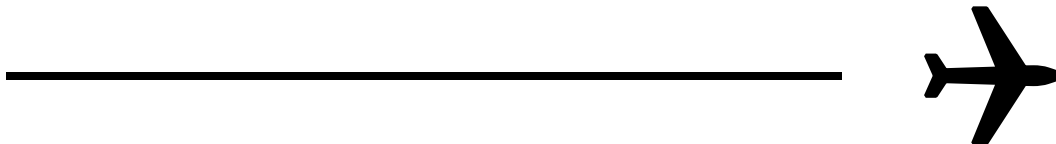


CDC 4C051N

Mental Health Journeyman

Volume 4. Treatment Planning, Psychotherapeutic Interventions, and Case Management



**Extension Course Program (A4L)
Air University
Air Education and Training Command**

**4C051N 04 0906, Edit Code 03
AFSC 4C051**

Author: MSgt Jeff L. Johnson

383d Training Squadron
US Air Force School of Health Sciences (AETC)
383 TRS/TRR
939 Missile Road
Sheppard Air Force Base, Texas 76311-2363
DSN: 736-1965
E-mail address: jeff.johnson@sheppard.af.mil

Instructional Systems

Specialist: Regina G. Lucas

Editor: Debra H. Banker

Extension Course Program (A4L)
Air University (AETC)
Maxwell Air Force Base, Gunter Annex, Alabama 36118-5643

THIS 4C051N CDC, *Mental Health Journeyman*, will provide you with the tools necessary to engage in treatment planning and selected psychotherapeutic interventions. You will also become more familiar with case presentation methods, and your role in the Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program.

Unit 1 takes the journeyman through the various stages of treatment planning from inception to termination. You will also become familiar with how to organize and present cases that you are responsible for at your clinic. Unit 2 focuses solely on psychotherapeutic interventions from the various counseling techniques to conducting groups. Unit 3 presents the various community resources you will have at your disposal and the unique role each of them provides. The unit also covers the ADAPT Program and what you will need to do to begin the process to obtain certification.

A glossary of abbreviations and acronyms used in this course is included at the end of this volume.

Code numbers on figures are for preparing agency identification only.

The use of a name of any specific manufacturer, commercial product, commodity, or service in this publication does not imply endorsement by the Air Force.

To get a response to your questions concerning subject matter in this course, or to point out technical errors in the text, unit review exercises, or course examination, call or write the author using the contact information on the inside front cover of this volume.

NOTE: Do not use the IDEA Program to submit corrections for printing or typographical errors.

Consult your education officer, training officer, or NCOIC if you have questions on course enrollment, administration, or irregularities (possible scoring errors, printing errors, etc.) on unit review exercises or course examination. For these and other administrative issues, you may also access the ECP E-Customer Support Center (helpdesk) at <http://www.auecampussupport.com> and do a search for your course number. You may find your question has already been answered. If not, submit a new question or request, and you will receive a response in four days or less.

This volume is valued at 9 hours and 3 points.

NOTE:

In this volume, the subject matter is divided into self-contained units. A unit menu begins each unit, identifying the lesson headings and numbers. After reading the unit menu page and unit introduction, study the section, answer the self-test questions, and compare your answers with those given at the end of the unit. Then complete the unit review exercises.

	<i>Page</i>
Unit 1. Treatment Planning and Establishing Goals	1–1
1–1. Treatment Planning	1–1
1–2. Long- and Short-term Goals	1–7
1–3. Develop a Relapse Prevention Plan	1–13
1–4. Termination/Discharge	1–17
1–5. Written Treatment Plans	1–18
Unit 2. Selected Psychotherapeutic Interventions.....	2–1
2–1. Conducting Counseling	2–1
2–2. Conducting Groups	2–17
Unit 3. Case Management, ADAPT, and Population Health.....	3–1
3–1. Case Management	3–1
3–2. Alcohol and Drug Abuse Prevention and Treatment Program.....	3–9
3–3. Air Force Population Health	3–16
 <i>Glossary.....</i>	 <i>G–I</i>

Please read the menu for Unit 1 and begin. ➡

Unit 1. Treatment Planning and Establishing Goals

1–1. Treatment Planning.....	1–1
601. Identify strengths and weaknesses	1–1
602. Identify problems and needs	1–2
1–2. Long- and Short-Term Goals	1–7
603. Identify concepts of goals and objectives	1–7
604. Identify the process of selecting and defining goals	1–8
1–3. Develop a Relapse Prevention Plan.....	1–13
605. Identify determinants of relapse	1–13
606. Identify key elements of developing a relapse prevention plan	1–14
1–4. Termination/Discharge	1–17
607. Identify common aspects of treatment termination.....	1–17
1–5. Written Treatment Plans.....	1–18
608. Developing a written treatment plan.....	1–18
609. Assessment of treatment progress.....	1–20

THIS UNIT focuses on the various basic steps required for treatment planning. You will study the key steps needed to build and complete a treatment plan. You will also learn about post-treatment planning, referred to as relapse prevention, in the latter portion of this unit.

1–1. Treatment Planning

Treatment planning combines the development of a common language that describes the multidimensional assessment process and identifies the core components for the continuum of care. The treatment plan’s common-language approach also enables other caregivers to use the treatment plan with a uniform definition for identifying key processes. Once you learn the steps in this lesson, you will use them your entire career.

601. Identify strengths and weaknesses

Identifying your patient’s strengths and weaknesses will be vital as you begin treatment planning. Many of the patient’s strengths or weaknesses may have been identified as you conducted your initial assessment. If the patient has a difficult time identifying his or her strengths and weaknesses, you can rely on what you have gathered during the assessment, which can provide a launching platform for progress. For example, “TSgt Watson, I see one of your strengths is you’re self-confident and very organized.” This could be used later as you begin to match the patient’s resources or strengths with goals.

Strengths

Often patients have lost sight of any positive aspect of their lives by the time they make contact with you in a clinical setting. Addressing this area seems simple enough, and you will usually have one of two types of patients answering this question. For some patients, identifying strengths is easy. They can rattle off a list until you literally have to stop them. For others, this is an extremely difficult task. The substance-abusing, substance-dependent, depressed, or demoralized patient may genuinely not be able to readily identify any positive aspect of his or her life. You can provide suggestions such as friends, hobbies, interests. If the patient has made an attempt to resolve his or her problem and failed in the past, this is still recognized as strength, as he or she is willing to take risks to solve problems. Encouraging your patient to identify the simplest of attributes is beneficial. You may provide your observations of what you may have identified earlier in the process.

Strengths also include accomplishments or positive performance by the patient. As mentioned earlier, you can provide suggestions, but the patient ultimately needs to identify what he or she considers a strength. It is best to build from the resources the patient already possesses than to attempt to build from scratch.

Weaknesses

After identifying the patient's strengths, ask what he or she considers as his or her weaknesses. Most patients can identify some aspects of their lives that they would like to approach differently. With this said, the narcissistic or substance-abuse/dependent patient may quickly point out his or her perceived weaknesses in others, rather than in himself or herself. These patients should be redirected to focus on their weaknesses. Perhaps they procrastinate, have poor self-image, or are unable to control their substance usage. It is human nature to be your own worst critic. However, the patient that has poor insight may not see his or her destructive behavior as a weakness; rather he or she is a victim of environmental circumstances. "I would never have gotten a DWI and arrested if I hadn't gotten pulled over by that cop." "I was only trying to teach the kids a lesson! Our family would still be together if he or she hadn't gotten everyone involved." Failing to see a fault in one's self is diagnostic as well.

As a minimum, the list of strengths and weaknesses should have at least three items under each.

602. Identify problems and needs

I can't tell the forest for the trees! Many patients mislabel "wants" as "needs." And why not? We are surrounded by *wants* that somehow become needs. If your child doesn't get the latest fashion or video game, it's not because he or she wants it—according to them; it's because he or she *needs* it to fit in. I can't blame this phenomenon on children alone. We, as adults, have masked many of our wants as needs. Telling the difference at times can be confusing.

In this area, you will spend time clarifying what is the stem of the "here and now" problems. This will also require looking at what some of the patient's *needs* verses *wants* might be.

Problems

The patient's initial presentation at your clinic may be filled with a litany of issues. The patient may not really know or understand what his or her primary problem may be. Many are bewildered and exasperated by what appears to be multiple problems with no resolution. It is important to separate the symptoms from the problem. In other words, has the patient presented a list of issues that are by-products of a larger problem? The causation of the presenting problems may be masked by something else. For example, a patient's financial problem may be the result of a gambling problem, his or her depression may be the result of alcohol use or unresolved bereavement, his or her anxiety may be the result of wrongdoing, and so forth. Helping patients identify the origin of the problem promotes insight and is the first step in patient ownership of the problem.

Once the problems have been identified, the patient should be asked to help prioritize the list. The most disruptive, pain-causing, consequential problem should be listed first. The patient should be primarily in charge of creating this list, but you are not absent. It is with your help, guidance, and objective insight that you begin to create a starting point. Helping the patient focus on a solvable problem will require you, as the counselor, to remain focused. You do not want to become overwhelmed or lost in the patient's confusion. If the patient has a difficult time prioritizing his or her problems, have the patient organize each by the most consequential: "If this problem is left unattended, what is the worst possible outcome?" At this point you should reflect back on the patient's self-identified strengths and match them with a problem the patient may best benefit from.

The patient then begins to prioritize his or her problems with your guidance. Avoid taking ownership of the patient's problems. No matter how difficult or seemingly overwhelming the issue, there is always something that can be done. It may not be the desired outcome the patient was hoping for or wanting, but there is always something that can be changed. The patient will not remain depressed,

anxious, miserable, crazy, or helpless forever. Every patient has options and can choose alternatives toward resolution. You, the mental health journeyman, must remain focused and consistent as the patient seeks reassurance and guidance. Counselors should always remember who the primary stakeholders for outcomes are in the counseling process. You are not responsible for fixing, solving, or confronting problems for patients. You should be available to and provide the tools for the patient to fix the problem, not do the work for him or her. Ultimately, the patient must make changes, set long- and short-term goals, and live with his or her decisions.

Needs

As you provide mental health assessments, you are meeting a basic need of the individual as a “whole person,” and you are able to achieve a higher level of health for the patient. Abraham Maslow is known for establishing the hierarchy of human needs. Maslow identified basic needs necessary for existence and higher level needs for healthy integration of the whole being. He proposed a hierarchy of human needs as an explanation for the forces that motivate human behavior. Our basic Mental Health Apprentice course integrates Maslow’s hierarchy of needs throughout all assessment and care processes. As you progress as a journeyman, you have obtained skills and performed more specialized assessment and patient care than the apprentice level. Your increased responsibilities will involve meeting more of the patient’s needs as a whole person and to incorporate and complete all aspects of his or her care.

Patients often present problems that center around *wants* more than *needs*. Attempting to dislodge that fact can prove difficult, if not impossible at times. Patients often complicate their lives by redefining what necessities are versus luxuries. Looking at Maslow’s hierarchy of needs, it becomes apparent how simple and basic our *needs* are compared to how complicated our *wants* can be.

Identifying needs is key to problem definition. Helping the patient define which problems relate to *wants* versus those related to *needs* will add more gravity and significance to those that are identified.

Human needs theory

While the science of medical advances changes constantly to meet the needs of the patient, so too do the patient’s hierarchy of needs change. There are five basic levels of Maslow’s hierarchy of needs; when incorporated with treatment planning, these five basic levels are the beginning of addressing the patient’s physiological needs. Let’s take a closer look at our hierarchy of needs.

Evolving hierarchy of needs

Once a particular need is met, it does not remain satisfied forever. The need must be replenished from time to time. With any hierarchy, the lowest levels are met in succession to reach the top. This is most obvious when we are talking about the physiological needs of nutrition, rest, and oxygenation. These elements are met repeatedly. When we identify the needs of our patients, we often begin with the very basic foundation. We not only care for their physiological needs but also provide security, belonging, and self-esteem.

Physiological needs

Physiological needs are the very basic that are essential to maintaining life; including oxygen, water, food, sleep, stimulation, activity, sex, and so forth. When these needs are not met, the individual may experience sickness, irritation, pain, or discomfort. More importantly, the necessity of these needs is very strong and, if deprived over time, can result in death.

Once these needs are met, the individual can begin focusing on the next level of the hierarchy. Rather than the physiological needs, other levels of needs become important, and these motivate and dominate the behavior of the individual.

Security needs

Once the physiological needs of the patient are met, the need for security and belonging demand attention. Security needs for most adult patients mainly focus on establishing stability and consistency in a chaotic world. If a patient's safety or security is in danger, other things seem unimportant, and it's difficult to focus on anything else. This area also focuses on the reassurance that his or her physiological and safety needs will be met. When there is a structured treatment process established along with a peaceful environment, you, as mental health journeymen, enhance the feelings of security for the patient. This security will help to decrease anxiety and fear. This is important in allowing the patient to feel more in control. Meeting the needs of security also enhances the patient's concern for his or her future. An example of someone who is seemingly stuck in this level of the hierarchy would include a spouse in an abusive relationship. He or she is unable to move to the next level, as he or she is constantly concerned for his or her safety.

Children and elderly patients are particularly susceptible to stress created by an unfamiliar, disorderly, or hazardous environment. People value order and routine in their daily lives and thrive better in an environment in which they believe these things to be true.

Adults who suddenly become ill might be anxious about finances, loss of control, change in their body image, and what may happen to them in the future if they must cope with the effects of a permanent disabling illness or injury.

Meeting the patient's need for belonging can be provided through the means of communicating, encouraging, sharing thoughts and feelings, and answering as many of the patient's questions as possible. Health care providers can meet the basic physiologic needs (e.g., nutrition, activity, etc.) of a conscious, coherent patient without communication. It is very difficult to meet the other levels of their needs (e.g., self-esteem, belonging) without good communication. Through adequate feedback, clarification, and validation via communication, the patient plays a vital part in his or her treatment planning and satisfying this level of the hierarchy. The patient's participation at this level gives him or her the sense of belonging necessary to move to the next level of self-esteem.

Affiliation

The need for friendship, love, and a sense of belonging is a characteristic of this level of the hierarchy. When physiological and security needs are satisfied, the needs of affiliation emerge. This might entail simply feeling a part of a family unit as a whole and filling a specific role in the family (e.g., mother, father, sibling, aunt, etc.). Belonging for others may be a formal sense of belonging to an organization, such as a church, synagogue, mosque, social organization, sports team, cultural group, and so forth.

The sense of contributing and belonging is emphasized in this area to build to the next level of the hierarchy. Many people have a desire to fulfill the feelings of affiliation and belonging. When you PCS'd, you immediately began searching for a group (e.g., peer group, squadron group, religious organization, etc.) to establish your sense of belonging.

This area is often difficult for patients suffering from substance abuse/dependence diagnoses or severe mental disorders, as they are often either isolated or involved with parasitic social groups. Ironically, the hierarchy for the substance abuser deteriorates from the top down and leaves the user with only the basic of needs, which is sometimes even difficult to maintain.

