1121–1134.

Lang, J.M., & Connell, C.M. (2017). Measuring costs to community-based agencies for implementation of an evidence-based practice. *Journal of Behavioral Health Services & Research*, 44, 122–134.

Lick, D.W. (2005). A new perspective on organizational learning: Creating learning teams. *Evaluation and Program Planning*, 29, 88-96.

Lyon, A.R., Stirman, S.W., Kerns, S.E.U., & Bruns, E.J. (2011). Developing the mental health workforce: A review and application of training approaches from multiple disciplines. *Administration and Policy in Mental Health*, 38, 238-253.

Martino, S., Ball, S., Nich, C., Frankforter, T.L., & Carroll, K.M. (2009). Correspondence of motivational enhancement treatment integrity ratings among therapists, supervisors, and observers. *Psychotherapy Research: Journal of the Society for Psychotherapy Research*, 19(2), 181–193.

Martino, S., Parish, M., Añez, L., Nich, C., Canning-Ball, M., Hunkele, K., ... Carroll, K.M. (2016). The effectiveness and cost of clinical supervision for Motivational Interviewing: A randomized controlled trial. *Journal of Substance Abuse Treatment*, 68, 11-23.

McCay, E., Carter, C., Aiello, A., Quesnel, S., Howes, C., Beanlands, H., ... Lord, C. (2017). Training frontline community agency staff in dialectical behavior therapy: Building capacity to meet the mental health needs of street-involved youth. *The Journal of Mental Health Training, Education, and Practice*, 12(2), 121-132.

McMillen, J.C., Hawley, K.M., & Proctor, E.K. (2016). Mental health clinicians' participation in web-based training for an evidence supported intervention: Signs of encouragement and trouble ahead. *Administration and Policy in Mental Health and Mental Health Services Research*, 43, 592-603.

Milne, D., Sheikh, A., Pattison, S., & Wilkinson, A. (2011). Evidence-based training for clinical supervisors: A systematic review of 11 controlled studies. *The Clinical Supervisor*, 30(1), 53-71.

Morris, J.A., & Stuart, G.W. (2002). Training and education needs of consumers, families, and front-line staff in behavioral health practice. *Administration and Policy in Mental Health*, 29(4/5), 377-402.

Nissen, L., Pendell, K., Jivanjee, P., & Goodluck, C. (2014). Lifelong learning in social work education: A review of the literature and implications for the future. *Journal of Teaching in Social Work*, 34(4), 384-400.

Olmstead, T.A., Abraham, A.J., Martino, S., & Roman, P.M. (2012). Counselor training in several evidence-based psychosocial addiction treatments in private US substance abuse treatment centers. *Drug and Alcohol Dependence*, 120(1-3), 149-154.

Olmstead, T., Carroll, K.M., Canning-Ball, M., & Martino, S. (2011). Cost and cost-effectiveness of three strategies for training clinicians in motivational interviewing. *Drug and Alcohol Dependence*, 116(1-3), 195-202.

Pottick, R., Bilder, S., & Vander Stoep, A. (2008). US patterns of mental health service utilization for transition-age youth and young adults. *Journal of Behavioral Health Services & Research*, 35(4), 373-389.

Reding, M.E.J., Guan, K., Regan, J., Palinkas, L.A., Lau, A.S., & Chorpita, B.F. (in press). Implementation in a changing landscape: Provider experiences during rapid scaling of use of evidence-based treatments. *Cognitive and Behavioral Practice*.

Reeves, S., Freeth, D., Glen, S., Leiba, T., Berridge, E-J., & Herzberg, J. (2006). Delivering practice-based interprofessional education to community mental health teams: Understanding some key lessons. *Nurse Education in Practice*, 6, 246-253.

Regan, J., Lau, A.S., Barnett, M., Stadnick, N., Hamilton, A., Pesanti, K., ... Brookman-Frazee, L. (2017). Agency responses to a system-driven implementation of multiple evidence-based practices in children's mental health services. *BMC Health Services Research*, 17, 671-684.

Roundfield, K.D., & Lang, J.M. (2017). Costs to community mental health agencies to sustain an evidence-based practice. *Psychiatric Services*, 68(9), 876-882.

Ruzek, J.I., Rosen, R.C., Garvert, D.W., Smith, L.D., Sears, K.C., Marceau, L., ... Stoddard, A.M. (2014).

Online self-administered training of PTSD treatment providers in cognitive-behavioral intervention skills: Results of a randomized controlled trial. *Journal of Traumatic Stress*, 27, 703-711.

Senge, P.M. (1990). *The fifth discipline: The art & practice of the learning organization*. New York, NY: Double-day Business.

Shapiro, M., & Kazemi, E. (2017). A review of training strategies to teach individuals implementation of behavioral interventions. *Journal of Organizational Behavior Management*, 37(1), 32-62.

Sholomskas, D.E., Syracuse-Siewert, G., Rounsaville, B.J., Ball, S.A., Nuro, K.F., & Carroll, K.M. (2005). We don't train in vain: A dissemination trial of three strategies of training clinicians in cognitive-behavioral therapy. *Journal of Consulting and Clinical Psychology*, 73(1), 106-115.