Self-esteem and love

Self-esteem and love are interrelated. It is apparent one cannot truly love others until one first loves and accepts oneself. Self-esteem is developed from feelings of independence, competence, self-respect, and recognition from others. Many people achieve these goals through various roles in life (e.g., husband, wife, father, mother, community leader, etc.) that contribute to self-esteem. Performers appreciate applause. We need to feel needed. Beer commercials, aside from promoting the alcohol as

a lubricant for sexual encounters, also show the camaraderie of drinking with friends. When was the last time you saw a beer commercial of someone drinking alone?

Mental stimulation, and motivation to seek knowledge and learning, plays a role in personal self-esteem. Teaching the patient the building blocks for treatment planning to reach the final goal of the care plan will build self-esteem as the patient begins to assume more responsibility for outcomes. This is instrumental in helping the patient rebuild feelings of competence, independence, and self-respect.

Love consists of both the giving and receiving of love. An infant will withdraw and spiral to a deteriorating state without love despite having its physiologic needs met. In extreme cases, prolonged deprivation of love can bring about neurotic behavior and organic illness. While you, as a mental health journeyman, cannot provide love in a relationship, you can fulfill the patient's needs by showing empathy, communicating, motivating, and demonstrating a genuine desire to assist him or her in regaining his or her self-esteem.

Self-actualization

Self-actualization, or reaching one's full potential, is an area that people are unable to reach until the lower levels of the hierarchy are met. This level represents an individual who has reached his or her maximum potential or achieved self-fulfillment or peace. This level tends to vacillate based upon ongoing accomplishments or changes in the individual's life or goals. Once reached, self-actualization is often limited to a short period of time due to the ever-changing goals and decisions of an individual.

Using the hierarchy of needs

The hierarchy of needs suggests the succession of needs must be completed to successfully complete the next level. For example, the three lowest categories of needs—physiological, security, and affiliation—are also known as deficiency needs. In other words, unless these needs are satisfied, an individual will fail to develop into a healthy person, both physically and psychologically. In contrast, self-esteem and self-actualization needs are known as growth needs. Satisfaction of these needs helps a person to grow and develop as a human being.

Culture and needs

It would be irresponsible to believe the hierarchy of needs is a one-size-for-all explanation of how individuals must meet the succession of needs or events to reach their full capacity without considering cultural differences. The needs hierarchy is based on United States's cultural values. In cultures that value uncertainty avoidance, such as Japan and Greece, job security and lifelong employment security are stronger motivators than self-actualization. In other countries, such as Denmark, Sweden, and Norway, the value and rewards of a high quality of life are much more important than productivity or belonging. China, Japan, and Korea value collectivism and affiliation over individual achievements; security and affiliation are considered more important than personal-growth needs.

Cultural differences should always be considered when identifying needs. The hierarchy of needs concept may be universal; however, the logical succession of needs differs from culture to culture. This is an important consideration as you continue to formulate a treatment plan and begin identifying goals.

Spirituality

While Maslow certainly provided a unique outline for human hierarchy of needs, some would contend the absence of spirituality as a need makes the succession of needs incomplete. Individuals seek solace in prayer and meditation.

Spirituality is not synonymous with religiosity as some people often assume. One does not need to be religious to be spiritual, or visa versa. *Spirituality* broadly defined is an inner sense of something

greater than oneself, whereas *religiosity* is the outward concrete expression of a specific religion or practice.

The need to believe in a power higher than ourselves is a fundamental principle of Alcoholic's Anonymous. The higher power does not necessarily need to be "God" in the sense of a supreme being, but rather a god of an individual's own interpretation. The understanding that there is a power greater than the individual often creates a feeling of a deeper spiritual purpose and divine direction. Again, the need to connect with or believe in a higher power is especially significant for those patients in recovery or seeking sobriety.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

601. Identify strengths and weakness

1. Which patients may not be able to readily identify any positive aspect of their lives?
2. Patients with poor insight do not view their destructive behavior as a weakness; rather, they view it how?

602. Identify problems and needs

1. What is the first step in patient ownership of a problem?
2. What should be listed first when identifying problems?
3. Abraham Maslow proposed a hierarchy of human needs for what reason?
4. What is essential to maintaining physiological needs?
5. What is the focus for most adults as it relates to security needs?
6. Why is the hierarchy need of self-actualization often limited to a short period of time?

1-2. Long- and Short-Term Goals

Goals occupy a place of central importance as it relates to treatment planning. The general notion that a patient will improve, feel empowered, or pursue more positive aspects in his or her life is an expectation from treatment. This is why he or she sought help to begin with in most cases.

Please note: *counselor* and *journeyman* are synonymous throughout this lesson.

603. Identify concepts of goals and objectives

For some people, establishing goals requires little effort. They know exactly what they want and need to do and are able to develop long- and short-term goals associated with their interests and aptitude. Such people create goals relatively easily. For others, the process requires careful self-exploration and planning to find goals that coincide with their resources, abilities, values, and lifestyle expectations.

Some patients have always avoided establishing goals for a variety of reasons. You should explore those reasons with the patient. Some individuals will avoid setting goals because they actually fear success. Success will bring additional responsibilities and expectations they do not want. Others avoid goal setting for fear of failure. If they set a goal and do not achieve it, they will have yet another failed attempt at success. And still, there are some who operate with the “lottery” or “Santa Claus” mentality that something good will come their way with little effort if any at all—it’s just a matter of time. Discuss previous goal setting, or lack thereof, and examine the outcomes or reasons for goal avoidance if necessary.

Assisting the patient in brainstorming ideas and ascertaining what resources he or she may have to assist in creating long- and short-term goals is a key process in establishing goals. If the patient is able to visualize himself or herself beyond his or her current situation and participate in taking steps, albeit small steps, towards a goal, it will instill hope.

As you begin the process of identifying goals and objectives, you may wonder where you should start. Identifying potential goals is most productive during the intake interview as you identify what some of the patient’s stated goals may be. The patient may have no goals and may be at your clinic simply because he or she was directed to be there. All the patient is hoping for is to be left alone. Goal identification can occur by questioning your patient’s motivation or reason for coming to your clinic. Why are you here? What do you hope to leave with? Or, a question most often productive for the resistive or ambivalent patient, “What aspects of yourself or your life situation would you most like to change?” Establishing and maintaining rapport will facilitate a natural exchange of ideas and avoid leaving the patient feeling as if he or she is being interrogated.

The following lesson should give you an overview of the steps you will need to take to guide a patient through establishing goals.

Goal defined

The goal is an outcome statement of what the patient will ultimately attain through treatment that is important to the patient. It focuses on the positive. It is realistic, achievable, and is seen as worthwhile by the patient. The goal should be a positive statement that, if met, should affect one or more of the symptoms of the diagnosis.

Establishing goals creates focal points towards which the patient should expend energy. Short-term goals provide acute relief or feelings of accomplishment. Long-term goals suggest the patient is invested over a period of time. A major therapeutic task is identifying a starting point with the patient. It is important the patient designate the starting point with the counselor being in agreement. Agreement is key to success in creating goals. If you identify a problem that you feel the patient would benefit from undertaking and the patient has another in mind, you will be working in possible opposite directions. Senior Airman Sauv , for example, may have sought your assistance following a letter of reprimand (LOR) from his supervisor for repeated incidences of being late to work and failing his career development courses (CDC). As he describes his issues, you begin to notice a

pattern of procrastination, disregard for Air Force core values, and partying more often than studying. You are convinced he needs to develop better work ethics, adhere to Air Force core values, and prioritize his off-duty time to compliment his work/study requirements. From Senior Airman Sauv  's perspective, he desperately wants to figure out why his supervisor is out to get him and is treating him unfairly. Any progress in treatment will likely go nowhere until you, as the counselor, and Senior Airman Sauv   can establish a common goal that is desirable and possible.

Choosing a possible or even plausible goal can be extremely difficult if the patient is feeling overwhelmed. The following examples might be statements where the patient's desires are impossible to achieve. Following the death of his wife a grieving spouse states, "I'll never be happy again unless I can have my wife back." "If I could just erase that DWI from my record, life would be different," says another NCO. Obviously, these things cannot be achieved. In the patient's overwhelmed mindset, he or she feels there is a remote chance you could make the world "right" for him or her again. In these cases, the patient must be steered towards achieving a goal that might be the least important to him or her at the moment. For the grieving patient missing his deceased wife, it might be that he will consume at least two full meals per day over the next three days. In achieving something relatively simple, the patient can feel a sense of success at the end of a designated time period.

Objective defined

An objective is a short-term step the patient will take toward attaining the long-term treatment goal that can be realistically achieved within a period of time.

Establishing a goal based upon realistic, resolvable, and obtainable milestones is essential. Milestones in this case are objectives. Every goal must have at least one objective that defines how the patient plans on achieving his or her goal. For instance, your goal may be, "I want to get promoted to Senior Airman below-the-zone (BTZ)." There are several steps to achieving this goal, including demonstrating your preparedness to assume more responsibility ahead of your peers, preparing to meet a board, and becoming knowledgeable of the contents of the Professional Development Guide (PDG). One of your objectives towards obtaining your goal might be, "I will study each evening for one hour beginning three months before I meet the board." To better illustrate the relationship between goals and objectives, look at the following example:

- **GOAL:** Achieve Senior Airman BTZ.
 - **OBJECTIVE 1:** Study one hour each evening beginning three months prior to meeting the board.
 - **OBJECTIVE 2:** Practice meeting a board with my supervisor three times before meeting the actual board.
 - **OBJECTIVE 3:** Volunteer for additional responsibilities and duties to demonstrate my preparedness.

Achieving goals empowers the patient. Once one goal is achieved, the patient then moves to the next. Goals should be solid and achievable, but they will change at times. As patients mature and their life circumstances or values change, their goals will change as well. This ever-evolving process begins to help define self-esteem and self-actualization. As you studied in the hierarchy of needs, self-actualization is often short-lived, as individuals begin to strive for more and more lofty goals. This is how the hierarchy of needs begins to tie into other aspects of the treatment plan.

604. Identify the process of selecting and defining goals

This lesson will explain the concepts of goals and objectives and put them into practice. By carefully following the process described in this lesson, you will be able to identify the key components of establishing goals and objectives.

Selecting

Helping a patient select proper goals is not always easy. Although the patient is responsible for making the final goal selection, you will probably need to guide him or her in the process.

Explain the purpose of the goal

Explaining the purpose of the goal allows the patient an opportunity to begin formulating ideas about what outcomes he or she would like to achieve from treatment. The counselor should explain exactly what a goal is, its purpose, and the patient's role in establishing goals. Some patients may have never set goals and the entire process or concept is foreign to them. For these patients, you may use examples of successes you are aware of as a result of someone being goal driven. Ask the patient for examples of persons he or she may consider successful and how the individuals achieved their fame or notoriety.

The establishment of goals is a contract between you and the patient. The contract identifies what the patient has agreed to pursue. Keep in mind, the patient is the primary stakeholder and is responsible for outcomes. Too many times, the new clinician will assume responsibility for key components of the patient's goal. While your efforts may seem noble in your attempt to help the patient, it teaches the patient very little regarding assuming control and responsibility for the direction of his or her life. You should provide support, suggestions, and guidance when necessary, but the contract does not commit you to do the labor of goal achievement.

Ask the patient what he or she would be willing to do to create change in his or her life. Have the patient identify all positive outcomes that he or she is hoping to achieve through counseling/treatment. Assist the patient in identifying positive changes he or she would like to see within a specified time frame. "Where would you like to be in six months?" What would you like to be doing a year from now?" Begin prodding the patient for clarity regarding his or her future aspirations and how he or she plans on achieving his or her ideas.

Keep the goals positive rather than a negative. Ask the patient to focus on what he or she *wants* to do over the next six months, rather than what he or she *doesn't want* to do. Instead of saying, "I'm not going to gamble at the casino anymore," the patient should be redirected to focus on what he or she will do instead of gambling. Something (the goal) must now fill that void and that goal should be the focus of the patient. For example, the patient may decide to begin his or her Community College of the Air Force (CCAF) degree. To do this, the patient will need to take college classes, which will take the place of going to the casinos.

Does the patient own the goal?

It is imperative that the patient takes ownership of the goal. In other words, is it the patient's problem to solve?

Many patients will begin describing a problem that minimizes their role or contribution. Projecting blame keeps the responsibility of the problem on someone or something else. Be attuned to the patient's suggested goal and ensure it is one he or she is solely in charge of changing or implementing. The patient's ultimate goal cannot rely on the actions or inaction of someone else.

As the patient begins creating goals, ensure the goals are achievable. For instance, if the patient voices a goal as, "I want my supervisor to listen to me more" or "I want my kids/spouse to help out more around the house," you should quickly point out that his or her ability to control the outcome of the stated goal is beyond his or her control and is destined to failure. The patient must be in complete control of the choices and changes if he or she wants to meet the goal. Perhaps the patient cannot make the supervisor listen to him or her more, but the patient can create an environment or examine his or her behavior (perhaps the patient talks excessively, exaggerates, or acts immaturely, and the supervisor tunes him or her out) where the supervisor may be more interested in what the patient has to say.

Is the goal realistic?

As patients select and organize goals, counselors should be wary of goals that are not feasible or are inconsequential in nature. “I’m going to make Senior Airman BTZ!” is not feasible if the patient has been court-martialed. Unrealistically high goals should be discouraged, while less lofty, but achievable, goals should be suggested.

Likewise, goals that are inconsequential in nature are not acceptable. The overweight patient, who must lose 30 pounds to meet standards within six months, would be cutting short his or her potential success if he or she vowed to lose only 15 pounds within that time frame. This can simply be described as a hollow victory, as nothing of consequence was achieved. In this case, the patient still remains overweight and never committed to reaching the necessary goal.

Advantages of goal achievement

The patient should make a written list of what advantages are anticipated if his or her goal is fulfilled. You should carefully examine the advantages of the patient’s stated goal achievement for a variety of reasons, primarily to ensure the anticipated outcome is worth the effort the patient is willing to put into achieving the goal. For example, if the patient believes by accomplishing X, Y, and Z that he or she would be promoted and earn significantly more money, the patient is likely to work hard to accomplish those things. However, if after achieving those tasks the patient finds that, rather than a promotion, he or she is simply moved laterally to another job without an increase in pay, the patient may lose interest in the goal or simply not engage in further goal setting.

This is why it is important to identify the *cost* versus *benefit* effect of all identified goals. In other words, what is being given up (cost) versus what is gained (benefit) from goal achievement? What exactly is the patient hoping will occur that will alter his or her life for the better as a result? Is there a potential unforeseen negative consequence of goal achievement?

Disadvantages of goal achievement

The outcome of achieving a goal should never intentionally result in a disadvantage for the patient. However, this can unexpectedly happen. Perhaps your patient is overwhelmed with working three jobs. He or she desires more time with his or her family and a goal includes making more time for his or her family. He or she decides to quit one of the jobs to fulfill this goal. All is well until the end of the month when the patient is presented with a quandary of not having enough money to meet his or her financial obligations. This, of course, would be an unanticipated negative outcome.

A thorough exploration of the patient’s goals might have avoided this negative outcome. You should query the patient regarding anticipated and unanticipated outcomes to goal achievement. You should entertain all potential consequences with the patient. Refer back to cost versus benefit factors when identifying goals. Again, a goal should never result with the patient at a disadvantage.

Identify possible goals

Using the conditions above, the patient has now formulated numerous goals. At this point the patient, with the help of you, the counselor, would begin organizing the goals based upon the criteria listed above.

Defining

Defining success in meeting goals takes a little work and analysis. Asking the following questions or establishing “checkpoints” is essential to help the patient identify success.

What are the overt and covert behaviors attached to this goal?

Continually clarifying the patient’s feedback will often lead to an increase in the patient’s level of investment. Is the patient behaviorally participating in the goal-achieving process or cognitively disinterested? Is the patient attempting to satisfy the “program,” or is he or she genuinely seeking change? “When you say you want to build your self-esteem, how will you be acting or thinking as a

man/woman with increased self-esteem?” “You say you want to lose 10 pounds. What do you see yourself doing?”

Patients enter treatment for a variety of reasons, some of which are not of their choosing. For instance, MSgt Boothe may be self-referred and identifies communication problems with his spouse as the reason for his visit. However, later he may reveal he promised his wife he would see someone about their relationship, but admits he is simply satisfying his wife’s request and doesn’t have any investment in the outcome. This is often true initially with substance abuse patients as well. If you feel you are being manipulated, you should confront the behavior and clarify the patient’s intentions for treatment.

What conditions must occur for change?

Clarify the boundaries and settings in which the anticipated stage for change will take place. Some goals will involve interacting within a relationship or with a specified group of people. For instance, a female patient may have a goal of being more assertive with her husband in their decision-making actions. The focus of the outcome for this goal will primarily involve her husband. If the patient practices her assertiveness with every relationship she has or every individual she encounters, there could be negative consequence in her pursuit to change. Again, what are the parameters or boundaries for change?

Identify successful milestones in the goal

You, along with the patient, must create checkpoints or milestones along the path to success. This will be a specified period of time where you and the patient reassess what has been achieved thus far. There should be specific outcomes anticipated at each milestone and progress will be measured at that time. The goal itself should be specific and clear.

Be specific regarding what constitutes success in achieving goals. Your patient may be grossly overweight. As a stated goal, he or she articulates and formulates a plan to lose weight. Suppose the patient returns in two weeks and states he or she has lost one pound. The patient returns a month later and has lost an additional one pound. Does this constitute success? Yes, because there were no specific parameters towards a specific goal. Clarity is essential. “I will lose 30 pounds in six months.” This statement creates boundaries and is clear regarding the outcome.

Identify objectives

Objectives were defined previously in this lesson. Ensure your patient’s objectives are steps towards goal achievement. Some objectives can be so broad or far reaching, they become goals. Keep it simple. As you’ll recall, the objectives are steps or milestones towards achieving a goal. Assist your patient in remaining focused on his or her goal.

Organize objectives by immediacy and degree of difficulty

Once the objectives are identified, organizing each of them into a natural flow of events is the next step. Which objectives need to be accomplished first prior to progressing to the next level? Creating a decision tree, goal pyramid, or whatever other prioritizing method best works for you and the patient will help organize the objectives. Document and maintain the decision method in the patient’s record. You will need this later for reference as your patient progresses and to serve as part of a treatment contract.

Identify obstacles that could prevent goal achievement

In this area, the counselor should review all potential obstacles that could prevent successful completion or implementation of a goal. The patient has primarily been focused on what he or she hopes to achieve up to this point, most likely without much regard for what could possibly obstruct success. Simply asking the patient to review his or her list of goals and objectives can prompt him or her to begin evaluating possible obstacles. The patient’s goal may be to become debt free in a year. The patient may have plotted and organized his or her bills based upon immediacy and the need.

However, if the patient is anticipating a loss of employment over the next year, it's obvious his or her planning is not leading towards goal achievement.

For the substance abuser, the goal towards sobriety might include avoiding individuals with whom the patient consumed or used drugs. This sounds like a great goal, but what if the patient's former companions are also individuals with whom he or she works daily. What if their roommate or significant other is a person he or she regularly used substances with? How can this be solved?

Identify required resources

Some patients will have many resources, while others may have "burned too many bridges" to have reliable individual resources. If the patient's goal is sobriety and his or her family is supportive of his or her efforts, this could be listed as a resource. You, as the counselor, may be listed as a resource; although you should limit your role to one of encouragement and focus in the patient's attempt to complete a goal. Money, time, supervisors, spouse, family, and spirituality are just a few examples of what the patient may have at his or her disposal. Encourage the patient to explore all venues.

Review of progress

Goals should be realistic, achievable, measurable, and descriptive. The counselor's role in assisting the patient establish goals should focus on these areas. Generalized goals should be avoided and each patient should have an individualized plan. You should identify specific time periods that objectives or milestones will be examined. Has progress been made? Is the progress resulting in the expected outcome? Is the patient procrastinating? If so, why?

Along with avoiding generalized goals, nondescript or vague goals established by the patient should be challenged. Simply stating "ineffective coping skills" or "family dysfunction" is not a goal. The counselor needs to encourage the patient to be specific in detailing his or her goals with the aforementioned parameters of realistic, achievable, measurable, and descriptive being satisfied.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

603. Identify concepts of goals and objectives

1. Identify common reasons why patients avoid establishing goals.
2. What occurs when a patient is able to visualize himself or herself beyond his or her current situation?
3. Define goal.

604. Identify the process of selecting and defining goals

1. What occurs when the clinician assumes responsibility for key components of the patient's goal?
2. What is meant by identifying the *cost* versus *benefit* effect of identifying goals?

3. During what part of establishing goals would the counselor review all areas that could prevent successful completion or implementation of a goal?

1–3. Develop a Relapse Prevention Plan

Relapse prevention is one of the most important aspects of treatment planning. All of your patient's efforts and your time and energy put forth to help your patient is for naught if a clear relapse prevention plan is not in place and used. In this area, we will focus primarily on substance abuse/dependence recovery/relapse. This can be tailored for use with other addictive behaviors as well. There are many models available from which you may subscribe. These include Alcoholics Anonymous Model, Developmental Model of Relapse Prevention, Cognitive-Behavioral/Social Learning Model, and Cognitive Behavioral Model, to name a few. You should research each to ascertain which model best suits your counseling style, values, beliefs, and so forth. We've chosen the primary determinants of relapse based upon a common theme in all of the models listed above. After examining these determinants, we will identify the primary components of a relapse prevention plan.

605. Identify determinants of relapse

The areas listed in this lesson are usually the same venues or social arenas in which the patient's usage thrived in the past. The patient's recognition of which areas are proven "slippery spots" promotes insight and can prove beneficial in avoiding a relapse later.

Environmental

As patients progress through treatment, they will often voice a newfound sense of hope and determination. "I'm never going back to that again." The patients' belief that they have power over their addiction is fostered by the security and protected environment treatment affords. However, upon returning to their normal environments, patients begin to feel vulnerable to loss of control.

Many environmental high-risk situations may beckon your patient's attention. The need to feel part of a group again may lure your patient to hang out with old drinking partners, to visit bars/clubs where he or she frequently used to in the past. Boredom or lack of enjoyable activities can contribute to the substance user's relapse. The mnemonic HALT (Hungry, Angry, Lonely, or Tired) is an excellent example of triggers that can prompt the substance abuser to thrill seek or return to his or her former environmental surroundings.

Behavioral

It has been proven time and again, patients with few or no coping skills are likely to deal with adversity by returning to their using lifestyle. Abstinence with the absence of problems is what some users imagine. A substance-free, sober lifestyle requires the patient to engage in "normal" family, occupational, and stress management behaviors while resisting the urge to use again. It is difficult, especially when faced with adversity. This is why teaching patients new decision-making and problem-solving skills cannot be emphasized enough.

Cognitive

The patient's thinking and expectation can often affect or determine relapse. What are the patient's coping abilities? What expectations does he or she have regarding sobriety? What does the patient think about sobriety as a way of life? Patients may "walk the walk" or "dance the dance" during treatment, but are they internalizing their new patterns of thinking?

Affective

Now that the patient is not self-medicating, how is he or she preparing to deal with his or her feelings? Was he or she drinking to mask depression or anxiety before treatment, or was the depression and anxiety a result of the patient's drinking? In either case, when these feelings return, and they will, how is your patient equipped to handle them? The patient should recognize the onset of these feelings and be able to articulate them to someone in a productive manner.

Relational

This is perhaps the most difficult and problematic as it relates to potential for relapse. Many "bridges" may have been burned along the patient's destructive path. In fact, the family is the most significant relationship harmed in the user's life. It is nearly impossible for the patient to enjoy all of the support, understanding, and stability his or her family can provide unless the family is engaged in the same process of recovery.

Likewise, the patient may be returning to a home where his or her partner continues to use substances. This is most certainly a recipe for relapse. Much time should be spent creating, rehearsing, and preparing for the temptation of use that will surely follow.

In addition to reacclimating to the addict's family, he or she may face issues relating to his or her occupational status and leisure activities. A civilian may have lost his or her job as a result of behavior associated with substance abuse. A military member may have been demoted; thereby creating a financial strain. He or she may need to get an additional job in to meet financial obligations.

Leisure activities in the past meant the patient would engage in some form of activity that centered on substance use/abuse. Without a clear plan and solid leisure activities to keep your patient entertained, the recovering individual has lots of time on his or her hands. Boredom is the leading cause of relapse.

606. Identify key elements of developing a relapse prevention plan

Recovery requires the patient to restructure every aspect of his or her life. The relapse prevention plan will serve as a guide/contract for the patient. We'll look at a relapse prevention plan in detail momentarily, but it is important to understand that this portion of treatment planning is so vital; it could easily be referred to as the patient's "survival plan." The patient's very survival depends on his or her investment and commitment to change.

The relapse prevention plan is described as a guide; as the patient will be writing the road map to sustained abstinence and long-term recovery if he or she sincerely works his or her plan. This treatment contract between the patient, counselor, treatment team, and command is usually signed by each of the stakeholders. We will look at key areas of a relapse prevention plan and discuss each. The degree of difficulty it will require for a patient to create a plan is often based on one or more of the following factors:

1. The severity and length of the patient's substance use.
2. The patient's perception of the problem.
3. The patient's motivation to remedy or change.
4. The patient's current support system.
5. The extent the substance has affected each aspect of the patient's life.

It is well-documented that treatment outcomes are based upon the patient's motivation. Too many times the patient's spouse, supervisor, or even counselor is more invested in change than the patient. Ensure the relapse prevention plan is the patient's work. You may and should assist if the patient has questions, but the patient should be formulating the plan. The plan should be specific and, more importantly, feasible.

The plan is ever-evolving and changing as the patient advances in recovery. Before we begin the process of identifying key elements of the relapse prevention plan, we need to look at possible obstacles.

Patients understanding of their diagnosis

The ability of the patient to articulate the meaning of his or her diagnosis and understand clearly the consequences of returning to an abuse/dependent lifestyle is paramount. Have the patient articulate in written format what his or her diagnosis is and what it means to him or her. Identify behaviors that have been destructive as a result of the patient's substance usage.

Support system

The patient should be asked to define his or her family in this section. Who are the individuals listed and what role do they have in the patient's life? Has the patient told or not told family members about his or her addiction? If not, the patient should explain why he or she has not told his or her support system. If he or she has told his or her support system of his or her addiction, what was the reaction from the family members?

The patient should identify any support groups he or she may have attended in the past. This should include Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Adult Children of Alcoholics (ACOA), Gamblers Anonymous (GA), and so forth. Does the patient plan on attending AA/NA as part of his or her recovery? The patient should explain both positive and negative responses to this question. If he or she is not planning on attending AA/NA, what alternative support group will the patient be using?

Does your patient have a sponsor? If so, who? A first name is usually acceptable for this answer.

Have the patient specifically identify the schedule for AA/NA and other supporting agencies or appointments he or she may be using.

The patient should identify whom he or she considers a part of his or her support group and why. In this case, the patient should provide the individual's name, address, phone number, and so forth. The purpose of this is to ensure someone whom the patient can make contact with and who is familiar with the patient's treatment will, in fact, support the patient.

Ongoing self-care

Self-care focuses on the patients internal motivation and self-drive. The items addressed in this area require an inventory of the patient's occupational, social, and family arrangements.

This area should include at least the following topics in detail with realistic expectations:

- Identify characteristics of a healthy living arrangement.
- Exercise, nutrition, and sleep.
- Recreation, hobbies, and vacation.
- Holidays and family time.
- Characteristics significant for occupational satisfaction.
- Social activities and friends.
- Emotion management (i.e., anger, anxiety, depression, etc.).

This is a sampling of items that could be included in this area. Many more could be added based upon the patient population and your expectations of a relapse prevention plan.

Patient's past use

The purpose of this section is to reconstruct a comprehensive detailing of the patient's substance use history and ask, "Did the drugs/alcohol do for you what you wanted it to do?" This is used later to

help identify “triggers” that may result in relapse. Asking the following four questions will usually suffice; however, you may add more to tailor the plan to the specific needs of your program:

1. Amount. How much alcohol/drugs were you using?
2. Frequency. How often did you use?
3. Substance goal. What were you hoping the substance you used would accomplish?
4. Results. What were the consequences? Identify both positive and negative outcomes.

Warning sign identification

The goal is for the patient to construct a list of “triggers” that will likely lead to the relapse. There is typically a series of “wrong turns” the patient makes along the way to getting drunk or relapsing. Identifying warning signs/triggers allows the patient to reconstruct events that have led to substance use in the past. By doing so, he or she can now formulate alternatives or avoid situations that could lead to relapse. It is hoped that by this point the patient has enough tools, resources, and commitment to sobriety that he or she will readily identify high-risk situations and begin developing coping strategies. Identifying these budding signs and self-defeating behaviors/thoughts before they lead to resuming substance usage will be the focus of creating a plan.

Ask the patient to list high-risk situations (triggers) that will create an environment whereby the patient will want to drink/use. This should be followed by a plan describing what general coping strategy will be employed, or how the patient will avoid or manage the situation. The patient’s plan should include some or all of the resources listed above; including self-care, support systems, and the patient’s understanding of his or her diagnosis. Encourage the patient to list as many as possible.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

605. Identify determinants of relapse

1. What does the mnemonic HALT represent and what is it an example of?
2. What occurs when a patient has little or no coping skills?
3. What is considered a certain recipe for relapse?

606. Identify key elements of developing a relapse prevention plan

1. The ability of a patient to create a relapse prevention plan will be based upon what factors?
2. What is the purpose of identifying warning signs/triggers?

1-4. Termination/Discharge

The focus during the assessment is ascertaining the patient's level of functioning, decision-making ability, potential resources, and so forth. All of this is gathered to begin focusing on problem resolution and eventual termination/discharge.