Sigel, B.A., Benton, A.H., Lynch, C.E., & Kramer, T.L. (2013). Characteristics of 17 statewide initiatives to disseminate Trauma-focused Cognitive-Behavioral Therapy (TF-CBT). *Psychological Trauma: Theory, Research, Practice, and Policy*, 5(4), 323-333.

Stein, K.F., Connors, E.H., Chambers, K.L., Thomas, C.L., & Stephan, S.H. (2014). Youth, caregiver, and staff perspectives on an initiative to promote success of emerging adults with emotional and behavioral disabilities. *The Journal of Behavioral Health Services & Research*, 43(4), 582-596.

Storey, G.S. (2017). *An empirical analysis for Bring-Your-Own-Device (BYOD) policy adoption in organizations* (Doctoral dissertation). Retrieved from ProQuest Dissertations Publishing (No. 10265019).

Substance Abuse and Mental Health Services Administration. (2015). *Racial/ethnic differences in mental health service use among adults*. HHS Publication No. SMA-15-4906. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2017). *Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health* (HHS Publication No. SMA 17-5044, NSDUH Series H-52).

Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from: <https://www.samhsa.gov/data>

Tebes, J.K., Matlin, S.L., Migdole, S.J., Farkas, M.S., Money, R.W., Shulman, L., & Hoge, M.A. (2011). Providing competency training to clinical supervisors through an interactional supervision approach. *Research on Social Work Practice*, 21(2), 190-199.

Trotter, Y.D. (2006). Adult learning theories: Impacting professional development programs. *The Delta Kappa Gamma Bulletin*, Spring, 8-13.

U.S. Government Accountability Office. (2008). *Young adults with serious mental illness: Some states and federal agencies are taking steps to address their transition challenges*. Publication No. 08-678. Washington DC: U.S. Government Accountability Office.

van Zyl, M.A., Antle, B.F., & Barbee, A.P. (2011). Using training to change the learning environment in public child welfare organizations. In M. Roberts-DeGennaro & S.J. Fogel (Eds.), *Using evidence to inform practice for community and organizational change* (pp. 177-199). Chicago, IL: Lyceum.

Walker, J.S. (2015). A theory of change for positive developmental approaches to improving outcomes among emerging adults with serious mental health conditions. *Journal of Behavioral Health Services & Research*, 42(2), 131–149.

Walker, J.S., Baird, C., & Welch, M.B. (2018). *The AMP+ skills enhancement training for peer support providers*. Portland, OR: Research and Training Center for Pathways to Positive Futures, Portland State University. Retrieved from: <https://www.pathwaysrtc.pdx.edu/state-of-the-science-articles-2018-amp-plus>

Walker, J.S., & Flower, K.M. (2015). Provider perspectives on principle-adherent practice in empirically-supported interventions for emerging adults with serious mental health conditions. *Journal of Behavioral Health Services & Research*, 43(4), 525–540.

Walker, J.S., & Gowen, L.K. (2011). *Community-based approaches for supporting positive development in youth and young adults with serious mental health conditions*. Portland, OR: Research and Training Center for Pathways to Positive Futures, Portland State University. Retrieved from: <https://www.pathwaysrtc.pdx.edu/pdf/pbCmtyBasedApproaches09-2011.pdf>

Walker, J.S., & Gowen, L.K. (2012). Transition education for adolescents with serious mental health concerns. In M. L. Wehmeyer & K. W. Webb (Eds.), *Handbook of transition education for youth with disabilities* (pp. 475–493). New York, NY: Routledge.

Walker, J.S., Gowen, L.K., Jivanjee, P., Moser, C., Sellmaier, C., Koroloff, N., & Brennan, E.M. (2013). *Pathways to Positive Futures: State-of-the-Science conference proceedings*. Portland, OR: Research and Training Center for Pathways to Positive Futures, Portland State University. Retrieved from: <https://www.pathwaysrtc.pdx.edu/pdf/pb-2013-proceedings.pdf>

Walker, J., & Matarese, M. (2011). Using a theory of change to drive human resource development for wraparound. *Journal of Child and Family Studies*, 20, 791–803.

Walker, J.S., Seibel, C.L., & Jackson, S. (2017). Increasing youths' participation in team-based treatment planning: The Achieve My Plan enhancement for wraparound. *Journal of Child and Family Studies*, 26(8), 1–11.

Weisz, J.R., Chorpita, B., Palinkas, L.A., Schoenwald, S. K., Miranda, J., Bearman, S.K., ... Research Network on Youth Mental Health. (2012). Testing standard and modular designs for psychotherapy treating depression, anxiety, and conduct problems in youth. *Archives of General Psychiatry*, 69(3), 274–282.

Westbrook, D., McManus, F., Clark, G., & Bennett-Levy, J. (2012). Preliminary evaluation of an online training package in Cognitive Behaviour Therapy: Satisfaction ratings and impact on knowledge and confidence. *Behavioural and Cognitive Psychotherapy*, 40(4), 481–490.