607. Identify common aspects of treatment termination

Treatment termination or discharge planning begins at the moment the patient presents himself or herself for evaluation. The initial intake is the first step towards termination or discharge planning. This final phase of treatment often creates a feeling of loss for the patient, who may resist this change. The patient may experience feelings of anxiety, fear, helplessness, and loneliness when faced with the prospect of terminating treatment. The patient should know these feelings are a natural, and justified, part of terminating any relationship. Reassurance and reviewing therapeutic accomplishments will reassure the patient of his or her self-confidence.

There are six reasons that generally result in terminating a therapeutic relationship:

1. Symptom relief.
2. Improved social functioning.
3. Greater sense of identity.
4. More adaptive defenses.
5. Accomplishment of goals.
6. Impasse in therapy that the counselor is unable to solve or is beyond the counselor's expertise.

There is one additional reason not often encountered in the civilian community—the PCS or extended TDY of the counselor or patient. This unanticipated end to a therapeutic relationship must be dealt with as quickly as possible. Knowing resources that can provide continuity and help alleviate the patient feeling completely abandoned will be crucial. We will discuss resources later in this volume; however, preparing for the unexpected should be a part of any treatment plan.

Treatment termination can prove to be a difficult or awkward period of time for both the counselor and the patient. Patients often begin to avoid sessions as treatment nears an end. This is done by not showing for appointments, arriving late, or refusing to communicate in a therapeutic manner. Sometimes the patient may demonstrate a regressive behavior to show the counselor “Hey, I’m still sick!” Recognizing and openly addressing the behaviors allow your patient to express his or her anger or frustration at treatment termination rather than acting out.

Have you ever had the patient who refuses to move on? In the Air Force community, it’s often easy for a patient to stay engaged despite our desire otherwise. We run into him or her at the base exchange (BX), commissary, or child development center (CDC), or he or she may work at the front desk of a clinic in the medical group. For those of you who reside in the dorms, this presents an even more imposing issue. If the former patient refuses to understand clear boundaries for those of you residing in the dorms, elevate your concerns through your chain of command. Despite your desire to help, you will need your time away from work as well. It might seem flattering at first to be the “dorm psychologist,” and you may appreciate the attention and respect you are given, but the consequences of giving out medical advice when you are not licensed to do so can be high.

Continuing a relationship outside the formal treatment setting is not recommended and should be avoided. This sometimes allows a dependency to form as the patient feels you are always at his or her disposal. It also fosters resentment from you, the counselor, towards your patient, as you are never “off duty.” Clear boundaries will discourage contact outside the therapeutic relationship and clarify patient expectations following the termination of treatment. Furthermore, to avoid any perceived notion of an inappropriate or unethical counselor-patient relationship posttreatment, it is best to not engage in an after-treatment relationship.

The counselor may follow up within a specified time with a phone call or letter seeking the status of the patient. This is appropriate, but shouldn't encourage a reengagement of treatment. It's a balance of boundaries and remaining genuinely empathic to the patient.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

607. Identify common aspects of treatment termination

1. Identify common feelings patients often experience with the prospect of terminating treatment.
2. What are the six reasons a therapeutic relationship is terminated?
3. What can occur if a relationship is maintained outside the formal treatment setting?

1-5. Written Treatment Plans

The mantra that has been stated many times throughout your CDCs has been "If it isn't documented, it didn't happen!" This mantra continues here as well. The written treatment plan should be viewed as a contract between you and the patient with a plan for progress. This lesson will outline specific criteria for developing a written treatment plan.

608. Developing a written treatment plan

Imagine, if you will, hiring a contractor to build your first home. You're excited about the possibilities and options as you tell the contractor about ideas and plans. You've always envisioned your new home having three bedrooms, three bathrooms, and a fireplace that is the centerpiece of the family room everyone gathers around. The contractor listens intently as you describe your aspirations for the new home. At the conclusion of your description, the contractor states he or she will begin working on your dream home next week. Without as much as a blueprint to work from, the contractor begins to build your dream home based simply upon your vague description. Do you think you'll be pleased with the results? Unlikely! A written treatment plan is the "blueprint" that you and the patient create. It is the foundation that you will build from and craft as you work through reconstructing or, in some cases, constructing a more productive life for your patient.

The treatment plan is the overall management strategy for treating people. Treatment plans are considered the written contract between the patient and counselor providing a road map for progress. It is not dictatorial in the sense of the counselor telling the patient what the patient will or should do to "fix" his or her problem or issues. In fact, the treatment plan is often ever-evolving, vacillating, and fluid, based upon accomplishments or relapses by the patient.

The written treatment plan is significant in that it appears contractual. Any plan that is not written is subject to interpretation and memorization. You or the patient may forget aspects of the plan or change the plan based simply upon recollection of what you "think" you had agreed upon. The written treatment plan provides a reference point and should clearly articulate what you and the patient agreed on.

Treatment plans will sometimes address many items, but, like the "blueprint," the treatment plan must contain some core items. Core items for a treatment plan include explaining to the patient the

assessment results. This is an immediate launching point. Knowing the physiological, psychological, and educational functioning level of your patient will provide a beginning in the treatment plan. Goal identification will always be an intricate part of the written treatment plan. Identifying “triggers” as part of the relapse prevention plan is also part of the written treatment plan. And lastly, the plan must include a termination or discharge plan.

You must also know some key attributes of your patient prior to beginning the treatment plan. We addressed these earlier when we identified the patient’s strengths, weaknesses, problems, and needs. Knowing your patient’s personal capabilities and resources is important; as these will be called upon often for the patient to make the plan successful.

An individualized written treatment plan must be prepared for every patient entering treatment. As much as we have moved toward making assessments, psychometrics, and administrative tasks universal, it is important the treatment plan remain specific and unique to each patient. There are many different formats for writing treatment plans; however, each should include the areas identified in this lesson.

Ideally, the plan incorporates, to some extent, the World Health Organization’s (WHO) five dimensions of health:

1. Physical.
2. Social.
3. Mental.
4. Spiritual.
5. Intellectual.

These five areas were explored to various degrees in the initial assessment and you, as the counselor, should have a grasp of the patient’s abilities or deficiencies in each.

Treatment planning should develop from the assessment process and embrace the importance of appropriate patient-treatment matching. Taking all of the areas of the assessment, including strengths, weaknesses, problems, needs, short- and long-term goals, and relapse prevention, and organizing them into a comprehensive building block for the patient to move from one milestone to the next, provides you and the patient a launching platform to move forward in treatment.

The treatment plan must also address the need not only for rehabilitation, but also for “habitation.” Rehabilitation emphasizes the return to a way of life previously known and forgotten or rejected; habitation is the patient’s initial socialization into a productive and responsible way of life. While this area is often used to assist the substance-abusing patient, it may also be used for patients experiencing problems, which are socially isolating dysfunctions.

Based upon the patient’s identified needs, problems, strengths, and weaknesses; you can begin to explore, document, and match resources available to the patient. A good treatment plan provides a comprehensive set of tools the patient can easily access and employ as needed.

Components of the treatment plan

Two key concepts guide the development of every treatment plan for every patient:

1. The plan should be individualized.
2. The plan should be participatory.

The counselor does not devise the treatment plan for the patient. Instead, the counselor and patient prepare the plan together. This is not only symbolic of the patient’s investment in his or her treatment and outcomes but gives the patient an ownership stake of yet another aspect of his or her treatment. The patient, after all, is the primary stakeholder and most effected by the plan’s outcome. The patient’s ownership and investment in the treatment planning process are two very good reasons why

the counselor's personal values should not be superimposed on the process. This is not to say the counselor has no say in the treatment plan; the counselor is very involved. However, this joint decision making should reflect a shared effort of working towards a common goal, not as something imposed.

Treatment planning goals and objectives

The establishment of goals and objectives should be documented as part of the treatment plan. As you may recall earlier in this volume, we discussed the process of the formation of goals and objectives. Keep in mind, when you include the final goals and objectives in the treatment plan, they should be clearly defined and articulate what the anticipated outcome from goal accomplishment will provide.

This area of the treatment plan will vacillate from time to time based upon the patient's ability to accomplish goals or unanticipated relapses in treatment.

This area of the treatment plan should be designed to help the patient establish a positive sense of self and self-esteem. The patient participates in the process of setting the goals but doesn't dictate them. Again, this is participatory by the patient and the counselor. Incorporated and documented in the goals and objectives should be examples for the patient regarding handling life and relationships in a variety of arenas, including friends, fun, family, sex, occupation, and problem solving. The patient must be shown illustrations of successful living, especially positive examples in his or her life, if any are identifiable.

Simply establishing goals is not enough. Therapeutic goals must translate to behavioral indicators. Measures of improvement or milestones must have tangible, observable outcomes. For the substance abuser, this might include making new friends, becoming more physically active, or staying abstinent. Goals and objectives can also encompass elements that address the patient's spiritual and social life. Becoming involved in AA or self-help groups, or volunteering or attending church are examples of tangible, observable outcomes.

Treatment flexibility

The treatment plan must be tailored to the patient as much as resources and time will allow. A good plan is dynamic, evolving, and flexible. Inevitably, events will occur over time that necessitate altering goals and objectives. The treatment plan should be designed to address three types of potential problems:

1. Attrition.
2. Noncompliance.
3. Inadequate progress.

Mechanisms should be built into the treatment plan to handle these problems. It is easy for the novice counselor to take ownership of the patient's lack of progress when problems arise. Remember, the patient is the primary stakeholder in treatment outcomes and must accept responsibility for failure or success. With this said, you should always evaluate any treatment failures or aborted attempts to allow you and your services to identify areas for improvement if necessary.

In some cases, flexibility must work the other way. Sometimes the patient responds so well that treatment can be accelerated or streamlined.

609. Assessment of treatment progress

The process of assessment doesn't end once the patient has been assessed and a treatment plan formulated.

Assessment tools

Assessment is part of the ongoing treatment process—an essential tool that can determine:

- The value of the treatment chosen.

- How the treatment or treatment plan should be adjusted.
- How realistic are the goals that have been set.
- What additional linkages need to be made between the patient and other agencies.
- When the maximum benefit of the intervention has been achieved.
- The plan for further intervention, if needed.

The purpose of assessment during the treatment process is to determine how effective the treatment has been up to the assessment point, what kind of progress the patient is making, the appropriateness of the present treatment, and what the next level of treatment should be. Assessment in the course of treatment is longitudinal and not a single event. The ongoing assessment of treatment is productive in identifying early in treatment what is working and what isn't. For instance, has there been an inappropriate referral, misdirected treatment, or unrealistic goals? Identifying these will save you, the counselor, time and the patient the frustration of failing to succeed.

Progress assessment is a clinical management tool focusing on the patient already in treatment. In contrast to an intake assessment, which establishes a baseline for the patient, progress assessment measures the patient's response to the treatment that has been provided. It also measures change and degree of change, if any. This change may be either positive or negative.

How often should assessments be conducted? According to some involved in the treatment process, the answer to this question is, "As often as you can afford to." There are no set standards for the frequency of treatment progress assessments, and frequency is often dependent on resource availability. Different settings may dictate the frequency of assessments—long-term, short-term, residential, or outpatient will require assessments at differing intervals.

To measure treatment progress, you must identify exit outcomes in the written treatment plan. What is the anticipated outcome and how is it measured? All of this must be documented and reassessed as the patient progresses through treatment. Milestones should be identified and move towards discharge or termination of treatment.

Assessment results should also be explained to the client. It isn't really helpful for a client to spend hours answering questions and completing computer assessments if we don't tell them what information we have gathered from it. Imagine spending your entire day taking a battery of psychological tests and never having the results discussed by your physician. Explaining the results of the assessment is an important part of the ongoing treatment of a client.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

608. Developing a written treatment plan

1. How are treatment plans considered as they provide a road map for progress?
2. Identify the five WHO's dimensions of health.
3. What does rehabilitation emphasize?
4. Define habilitation.

5. What are the two key concepts that guide the development of every treatment plan?
6. Identify two reasons why the counselor's personal values should not be superimposed on the process.
7. What must measures of improvement or milestones include?

609. Assessment of treatment process

1. What can the assessment tool be used to determine?
2. Describe milestones in the assessment process.

Answers to Self-Test Questions**601**

1. The substance-abusing, substance-dependent, depressed, or demoralized patients.
2. They're a victim of environmental circumstances.

602

1. Helping patients identify the origin of the problem.
2. The most disruptive, pain causing, consequential problem.
3. As an explanation for the forces that motivate human behavior.
4. Oxygen, water, food, sleep, stimulation, activity, sex, and so forth.
5. Establishing stability and consistency in a chaotic world.
6. Due to the ever-changing goals and decisions of an individual.

603

1. Fear of success, fear of failure, and some operate with the "lottery" or "Santa Claus" mentality that something good will come their way with little effort, if any at all—it's just a matter of time.
2. It will instill hope.
3. Outcome statement of what the patient will ultimately attain through treatment that is important to the patient; focuses on the positive; is realistic, achievable; and is seen as worthwhile by the patient.

604

1. It teaches the patient very little regarding assuming control and responsibility for the direction of his or her life.
2. What is being given up versus what is gained from goal achievement?
3. Identifying obstacles that could prevent goal achievement.

605

1. Hungry, Angry, Lonely, and Tired; an example of triggers that can prompt the substance abuser to thrill seek or return to his or her former environmental surroundings.

2. Return to his or her using lifestyle.
3. The patient returning to a home where his or her partner continues to use substances.

606

1. The severity and length of the patient's substance use; the patient's perception of the problem; the patient's motivation to remedy or change; the patient's current support system; and the extent the substance has affected each aspect of the patient's life.
2. Allows the patient to reconstruct events that have led to substance use in the past; by doing so, the patient can formulate alternatives for or avoid situations that could lead to relapse.

607

1. Anxiety, fear, helplessness, and loneliness.
2. (1) Symptom relief.
(2) Improved social functioning.
(3) Greater sense of identity.
(4) More adaptive defenses.
(5) Accomplishment of goals.
(6) Impasse in therapy that the counselor is unable to solve or is beyond the counselor's expertise.
3. Allows a dependency to form as the patient feels he or she always has you at his or her disposal. It also fosters resentment from you, the counselor, towards your patient, as you are never "off duty."

608

1. A written contract between the patient and the counselor.
2. (1) Physical.
(2) Social.
(3) Mental.
(4) Spiritual.
(5) Intellectual.
3. The return to a way of life previously known and forgotten or rejected.
4. The patient's initial socialization into a productive and responsible way of life.
5. (1) The plan should be individualized.
(2) The plan should be participatory.
6. The patient's ownership and investment in the treatment planning process.
7. Must be tangible and have observable outcomes.

609

1. The value of the treatment chosen; how the treatment or treatment plan should be adjusted; how realistic are the goals that have been set; what additional linkages need to be made between the patient and other agencies; when the maximum benefit of the intervention has been achieved; and the plan for further intervention, if needed.
2. Should be identified and move towards discharge or termination of treatment.

Do the unit review exercises before going to the next unit.

Unit Review Exercises

Note to Student: Consider all choices carefully, select the *best* answer to each question, and *circle* the corresponding letter. When you have completed all unit review exercises, transfer your answers to ECI (AFIADL) Form 34, Field Scoring Answer Sheet.

Do not return your answer sheet to AFIADL.

1. (601) If a patient has made an attempt to resolve his or her problem and has failed in the past, this is recognized as a
 - a. weakness.
 - b. strength.
 - c. failure.
 - d. risk.
2. (601) As a *minimum*, how many strengths and weaknesses should be identified for each patient?
 - a. One.
 - b. Two.
 - c. Three.
 - d. Four.
3. (602) What is considered the *very basic* of Maslow's hierarchy of needs?
 - a. Self-esteem and love.
 - b. Physiological needs.
 - c. Security needs.
 - d. Affiliation.
4. (602) What level of Maslow's hierarchy of needs is characterized by the need for friendship, love, and a sense of belonging?
 - a. Self-esteem and love.
 - b. Physiological needs.
 - c. Security needs.
 - d. Affiliation.
5. (602) What level of Maslow's hierarchy of needs is often difficult for substance abuse/dependent individuals, or individuals with severe mental disorders?
 - a. Self-esteem and love.
 - b. Physiological needs.
 - c. Security needs.
 - d. Affiliation.
6. (602) What level of Maslow's hierarchy of needs is developed from feelings of independence, competence, self-respect, and recognition from others?
 - a. Self-esteem and love.
 - b. Physiological needs.
 - c. Security needs.
 - d. Affiliation.

7. (602) What level of Maslow's hierarchy of needs represents an individual who has reached his or her maximum potential?
 - a. Self-esteem and love.
 - b. Self-actualization.
 - c. Security needs.
 - d. Affiliation.
8. (602) What need is *not* considered a deficiency need?
 - a. Self-esteem and love.
 - b. Physiological needs.
 - c. Security needs.
 - d. Affiliation.
9. (603) What do short-term goals provide for the patient?
 - a. Acute relief or feelings of accomplishment.
 - b. Establishes a natural exchange of ideas.
 - c. Hope invested over a period of time.
 - d. Establishes rapport.
10. (603) What do long-term goals suggest for the patient?
 - a. A natural exchange of ideas.
 - b. Acute relief or feelings of accomplishment.
 - c. Shows they are invested over a period of time.
 - d. Establishes rapport between patient and counselor.
11. (603) Every goal must have *at least* how many objectives?
 - a. 1.
 - b. 2.
 - c. 3.
 - d. 4.
12. (604) Goals should *not* be
 - a. realistic.
 - b. optimistic.
 - c. descriptive.
 - d. measurable.
13. (605) Which determinant of relapse is considered the *most* difficult and problematic?
 - a. Affective.
 - b. Cognitive.
 - c. Relational.
 - d. Behavioral.
14. (605) What is the *leading* cause of relapse?
 - a. Loneliness.
 - b. Boredom.
 - c. Stress.
 - d. Peers.
15. (606) It is well documented that treatment outcomes are based upon the patient's
 - a. motivation.
 - b. judgment.
 - c. support.
 - d. insight.

16. (606) Reconstructing a comprehensive detailing of the patient's substance use history helps
 - a. terminate ongoing self-care.
 - b. verify the required support system.
 - c. predict ongoing self-care outcomes.
 - d. determine triggers that may lead to a relapse.
17. (607) During what stage of treatment does termination or discharge planning begin?
 - a. Initial intake.
 - b. Relapse planning.
 - c. Establishing goals.
 - d. Crisis completion.
18. (607) What action must occur to discourage contact outside the therapeutic relationship?
 - a. Create clear boundaries.
 - b. Improve social functioning.
 - c. Implement adaptive defenses.
 - d. Recognize failure to terminate treatment.
19. (608) What is considered the *overall* management strategy for treating people?
 - a. Treatment plan.
 - b. Relapse prevention plan.
 - c. Psychometric examination.
 - d. Goals and objective identification.
20. (608) Who should be devising the treatment plan for the patient?
 - a. Patient.
 - b. Counselor.
 - c. Supervisor.
 - d. Patient and Counselor.
21. (608) What is *not* one of the potential problems that should be addressed in the treatment plan?
 - a. Attrition.
 - b. Absenteeism.
 - c. Noncompliance.
 - d. Inadequate progress.
22. (609) What is *not* a purpose of assessment during the treatment process?
 - a. Translating the goals into behavior indicators.
 - b. Assessing the kind of progress the patient is making.
 - c. Determining what the next level of treatment should be.
 - d. Determining the appropriateness of the present treatment.
23. (609) What *must* you use to measure treatment progress?
 - a. Exit outcomes.
 - b. Goal milestones.
 - c. Frequent assessments.
 - d. Objective gatekeepers.

Please read the unit menu for unit 2 and continue. ➔

Unit 2. Selected Psychotherapeutic Interventions

2–1. Conducting Counseling	2–1
610. Identify common issues encountered by new counselors	2–1
611. Identify the basic skills for the counseling platform	2–4
612. Making clear and informed decisions	2–6
613. Identify the differences in selected psychotherapeutic approaches	2–7
2–2. Conducting Groups	2–18
614. Identify characteristics of psychotherapeutic groups	2–18
615. Identify characteristics of educational groups	2–19
616. Identify common group processes	2–19
617. Identify the benefits and contraindications of group participation	2–21
618. Identify common problems in group psychotherapy	2–22
619. Managing problem patients in group	2–23

THIS UNIT will introduce you to a variety of therapeutic milieus that you might use in the counseling process. Every patient is unique; your approach with each will need to be as unique. There is no “cookie cutter” approach to addressing problems with patients. You will need to familiarize yourself with each of the counseling approaches to use as you engage in counseling with patients. Whatever the issue before you or whatever the milieu you use, the outcome is always geared towards success.

2–1. Conducting Counseling

This unit will provide a brief overview of standard counseling approaches that can be applied to most therapeutic milieus. It certainly is not all inclusive, and you, the craftsman, should seek to educate yourself to the unique environment for which you may be working.

610. Identify common issues encountered by new counselors

Much of the issues discussed in these career development courses (CDC) deal with the patient and how you identify academic descriptions, behaviors, characteristics, expectations, and anticipated reactions. While we’re busy dealing with the patient, we tend to lose focus of what we, as journeymen and craftsmen, may be experiencing. Before we begin setting the stage for the basic skills of counseling and the various theories of therapeutic intervention, we will look at some of the major issues you typically face, particularly during the beginning stages of learning how to be counselors. Once you complete all of your academic training, you will begin to test and apply your newfound skills with patients. Some 4C0s soon realize they must work with themselves more than with the patient. When this occurs, you may begin questioning your abilities and adequacies, and you may start wondering what you could possibly bring to the counseling relationship. I have identified some useful guidelines that may help you as you prepare to begin counseling.

Dealing with anxieties

Most of you are looking forward to participating in patient care and experiencing the process of treatment. However, most beginning 4C0s, regardless of academic background, anticipate meeting their first patient with ambivalence. As beginners, we are likely anxiety ridden and ask ourselves the following questions:

- What will I say?
- What if I make a mistake?
- What will I be able to do to help?

- What if I get stuck?
- What will I do next?

I know this because, I, as well as your supervisors, have faced the patient for the first time and asked those very questions and many more!

A certain level of anxiety is expected and demonstrates that we are aware of the uncertainties regarding the patient, as well as our abilities to really be there and stay with them. Your willingness to recognize and deal with these anxieties, rather than ignore them, demonstrates your self-awareness and is a mark of courage. The fact that you experience anxiety and self-doubt is perfectly normal; it's how you deal with your feelings that count. One way is to talk openly to your peers and supervisor regarding your feelings. You will soon validate your feelings with this exchange and learn how others have confronted their feelings.

Self-disclosure and being yourself

Yes, it is normal to feel anxious when you begin counseling. Our usual reaction to feeling anxious is to become overly academic and mechanical in our approach to patients. Inexperienced journeymen often fail to appreciate the value of simply being themselves. I say this with trepidation, as you can easily err by going to extremes in either approach—mechanical or being yourself. On one hand, you can get lost in attempting to present a professional facade. Yet, being overly human or attempting to show you can relate to every situation with your patient is not beneficial either.

When being too mechanical, some journeymen are so focused on maintaining a stereotypical role of being a “counselor” that very little of them as a person shows through. This is very impersonal and can only make it more difficult to establish rapport. Some patients may view this approach as condescending. Some believe the more frightened and insecure we are in our abilities, the more we cling to the professional persona that affords us something to hide behind.

Being yourself can be taken too far as well. Blurring the lines between counselor and counselee is detrimental to a counseling relationship. Some journeymen, in an attempt to show the patient they can relate, will inadvertently burden the patient with stories of adversity the counselors have personally experienced. This transference often originates from the counselor's needs. When you do self-disclose, it should be for the benefit of encouraging patients to deepen their level of self-exploration or to enhance the therapeutic relationship. Too much self-disclosure from the counselor might make the client start to wonder, “Who exactly is the patient here?”

Perfectionism

In our quest to prove ourselves or get it right, we tend to place ourselves under tremendous pressure to perform. One of the most common self-defeating beliefs as beginning counselors is we must be perfect. We all know intellectually we are not perfect, but, emotionally, we convince ourselves there is no room for error. Some of the more common self-defeating thoughts you may encounter and we have all experienced at one time or another include:

- I must be perfect; if I'm not, I will do severe damage.
- I should know everything the patient asks me or talks about; if I don't know something, it will show incompetence.
- I should be able to help everyone who wants help; if I don't, it means I'm incompetent.
- If the patient doesn't get better or worsens, it's my fault.
- Making a mistake is horrible!
- I should always appear confident; there is no room for self-doubt.

Let's be candid. You *will* make mistakes. It doesn't matter if it's your first patient or you've been interviewing and counseling patients for years, you will make mistakes. If you spend all of your energy in mastering perfection in counseling, you will have little energy left to engage the patient.

Remember, it's the lesson learned from this mistake that is most important. When your supervisor tells you to remember something and not forget another item during your interview or counseling, it's most likely because he or she has made that very mistake and learned from it. When you make mistakes, and you will, share it with your peers—we all benefit from your experience.

Be honest about your limitations

We all have limitations. Sometimes, we need to read our job descriptions to instill confidence into what our jobs really are. If you do not have the skill, competency, or knowledge the patient requires, don't feign it. Patients are much more receptive to honesty than fake competence. You're not a chaplain, financial advisor, or lawyer, nor can you prescribe medication; but, you know where you can find these resources the patient may need or to answer questions or provide a service he or she may need. You are not omnipotent, nor should you try to be.

Likewise, do not identify something as a limitation simply because you haven't been exposed to a specific population, condition, or diagnosis. Take opportunities for exposure to diversified populations and become involved in activities that will allow you the experience of talking with individuals who have conditions or diagnoses you are unfamiliar with.

Understanding silence

Silence occurs during counseling the same as it does during the initial intake. No matter when it occurs, it is often very uncomfortable for the beginning counselor. It is not uncommon to feel threatened by the silence and do something counterproductive to alleviate the anxiety we feel.

Something counterproductive may mean filling the void with meaningless chatter or misguided statements to make you feel less anxious. Lecturing, excessive questioning, and advice giving in an effort to avoid silence are examples of when the patient may block communication. The fact is; silence can have many meanings. It may serve as a transition period for you to move to another point in the counseling process or for you to reflect upon what the patient has said. It may also be the patient reacting in a defiant manner and refusing to talk. This will happen from time to time with patients who are commander-directed to participate in treatment. Substance abusers are a good example of this. In addition to not wanting to participate in your program because they are directed to do so, they may also feel they do not have a problem to begin with. This will require the combination of patience and finesse on your behalf to help the patient move past his or her animosity.

Losing yourself in your patient

A common mistake for beginning journeymen is to worry too much about your patient. You may find that you lose sleep worrying about the decisions your patient may be making. When empathy becomes distorted and the counselor more closely identifies with the patient, it can be counterproductive. You will need to employ a method of "letting the patient go" and not bear his or her problems. You will be most therapeutic when you are fully focused and supportive on the patient in his or her therapeutic session. Allow the patient to grow by making decisions and learning new coping methods between sessions. You will undermine the patient's ability to independently make decisions if you are constantly there to guide him or her.

The idea of losing yourself in your patient is closely related to the term known as *countertransference*. This occurs when the journeyman's needs or unresolved issues become entangled in the therapeutic relationship. Recognizing countertransference will allow the counselor to remain focused on the patient's issues and remain objective. If you recognize that countertransference is an issue and intruding on your ability to objectively guide the patient, you should address your concerns with your supervisor or peers. This is an issue every counselor has had to deal with, and different approaches will work for each journeyman.

Decline giving advice

What? But I thought that's what counseling is all about! Counseling and advice giving are often used synonymously; however, it is wrong to do so. Many of you may have come into this career field thinking, "I would make a good mental health journeyman because my friends always come to me for advice. I've always been one who likes to help others." The idea that you dispense advice is often enhanced by the patient's notion that he or she will come to a counseling session, and you will provide him or her with a sense of direction or give him or her the answers to solve his or her problems.

Counseling should not be confused with dispensing information. Your role as a counselor is to help patients discover their solutions. Do not deprive the patients of their abilities to solve their problems and their abilities to act. When you begin advice giving, you assume responsibility for the outcome, and the patient has little to learn in this case. Counseling involves searching for solutions based upon the patient's capabilities. Ask the patient, "What possibilities do you see?" or "What have you done in the past that worked when this happened?" Encouraging the patient to make independent choices and accept the consequences of his or her choices promotes growth in problem solving. The short-term resolution that advice giving provides is far outweighed by the long-term effects of the loss of independence the patient experiences when the next problem comes along.

611. Identify the basic skills for the counseling platform

What expectations do patients have as they enter into a therapeutic relationship with you as the counselor? Is the patient genuinely concerned and invested in the outcome of his or her treatment, or is he or she manipulative, pursuing ulterior motives, or attempting to fulfill a promise to his or her spouse or supervisor/commander to get help? To understand the counseling process, we must first understand what the anticipated outcomes are that we are working towards together with the patient. You should establish early on what the patient anticipates the outcome to be and the reasons behind his or her motivation to seek counseling. Four specific areas should be addressed in the therapeutic relationship between you (the counselor) and the patient (counselee):

1. Behavior.
2. Personal barriers (i.e., poor self-image, self-defeating attitudes, etc.).
3. Ability to cope with adversity, both personal and environmental.
4. Clear and informed decision-making knowledge and skill.

We will define counseling and the counseling process, as well as review the specific stages of counseling.

Behavior

What is behavior and how does it impact the counseling process? Let's first define behavior and then look at how we can change behavior.

Defining behavior

The patient's behavior should be defined prior to attempting to instill changes. The purpose of defining behavior clarifies which behavior is detrimental, aberrant, counterproductive, and inconsequential. For instance, the patient may exhibit obsessive-compulsive disorder (OCD) behaviors. His or her occupation is to identify blemishes on fine gems prior to public sale. This is probably an excellent match given the perfection expected in fine gems. However, if he or she worked on an assembly line inspecting nuts and bolts as they quickly passed by, the patient would likely feel completely overwhelmed. His or her behavior then would become an obstacle. In the Air Force where perfection to detail is rewarded, this person may function very well in some tasks like crew chief or explosive ordinance disposal (EOD) but fail miserably as a triage technician in a busy emergency room. The bottom line is behaviors that result in problems must be identified. If the patient self-sabotages or intentionally causes himself or herself to appear incompetent or fail, the

behavior needs to be confronted. It is equally important that the patient recognize his or her behaviors that contributed to or caused the current problems.

Changing behavior

“It’s always been that way.” When you walked into your new duty section and inquired about some process that didn’t make sense, were you given that response? Hopefully not, but it is a response we are most comfortable with. You might know it can be done easier, quicker, and with much less hassle. However, when you suggest a change, you might get the leading response, “It’s always been that way.”

Changing behavior is one of the more difficult challenges for a patient. Changing behavior means the patient must do something he or she is unaccustomed or uncomfortable doing. However, the option is to remain the same and refuse to change. Sometimes a simple behavior change from the patient will resolve many other problems. Some counselors believe the patient must first change his or her thoughts and attitudes for change to occur, while others are not so sure. Behavior is one change that is the easiest to recognize, as it is measurable and observable.

Personal barriers

Many of us never achieve what we are capable of because of our self-image. Patients are no different. We form our self-image in several ways:

- Our regard for ourselves.
- Our mental picture of how we appear to others.
- Our picture of our physical self.
- Our idea (positive or negative, rational or irrational) of how we present ourselves to others and are judged by them.
- Our personal assessment of our character, personality, skills, abilities, and attributes.
- Our use of an accumulation of personal scripts from experiences (consciously or otherwise) throughout our lives to dictate how we approach people and situations.

If we think of ourselves as incapable of achieving something, especially if our life script has proven in the past this is true, then it must be so. It is no different for our patients. They may not have taken a chance or opportunity in the past, so therefore the patients’ perception is reality. The patients may not have accomplished anything they can look back on as successful, or, if they have achieved an accomplishment, they consider it the result of happenstance or luck. The patients will often remain in this self-defeating cycle, which is reflected in their behavior.

Ability to cope with adversity

The patient’s ability to cope with adversity and make sound decisions is key. Coping means successfully dealing with the problems that arise in life. Everyone differs substantially in how he or she copes with adversity. Some patients will engage in emotion-focused coping, a strategy that focuses on managing one’s emotions. This strategy includes the patient distracting his or her attention from the problem, denying the problem exists, and venting or sharing his or her emotions with others. Another strategy used by patients is problem-focused coping, which involves a direct approach to reducing stress and solving the problem. Patients who use this approach will take direct steps to solve the problem, including seeing a counselor or seeking advice from a trusted friend or family member.

The patient’s ability to employ sound insight and judgment is paramount as it relates to identifying options and alternatives in the face of adversity. Help the patient keep in perspective what he or she has control over and what is beyond his or her control. For instance, the patient who reports job dissatisfaction and wants to “quit” the Air Force should be redirected to focus on other options, as “quitting the Air Force” is not a viable option. Again, some problems or adversity are beyond the

patient's control. Recognizing this sometimes means the patient learns to cope with what he or she cannot change.

612. Making clear and informed decisions

"You sure don't want him around in a crisis!" "She really steps up to the plate when it counts!" Have you ever said or heard someone say something similar? This is often referred to as emotional intelligence. Emotional intelligence refers to your capacity to recognize your feelings and those of others, for motivating yourself, and for managing emotions well in yourself and in your relationships.

Emotional intelligence

Not to be confused with intelligence quotient (IQ), which measures academic capabilities or intelligence, emotional intelligence refers to the purely cognitive capabilities or functions displayed by individuals. Many people who are book smart may lack emotional intelligence skills. The patient certainly may have lost his or her ability or objectivity to clearly keep issues in perspective. It's not the end of the world! It may seem like it to your patient, but you must remain grounded as you guide him or her through understanding his or her difficulties. Don't be that provider who looks at your lab results and keeps repeating, "Uh Oh!" "Wow!" or "This isn't good!" The patient's ability to make or participate in sound decision making may not be available as the patient may feel overwhelmed or confused with compounding problems. Your ability to steer the patient towards better decision making and the patient's ability to self-assess his or her reactions to life's problems and crisis will begin a journey of personal satisfaction for the patient. As you see, your ability to remain objective and manage your emotional intelligence is as important as that of the patients.

Stages of counseling

Let's look at the three common stages of counseling from the patient's perspective and that of the counselor's.

Initial disclosure

This is the first stage and can often be the most uncomfortable for the patient and the counselor.

Patient

For the patient, this is often an awkward, difficult, and certainly risk-taking adventure—disclosing personal issues to a stranger. The patient will often give only partial information to gauge your reaction. As this process continues, the patient may communicate many issues and concerns at once. The counselor should be seeking clarification throughout this process to ensure he or she is certain of the patient's concerns.

Counselor

During this initial stage, the counselor must engage in building a therapeutic atmosphere with the primary focus of building trust. Empathic and genuine understanding of your patient's situation will be appreciated by your patient. Acceptance without judgment or inserting your personal beliefs will continue to build a trusting relationship.

In-depth exploration

In this stage, you will assist the patient to begin forming a clearer and more focused problem-oriented approach to his or her situation.

Patient

Here, the patient begins to explore a deeper understanding of his or her problems. Clarity regarding relevance and peripheral status begins to develop. Often during this stage, the patient will gain insight into his or her primary problem and tentatively begin setting goals.

Counselor

During this stage, the counselor begins to gain a greater understanding of the patient's primary problems and formulating diagnostic options. While empathy and trust will continue to be important factors in this relationship, confrontation and clarification may be required for the counselor to clearly understand the patient's decision-making processes. The counselor also begins arming the patient with tools the patient may use in dealing with the problem.

Commitment to action

This is the final stage and will require commitment to change from the patient.

Patient

At this time, the patient begins experimenting with alternative approaches to his or her problems. The patient begins goal setting and building realistic, achievable plans to support the goals.

Counselor

The counselor encourages the patient to explore options promoting effective goal setting and reality testing.

These primary stages are commonly anticipated reactions from patient and counselor alike. You will learn that your experiences will often produce different results with each patient. This discussion merely serves as a guide to form the foundation from which you can begin.

613. Identify the differences in selected psychotherapeutic approaches

Before we begin discussing the differing psychotherapeutic theories, we should define the term *theory*. For our purposes, a theory is a logical explanation or model based on observation, facts, hypotheses, experimentation, and reasoning that attempts to explain a particular psychotherapeutic approach. Theories are constantly subject to testing, modification, and refutation as new evidence and ideas emerge. Theories also have predictive capabilities that guide further investigation.

Each of the therapeutic milieus listed in this section offers differing approaches and beliefs. Identifying which approach best works for you in your environment and your personal beliefs will help define how you approach patients and assist them in finding solutions.

Many psychotherapeutic approaches exist in the treatment community. Some are common, while others are considered "fringe" approaches. In an effort to demystify what some of you may consider very academic material, let's take a closer look at the three basic approaches you will use in psychotherapy—cognitive, behavioral, and dynamic or psychodynamic.

Counselors who use the cognitive approach will look at dysfunctions and the patient's difficulties as arising from irrational or faulty thinking. In other words, the patient perceives the world in a particular way, albeit right or wrong, and responds to the world by acting or feeling a certain way. Counselors who follow the behavioral approach look at problems arising from the patient's behaviors that have been learned and performed over the years. The counselor who uses the dynamic or psychodynamic approach will look more at the patient's issues from early childhood, which then motivates him or her as adults at an unconscious level.

Treatment modalities refer to the venue in which the treatment will occur. For instance, will the counseling be the most commonly used one-on-one relationship with the patient, or will it occur in a group setting? We will discuss the different treatment modalities later in this lesson as well.

By clarifying some of the basics regarding counseling, the hope is that you can move beyond the procedural aspect. This lesson will provide an overview of some of the more common approaches seen in the military treatment community today.

Cognitive therapy

Cognitive therapy focuses on psychological disturbances that frequently originate from habitual errors in thinking. The word *cognitive* or *cognition* means to *know* or to *think*. Cognitive therapy was originally pioneered by Aaron Beck for use in the treatment of depression; however, Dr Beck and others have developed methods for applying its usage to other psychiatric problems.

As is outlined in the following table, the patient's cognitions are often based upon misguided or erroneous beliefs, attitudes, and assumptions. Often, patients may describe an all-or-none thinking simply based upon a one-time failed attempt or experience. This dependency of negative consequences often creates a pattern of indecisiveness, resulting in the patient feeling incapable of making the correct decision.

Cognitive Therapy	
Cognitive Distortions	Definitions and Examples
Overgeneralization	Making assumptions or conclusions and applying them to most every life event based upon a single event. For example, a young Airman that fails his or her CDC examination thinks, "I'll never be able to pass this exam. I should just get out of the Air Force."
Personalization	Personal meaning to external events erroneously. For example, "My commander said the unit's fitness program's scores are low, but I know he's really talking about me."
Dichotomous thinking	Extreme contradictory qualities—everything is either all good or all bad. "If I could pay off all my bills, all of my problems would be solved forever!" or "If I must PCS on a remote, I might as well be dead."
Catastrophizing	Always thinking of the worst possible outcomes. For example, "I'd better not enroll in college this semester because I know I'm going to fail and feel stupid." The patient's ability to weigh events based upon proportionality is often skewed. Minimal occurrences are spun into "end all" events for this patient.
Selective abstraction	Focusing on only peripheral details and drawing conclusions without acknowledging relevant information. For example, an Airman believes she is disliked and not supported by her commander or leadership because they rarely speak to her; however, she was selected as Airman of the Year for her squadron and was promoted BTZ.
Arbitrary inference	Always making a negative conclusion without supporting information. For example, a patient states the following, "My mom hasn't called in a week. I'm sure it means she doesn't care about me anymore."
Mind reading	In this instance, the individual thinks he or she knows what others are thinking of or about him or her. For example, "He thinks I'm incompetent and lazy because I haven't said anything during the entire meeting."
Magnification/minimization	Exacerbating or making light of the importance of events. For example, a plant dies that the patient is caring for and his or her reaction is, "That just shows you I can't take care of anything."
Perfectionism	When everything must be accomplished perfectly or the individual feels incompetent. For example, "I'm such a loser if I score anything less than a 95 percent on all my exams."
Externalization of self-worth	Basing one's personal value upon the approval of others. For example, "If I don't spend \$100 shopping with my friends, they will think I'm worthless."

Cognitive therapy is a structured and time-limited endeavor that has been most successful in treating depression, anxiety, phobias, and psychosomatic and pain disorders. The focus of treatment relates to reducing the dysfunctional thought process with supportive, balanced, and realistic thought content. Patients are encouraged to examine internal thoughts, feelings, and impulses. Focusing on automatic thoughts and identifying dysfunctional cognitive thinking are used to clarify the patient's problems.

Rational emotive therapy/rational emotive behavior therapy

Rational emotive therapy/rational emotive behavior therapy (RET/REBT) is a form of cognitive therapy established by Dr. Albert Ellis in 1955. The main tenet of RET/REBT is our thoughts affect the way we feel, which affects how we act. RET/REBT uses an “ABC” approach to how people look at themselves. “A” (activating event) is something happens. “B” (belief system) determines if what happened is good or bad, right or wrong. “C” (consequence) is what we do or how we react. “A” is filtered through “B,” which leads to “C.” Things or events don’t make us happy or sad; it is how we view those things/events that lead us to react in a certain way.

RET/REBT proposes that one’s belief system can be either rational or irrational. A rational belief system is one that gets us what we want without hurting us in the long term. An irrational belief system is one that gets us what we want without regards to hurting ourselves or others in the long run. Many people with problems hold on to their irrational beliefs even though these beliefs aren’t helping and, in fact, are hurting them. Dr. Ellis lists 10 irrational beliefs that lead to most all problems. The three core irrational beliefs are:

1. I must be liked/loved by everyone I consider significant in my life.
2. I must not make mistakes.
3. Life must be fair.

To resolve these problems, RET/REBT postulates the following:

- You are responsible for your thoughts, emotions, and actions.
- Your harmful emotions and actions are a product of an irrational belief system.
- You can learn new realistic views and learn how to use them, and, by doing so, you will lead a happier life.

It is the clinician’s job, by using the “DEF” system, to help the patient. “D” (dispute the irrational belief), plus “E” (explore alternate beliefs), plus “F” (formulate a new, rational belief system) help get the patient working towards solving his or her problems. By disputing irrational beliefs and replacing them with more rational/realistic beliefs, RET/REBT states that problems will be resolved.

Using RET/REBT in a clinical setting has many advantages. By its nature, RET/REBT is short-term counseling. Most, if not all, the work is done by the patient. The counselor’s role is to help the patient see what his or her irrational beliefs are and how he or she can dispute and change them. RET/REBT is easy to understand. Patients may have some difficulty in accepting that they are the ones who must make the changes, but they don’t have trouble understanding the basic principles. RET/REBT is easy to learn. There is no complicated philosophy to learn. Quite often what is being talked about is no more than common sense.

Using RET/REBT has some cautions. Learn about RET/REBT—what it is and what it isn’t. RET/REBT is not telling the patient what to do, but, rather, it is to dispute irrational beliefs and have the patient formulate and implement new rational beliefs. RET/REBT is not putting people down. Arguing with patients will only reinforce their beliefs.

Used appropriately, RET/REBT is a very effective approach for many patients.

Reality therapy

Reality therapy has been compared to the moral therapy of the early nineteenth century due to its roots in religious teachings. This therapy, unlike most traditional psychotherapies, forces the therapist to take a stand and often disclose his or her feelings regarding morality, responsibility, and accountability. It is goal-directed and focused on the present and future.

The adage, “It doesn’t matter where you’ve been, what matters is where you are going” is a perfect match for this therapy. This therapy focuses on present behaviors or issues that are the presenting problem and what the patient can do to change or face these issues. In reality therapy, it is felt there is

nothing that can be done to change the past, and spending time attempting to understand the patient's psychiatric past is futile and wastes time.

The following basic tenets of reality therapy are based on the opposite of traditional psychotherapy, which is debunked as part of reality therapy:

- Conventional or traditional categories of mental illness and efforts to treat them are useless.
- Patient's insight into his or her past is useless and meaningless.
- Reliving the past has very little, if any, therapeutic value.
- Insight into unconscious conflicts does not lead to behavior change.
- Traditional psychiatry avoids issues related to morality.
- Conventional therapy fails to teach the patient better behavior.

In reality therapy, the therapist assumes a maternal/paternal or teacher role—enforcing rules, teaching responsibility, and being tough, yet humane. This is often a confrontational and directive approach some therapists are uncomfortable assuming. This therapy is ideal for adolescent delinquents or adult petty criminals, as well as individuals with impulse disorders.

In reality therapy, it is felt that patients who seek psychotherapeutic intervention refuse to accept reality and are seeking love and self-worth. Another key concept is responsibility. It is felt that until a patient can accept responsibility and recognize the unique role he or she has played in the current situation, he or she will have difficulty moving on in life.

Transactional analysis

Transactional analysis (TA) is an easily understandable psychological theory about people's thinking, feelings, and behavior. Developed by Eric Berne, it is a way to understand complex interpersonal transactions. Berne recognized that the human personality is made up of three "ego states." Each ego state is an entire system of thought, feeling, and behavior from which we interact with each other. The parent, adult, and child ego states, and the interaction between them, are the foundation of TA. In psychotherapy, TA uses a contract for specific changes desired by the patient and involves the *adult* in both the client and the clinician to sort out behaviors, emotions, and thoughts that prevent the development of full human potential. Transactional analysts intervene as they work with clients in a safe, protective, and mutually respectful environment to eliminate dysfunctional behaviors and establish and reinforce positive relationship styles and healthy functioning.

One of the key concepts in TA involves examining the relationship that the patient has with other people in his or her life; including peers, spouse, family, and coworkers. The patient will fulfill one of the roles listed below as he or she interacts with others.

The parent

The parent is like a tape recorder with a collection of prerecorded, pre-judged, prejudiced codes for living. When an individual is in the parent ego state, he or she thinks, feels, and behaves as his or her parents. The parent decides, without reasoning, how to react to situations, what is good or bad, and how people should live. The parent can be either critical or nurturing.

The adult

A person functioning in the adult ego state functions as a human computer. Information is collected and stored or used to make decisions according to a logic-based program. The individual uses logical thinking to solve problems, making sure the parent or child emotions do not influence the process.

The child

When in the child ego state, the individual acts like the child he or she once was. The individual thinks, feels, sees, hears, and reacts as a child. When the child is hateful, loving, impulsive,

spontaneous, or playful it is called the natural child. When it is thoughtful, creative, or imaginative, it is called the little professor. When it is fearful, guilty, or ashamed, it is called the adapted child.

Strokes

Berne observed that human beings need strokes to survive and thrive. Understanding how an individual gives and receives positive and negative strokes, and changing unhealthy patterns of stroking, are powerful aspects of TA. Berne defined socially dysfunctional behavioral patterns of giving and receiving strokes as “games people play.” These repetitive and devious transactions result in negative feelings and low self-concepts. They mask the direct expression of thoughts and feelings.

Life script

Berne proposed that dysfunctional behavior is the result of self-limiting decisions made in childhood in the interest of survival. These decisions result in “life scripts” or the preconscious life plan that governs the way one lives his or her life. TA aims to change the life script.

I’m OK; you’re OK

“I’m OK; you’re OK” is the best-known expression of the purpose of TA. The goal is to establish and reinforce the position that recognizes the purpose and worth of each individual. TA regards people as OK and, thus, capable of changing and growing and having healthy interactions.

Contracts

TA practice is based on mutual contracting for change. Berne believed in making a commitment to “curing” his patients rather than just trying to understand them. To show his commitment, he introduced the tool of contracting with patients. This contract is an agreement entered into by both client and therapist to pursue specific changes that the client is interested in making.

Gestalt therapy

Gestalt therapy was first introduced in the mid-1940s by Fritz Perls and his wife, Laura. The Perls suggested that patients are manipulative and avoid self-reliance and responsibility. Gestalt therapy is often confrontational and encourages the patient to stand on his or her own two feet and take responsibility for his or her life’s problems. This complements a very basic assumption of Gestalt therapy, which states the patient has the capacity to “self-regulate” in his or her current environment, and adjusts his or her behavior and reaction to what is happening around him or her. It emphasizes the patient is responsible for his or her destiny.

The Perls made the analogy of comparing the unfolding of the adult personality to the peeling of an onion. They suggested people must rid themselves of five separate layers of neurosis to reach psychological maturity. The following table outlines the five layers:

Gestalt Therapy's Five Layers of Neurosis	
Layers	Definition
Phony	This layer is best described as the faux personality individuals initially display when interacting with others. We often react in an inauthentic and stereotypical manner. This layer is often where individuals will play games and present a false image of who they really are in an attempt to fulfill a role or expectation they feel others may have of or for them. This is also the layer where the phoniness of the charade becomes apparent and individuals will experience feelings of unpleasantness and pain.
Phobic	In this layer, individuals attempt to avoid negative feelings associated with revealing or seeing aspects of themselves they’d prefer to deny. During this stage, the individuals resist or deny aspects of who they really are. This is also a stage where individuals fear others will see through the charade they sometimes project and will most certainly reject them.
Impasse	This is a stagnant layer where the individual feels stuck in the current layer of maturation. The individual may depend on things out of his or her control to make decisions for him or her. This is sometimes described as a sense of deadness or that the individual feels nothing.

Implosive level	To gain an understanding of who we are, Perl suggests that individuals must fully experience the impasse level of deadness and understand the feelings that caused the level to occur. It is only after the patient experiences the implosive level that he or she can reach the climax of levels call the explosive level.
Explosive level	In this level, the individual no longer presents himself or herself in a false pretense or in a phony manner. The individual is comfortable with who he or she is and, thereby, seizes and uses a tremendous amount of power to take control of his or her life rather than attempt to fulfill roles others have created for the individual. This is the level where the individual will feel most alive and authentic.

This therapy focuses on the patient's failure to experience all aspects of him or her "self." Gestalt therapy suggests that people are repressed, and this repression blunts what should be a natural reaction to life events. The focus of awareness in the patient's reaction to life events will then allow appropriate expression of affect.

In Gestalt therapy, it is believed that continued repression of the ability to freely express yourself can lead and contribute to psychopathology. Repression is the most common form of interference as it relates to accommodating civilized societal demands. It is felt that any form of self-control interferes with normal healthy functioning.

The counselor actively assists the patient in identifying perceived obstacles that prevent the free expression of the patient's feelings. This therapy is conducted in the present tense and any attempt by the patient to gain insight into past issues that he or she feels may be relevant in his or her current situation is discouraged. Doing so leads to accusations that the patient is intellectualizing his or her problems. A much lauded mantra of Gestalt therapy emphasizes the therapist's concern with the "here and now, not the then and there."

Gestalt therapy is also used in a group setting and is often the scene of open and direct dialog. Patients are encouraged to speak freely and directly about other group members, and about their true feelings. Groups are also the scene for role playing and practicing the new skills the patient has began to foster.

This type of therapy requires a skilled, knowledgeable clinician. It can be confrontational and the counselor needs to be comfortable with his or her feelings and self-awareness. The charismatic, yet firm, approach will facilitate you, the counselor, to lead the patient to the awareness he or she has always possessed but likely never expressed.

Strategic family therapy

Strategic family therapy (SFT) originated in what was called communication therapy. SFT communication is not only the verbal interaction between the sender and receiver but also the behavioral aspects between individuals. The counselor will examine the family structure, focusing on hierarchy, boundaries, and interactions, verbally and behaviorally. The communication problems most often identified in dysfunctional families include disqualification, disconfirmation, and incongruent communication.

Disqualification

This involves communication that is intentionally misleading, misunderstood, and inconsistent, and often leaves the receiver with an impossible conclusion to an answer. An example of this is an older sibling asking the younger sibling: "When you were younger, did you walk to school or carry your lunch?" or "What size is that shirt blue?" There is no sensible response to either of the questions.

Disconfirmation

Disconfirmation involves denying or invalidating hurtful or demeaning statements to protect the sender's self-image. An example could include a spouse responding to a mate's inappropriate comment: "He really didn't mean that. He's always this way when he gets mad."

Incongruent communication

The oxymoron of communication, incongruent communication involves sending two opposite messages at the same time. There is no possible outcome the receiver could take to avoid being considered “mad or bad.” An example of this might be, “Shut your mouth and tell me what happened.”

SFT counselors are careful to differentiate between difficulties and problems. Difficulties are usually issues that can be solved or corrected with behavioral adjustments. However, some difficulties are uncontrollable and are simply a part of life. The adolescent child who consistently leaves dirty laundry on his or her bedroom floor is considered a difficulty. A behavioral change in the child’s daily routine will likely bring about change. An example of an impossible difficulty would be aging. Aging is simply something we cannot control or stop.

Problems are usually the result of difficulties that have escalated or been mishandled for a period of time. Refusing to acknowledge something is a problem neither makes it no longer a problem or is helpful in its resolution. The problem can involve a specific member of a family (i.e., a rebellious child or a substance-abusing parent) or it could be several members of the family.

Intervention

The SFT counselor will take time to meet each of the family members to learn about his or her perspective of the problem and his or her personal values. This will be essential later in the critical step known as reframing. Reframing means to change the conceptual or emotional setting or viewpoint in which a situation is experienced. This may include using an analogy to reframe a situation but being careful to include all of the facts that set the stage for the original problem. The clinician will then meet with the entire family unit and begin the process of finding out what steps, if any, have been taken to remedy the problem. Learn what successes or failures the family has encountered in an effort to correct the family dysfunction. Has it “just always been this way?” SFT is solely concerned with the problems of the here and now. Historical preludes to the current situation are not relevant and serve only to distract from resolving the current problem.

Again, the critical step of reframing allows the counselor to put forth all the facts for the family in a setting minus the emotional context the problem often carries. This allows the family to begin examining each of their unique roles and how they interact with each other, which contributes to the family’s dysfunction patterns. The SFT counselor is actively and, at times, aggressively involved throughout the therapy. Counseling is terminated once the desired change the family is seeking has been achieved.

Behavior therapy

Behavior therapy seeks to understand the patient’s problems and gain a clearer understanding of the patient’s behaviors relating to these problems—specifically, those behaviors considered problematic. Patients identify clear goals at the beginning of treatment, and goal achievement remains the focus throughout treatment. Behavior therapy involves a variety of approaches that have been honed over the years to address each problem specifically with a unique approach. Prior to engaging in behavior therapy, the crucial step of conducting behavior analysis must be accomplished to create an individualized treatment plan. There are two key concepts—behavior and behavior analysis—that must be explored.

Behavior

Literally speaking, behavior refers to the motor and verbal activity of the patient. However, the behavior therapist is more interested in what is sometimes deemed covert behaviors. The first two types of behavior are thoughts and feelings. These are not directly observable but, rather, are inferred from what the patient’s reactions are to events (i.e., congruency of spoken words, facial expressions, and physiological responses). The third kind of behavior to be noted is physiological responses—that is, noting changes in heart rate, body temperature, and so forth.

Behavior analysis

The process of behavior analysis consists of an in-depth review of maladaptive behavioral responses that has caused difficulties in the marital, family, social, occupational functioning, or other significant area of your patient's life. For example, perhaps your patient has difficulty speaking in public or when meeting new people. Obviously if your patient stutters upon meeting new people, this could have social and occupational ramifications. Perhaps the patient unwittingly increases the volume of his or her speech when he or she becomes agitated. This could affect all aspects of his or her life. The behavior analysis could also consist of overt, aberrant, and antisocial behaviors as well. Precipitating events should be reconstructed that led to the behavior, with the patient describing feelings leading up to the behavior. For example, is your patient afraid of heights, bodies of water, gas masks, and so forth?

Common therapeutic approaches

Some of the more common therapeutic approaches you may encounter as a mental health journeyman in behavior therapy are systematic desensitization, relaxation training, hierarchy construction, desensitization proper, flooding, graded exposure, and graded participant modeling.

Systematic desensitization

This is a core and basic behavioral treatment option for the behavior therapist. By having the patient face his or her fear through repeated or various forms of exposure, it is believed the patient's anxiety will decrease over time.

Relaxation training

This is used to encourage the patient to take control of his or her internal anxiety-provoking physiological responses. This method involves the patient repeatedly tightening and relaxing major muscle groups at the encouragement and direction of the counselor. This can and often is accomplished via an audio recording, although you should practice this approach and be familiar with the process, as audio equipment may not always be readily available.

Hierarchy construction

In this stage, the counselor reconstructs anxiety-provoking events through imagery. This can be used for any stimuli that is anxiety provoking, such as rejection, jealousy, criticism, or a phobia. Examples are a patient afraid to don his or her mission-oriented protective posture (MOPP) gas mask or a patient with a fear of public speaking, "You are in your MOPP gear and you are being told to place your gas mask on." "You are being introduced to an audience." In this stage, the counselor gradually walks the patient through the event and repeats the provoking theme with increasing levels of anxiety.

Desensitization proper

During this stage, the patient is walked through the least anxiety-provoking event to gradually increasing levels, again through imagery. The counselor enthusiastically encourages the patient with each milestone of accomplishment.

Flooding

Flooding consists of the patient confronting his or her anxiety-provoking event full force. The patient actually goes to the top of a building and looks down, or puts on his or her gas mask without any anxiety-reducing behaviors as a precipitous. This method believes that prolonged exposure to a specific anxiety will reduce the anxiety-provoking stimuli. In other words, the more the patient is exposed to something, the less anxious or fearful he or she becomes.

Graded exposure

Graded exposure walks the patient through the anxiety-provoking event. Using the graded exposure model, the patient with a phobia of heights would go to the second floor of a building and look out,

and gradually increase the height until he or she reached the top. This may take several sessions to complete.

Graded participant modeling

In this model, the patient observes as the counselor or others imitate the behavior the patient desires without anxiety. For instance, if a patient has an irrational fear of cats, the counselor may allow a cat to sit on his or her lap while he or she pets the animal. The patient would be encouraged to at least approach the animal and perhaps touch it before continuing to encourage the patient to allow the cat to sit on his or her lap.

Client-centered therapy

Associated with the works of Carl Rogers, client-centered therapy (CCT) is best known for its nondirective, empathic approach. This nondirective encounter is particularly different from other psychotherapies and, in fact, contrary to many. CCT insistence that the medical model of treatment is unsuitable in dealing with psychopathology or psychologically distressed patients makes this approach unlike other psychotherapies. The notion that the patient “runs the show” is often the perception as it relates to CCT. The CCT counselor promotes an environment where the patient feels accepted with unconditional judgment from the therapist. This approach in CCT places more responsibility on the patient. The primary notion of CCT is that people are very self-understanding and can change in a constructive manner with enough support and empathy from others.

CCT does not focus on treatment planning and the conventional parameters of treatment that a diagnosis often drives. Counselors should be consistently encouraging and listening to the patient catharsis. This is not a therapy where the patient comes to be “evaluated” on progress and provided alternative approaches to problem resolution. It is believed the patient has the capability and knows what is best for himself or herself, if only the patient had the ability to achieve his or her desires.

The CCT counselor must have the capacity to genuinely demonstrate several attributes for the conditions of therapy to be successful. Perhaps you’ve heard a patient say, “I feel better already!” having just seen the provider on one occasion. Sometimes it’s the ability of the patient to feel free to discuss his or her feelings, or perhaps the patient feels empowered that he or she can meet whatever challenge the patient faces. The counselor sets the stage for this to be successful.

There are three specific therapist attitudes that must be present in CCT:

1. Accurate empathic understanding.
2. Caring or unconditional positive regard.
3. Genuineness or congruence.

Accurate empathic understanding

The counselor’s ability to accurately and sensitively experience issues from the patient’s perspective is paramount in CCT. The patient will sense superficiality. As much as it is aggravating for most of us to communicate with someone “who’s been everywhere and done everything,” the patient is no less put off by a counselor who readily acknowledges every painful nuance the patient describes. Empathic understanding in CCT is to gain understanding from the patient’s perspective. The patient who describes the death of a spouse, bankruptcy, a serious medical condition, and loss of employment all in the course of a year is nearly unfathomable. Likewise, for the patient to have a counselor consistently state “I know how that feels” for every response reeks of insincerity.

Caring or unconditional positive regard

This portion of the therapeutic process calls for the counselor to abandon all judgments regarding the patient and interact in a neutral, accepting manner. This is very difficult for some counselors to sustain. In this area, the counselor neither approves nor disapproves of a patient’s thoughts, feelings, or behaviors. This is considered unconditional positive regard. This approach is not for the counselor

to naively believe or blindly follow everything the patient reveals. However, the counselor must remain neutral and engaged to maintain the therapeutic relationship.

Genuineness or congruence

This, simply put, is the counselor being natural. It means being honest with your patient when you feel he or she is not being forthright with you. It means expressing your feelings when asked by the patient in an honest manner. You must maintain boundaries and, if you are uncomfortable answering questions the patient poses, inform him or her of your feelings. This is not psychotherapy for the charismatic; most patients will see through this charade. The ability to connect and provide genuine interaction with the patient is paramount. The patient feels as if he or she knows you when the patient has finished his or her session. Many counselors are uncomfortable with this approach, as it requires some self-revelation and opening one's self up to a patient. This, of course, seems contrary to many of your other teachings.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

610. Identify common issues encountered by new counselors

1. What occurs when journeymen maintain a stereotypical role of being a counselor?
2. When should you self-disclose to a patient?
3. What occurs when a counselor is uncomfortable with silence during counseling?
4. What does encouraging a patient to make independent choices and accept the consequences of his or her choices promote?

611. Identify the basic skills for the counseling platform

1. What is the purpose of defining behavior?
2. Identify ways in which we form our self-image.

612. Making clear and informed decisions

1. During which stage of counseling will the counselor demonstrate acceptance without judgment or insertion of personal beliefs and continue to build a trusting relationship?

2. In which stage of counseling does the counselor begin to gain a greater understanding regarding the patient's primary problems and formulating diagnostic options?

613. Identify the differences in selected psychotherapeutic approaches

1. What are the three basic approaches you will use in psychotherapy?
2. What is the focus of cognitive therapy?
3. What are the three core irrational beliefs of RET/REBT?
4. What are the basic tenets of reality therapy?
5. Which therapy is ideal for adolescent delinquents or adult petty criminals?
6. Identify the ego states that form the foundation for TA?
7. What is the best-known expression of the purpose of TA?
8. What is the basic assumption of Gestalt therapy?
9. What are the communication problems most often identified in dysfunctional families?
10. What is the critical step of reframing?
11. Identify the process of behavior analysis.
12. In the caring or unconditional positive regard attitude presented in client-centered therapy, what is the counselor called on to do?

2-2. Conducting Groups

Organizing, conducting, and terminating therapeutic and educational groups can be challenging and rewarding. In this lesson, we will address the key components of psychotherapeutic and psychoeducational groups. This will also include the evolution of a group process, identify key processes of establishing a group, and examine the positive and negative aspects of each. You will also examine the common group problems and how these issues can be addressed.

614. Identify characteristics of psychotherapeutic groups

You will have the opportunity to participate in a variety of groups throughout your career. You will also have the opportunity to assist in choosing patients who might be good candidates to participate in group; we will discuss the selection process later in this lesson. While you may be accustomed to being referred to as the technician or other titles denoting your role in the clinic, in a group setting you are often referred to as the leader, conductor, or facilitator. This lesson will use the term *facilitator*.

Groups in general

Psychotherapeutic groups seek to assimilate patients who are currently experiencing issues (here and now) that would improve by interacting with others. This would include issues like identifying and expressing thoughts and feelings, trust, intimacy, assertive communications, self-esteem, family problems, or support for people in a crisis (i.e., bereavement groups, spousal abuse, and sexual assault). One important advantage psychotherapeutic groups offer over one-on-one counseling is the ability for the patient to assimilate with other people who are experiencing like problems. This is often very empowering for the patient when he or she is able to see other people successfully coping and managing their lives. Groups also afford the patient untold social aspects that prove beneficial for many.

Conducting group therapy

From the professional perspective, a positive aspect is groups are often an easy and efficient way to manage numerous patients at once. The first step in starting a therapeutic group is to examine the target audience and the anticipated outcome of conducting a group. A few questions you must ask yourself are as follows:

- Is there a need for a group from the population you serve or the patients you meet?
- What is the goal of the group?
- When will the group be conducted?
- Where will the group be conducted?
- How long will the group last? That is, is it open-ended, ongoing, or closed, or are there specific parameters the group will work towards for conclusion?

Open-ended or open groups meet on an ongoing basis and permit patients to join and finish at different times. An example of this may be bereavement support groups, substance-abuse support groups, and so forth. Closed groups are often used with psychoeducational groups where there is a definitive beginning and closure with all members joining and ending at the same time.

Psychoeducational groups help participants develop new skills as they acquire and share information.

Once you have determined the need for the group, the population and makeup of the group must be determined. One facilitator can effectively manage a group of eight to 10 participants. Certainly no more than 15 group members are recommended without a cofacilitator. Groups consisting of more than 10 patients will lose the valuable interaction between group members.

Group cohesiveness will be paramount in successfully orchestrating the group process. Homogeneity, patient age, and diagnostic issues will be important factors. Gender as well can be a factor to

consider, depending on the focus of the group. The focus of the group will dictate who is better suited for which group.

615. Identify characteristics of educational groups

Educational groups focus on changing specific patterns of behavior. All group members work towards the same goal of promoting change in behavior. The groups are usually structured in nature, time-limited for a specific number of sessions, and, unlike therapeutic groups, they have a closed membership. Group membership is not vacillating and most likely will not increase during the group's life. With that said, some educational groups will be ongoing with selected senior group members mentoring new members. This is especially helpful in substance abuse and medical problem groups.

Type of groups

Groups which fit the educational group mold are substance abuse, eating disorder, and medical subspecialty groups (i.e., diabetes, multiple sclerosis, smoking cessation, etc.). An educational group may imply there is an instructor and the participants will learn. This is only minutely true. This is an interactive process, and the candidates learn as much from each other as the information the facilitator passes along. There are milestones the facilitator will be pushing to achieve along the way, but it is the peers of the participant that often have the larger impact as they inspire potential, hope, and success.

Group interactions

Any time two or more people are gathered, there will be disagreements, misunderstandings, and/or manipulations. This is encouraged at times to help entertain a healthy discussion. However, when one person consistently is disruptive, it tends to disorganize others or create an atmosphere where others shut down.

A pregroup should be conducted with the potential candidates individually. This will give you the opportunity to explain the goals, expectations, and rules, and answer questions regarding confidentiality. Confidentiality is always a primary concern when you discuss group participation. Members want to be assured their personal issues will remain in the group and not discussed outside the group. While some rules are necessary for the group to function, the group itself may want to establish some rules. However the arrangement, the group rules should be written down and clear to all group members.

616. Identify common group processes

All new groups go through stages of development and, in the case of psychoeducational groups, end with the termination stage. We will briefly review these four common stages.

Beginning

This stage is characterized by much trepidation as group members are unsure of what to expect or what will be expected of them. Apprehension, dread, anxiety, and sometimes excitement mark the beginning stage of a group. This is also the stage where you should establish basic "ground rules" for participation in group. This is done democratically at times with the group members creating the rules, and in other settings the rules are already established prior to beginning the group. Some common rules you may encounter include:

- Respect—Members may disagree with, but must respect, other group members.
- Honesty—Members must be truthful about their feelings expressed in group.
- Confront—Members should be encouraged to challenge behavior that is dishonest or harmful to the group. This assertiveness should be in a constructive manner.
- Accept feedback—Members should listen to peer group members without being defensive.

- Use “I” statements—Group members can only talk for themselves, not for others. Often, group members will seek the security of making statements by stating “we think” or “we feel;” direct them to rephrase the statement using an “I think” or “I feel” comment. This encourages the members to take responsibility for their feelings.
- No rank—Members cannot use rank to control or avoid group discussion.
- Be direct—Group members must talk TO someone, not ABOUT someone.
- No rescuing—Let group members handle their issues and problems. Often, strong-willed members will attempt to rescue or defend other members they perceive as struggling. This doesn’t foster assertiveness or self-esteem with the patient being rescued or defended.
- Subgroups—Group members cannot discuss group interactions or processes outside the group setting.
- Confidentiality—Confidentiality is paramount in group settings. What occurs in group must stay in group. A breach of confidentiality must be dealt with swiftly. We will discuss consequences of breaking the rules later in this lesson.
- Uniform Code of Military Justice (UCMJ) applies—Group members must be informed that confidentiality only extends to therapeutic processes. Members must know that mental health providers and technicians are not afforded full confidentiality and, if they (the patients) reveal anything that is in violation of the UCMJ, it must be reported.

There are many potential group rules that can be established. These are just a few of the more common ones.

Conflict and controversy

This stage will arrive in one of two ways. One will be a verbal attack on the facilitator and the other will be an attack on a peer group member. The verbal attack on the facilitator is a challenge to the validity of you and the group as a whole. Attacking peers is often an attempt to distract or disrupt the group as a whole.

Aside from these conflicts, controversy can occur as the result of group members breaking the rules. When rules are established, consequences for breaking the rules must be discussed as well. For some rules like rescuing or using “I” statements, the consequence can simply be a reminder of the established rules. For other rules, such as breaking confidentiality or a member who uses confronting often and becomes aggressive, it could mean removal from the group. These consequences should be discussed at the very beginning so all group members are aware and understand the gravity of breaking the rules.

Working and cohesion

During this stage, the ‘birthing’ process of merging personalities has subsided and the group will be working together and supporting one another. There can still be conflict; however, the recovery stage for group members will occur much quicker.

Termination

Termination is more common in psychoeducational groups; as they are typically run on a timeline, with some exceptions. This is a difficult time as group members begin to understand the group is nearing completion. Often dependencies between group members and the facilitator will emerge, or group members will attempt to introduce new “bombshell” material to the group. Termination should be discussed midway through the group if it is to end, and explain the processes so group members are prepared when the time arrives. Termination is intended to tie up loose ends and ensure all unfinished business is complete or at least recognized for future counseling.

617. Identify the benefits and contraindications of group participation

With everything we do, there can be benefits or consequences with the outcome. Groups are no different. This lesson will guide you through some of the common benefits and contraindications to group participation.

Benefits

Participation in a psychotherapeutic or psychoeducational group often provides the patient with numerous benefits intrinsic to the group itself. This lesson will discuss some of the more common benefits; you will certainly add more of your own as you participate in groups and measure observable outcomes:

- Rejuvenation or generation of hope and optimism. Patients who attend group often begin to feel there “is a light at the end of the tunnel” when they interact with others who have like problems.
- A sense of safety, comfort, and support. Patients may feel overwhelmed in trying to face a problem alone. The security of forging ahead in numbers can be very reassuring.
- Identification of common goals and issues.
- Exchange of useful constructive information. The sharing of information in group often reveals effective coping mechanisms the patient may have never employed or been afraid to use for fear of failure.
- Interpersonal learning and imitative behavior.
- The opportunity for verbalization and catharsis. Some patients simply want to talk about their experience or problems. Patients will often describe relief at being able to discuss their issues in front of others.
- Encouragement and empowerment of participants. When patients discover they are not the only person experiencing like problems, it is often very encouraging. Often, patients feel completely alone as they attempt to tackle unknown territory. There is often a sense of reduction in the sense of isolation and uniqueness.
- Enhancement of one’s interpersonal and socializing skills. It is human nature to want to feel a part of a group. This might be family, peers, and so forth. However, sometimes patients will isolate themselves because of their perception they are alone or their problems are unique to only them.
- Unselfish regard for the well-being of others. There is always a hope that patients will gain empathy in the process of participating and interacting with others.
- Prompt and direct feedback about the member’s behavior.

Contraindications

Just as there are many benefits for patients who actively participate in groups, there are those who should not participate in a group setting. Thorough prescreening, discussed earlier in this lesson, should eliminate most patients who are not a good match for a specific group. The reasons for not including a patient in a group are varied. Some of the more common reasons are:

- Clearly when the person is not motivated to participate in the group process, he or she should not participate. With this said, in some therapeutic or psychoeducational groups, resistance to participation is common when it involves substance abuse and domestic violence.
- When the person is actively in crisis and other group members are not. Crises are normally best managed on a one-on-one basis. Critical incident stress debriefings (CISD) is an exception to this, as many times numerous group members may be in crises from exposure to an overwhelming incident.

- When the patient has articulated he or she is actively suicidal or homicidal. Patients who express suicidal or homicidal intentions should not participate in an outpatient group setting. Often, the group members are ill prepared for such a declaration and can prove counterproductive in helping the patient through this crisis.
- If the patient is extremely shy or has an unusual aversion of speaking in social settings, he or she should not participate in groups, unless the composition of the group is of like people and the group's focus is to help desensitize patients by exposing them to social settings.
- When the patient's interpersonal skills are very poor or the patient has a very limited awareness of his or her feelings or behaviors. Depending upon the group composition, individuals with poor interpersonal skills may be ostracized by more aggressive or accomplished group members.
- When the person is acutely manic, or his or her need for attention is so great it cannot be managed by the group. These individuals can quickly cause the group to lose focus or require constant redirection to keep the group on task due to their unfocused verbal meanderings.

These are just a few of the more common contraindications to participation in group. As you participate, you will discover other attributes patients possess that are not compatible with a group setting. Be attentive to these patients and attempt to tailor treatment to their specific needs. If you feel a patient is not appropriate for a specified group, discuss your concerns, including specific details regarding your feelings, with the provider overseeing the group.

618. Identify common problems in group psychotherapy

Some patients continually test boundaries whether in individual or group therapy. This can be for a variety of reasons, including passive aggressiveness, ulterior motivation, or lack of motivation, to name a few. The following is the most common types of group disruptions that you, as the facilitator, can anticipate.

Absenteeism

Absenteeism and tardiness must be addressed immediately when they occur. Often, there may be a low number of individuals in a group; a single absence can disrupt the flow of the group and leave other group members openly questioning the group's effectiveness. Much time is lost reorienting patients who have missed a session, and this should be addressed by the facilitator or the group as a whole. The latter is preferable as the offending group member is directly confronted by those he or she affected the most.

Dropouts

The longer the therapeutic group continues, the more likely dropouts will occur. Dropouts typically occur for two reasons. One, the patient feels he or she is "fixed" and no longer benefiting from the group as a whole, or the issues being addressed are too painful and perhaps the patient is unwilling to face them and will drop out. Some patients give notice of their intent. This is most desirable as other group members have an opportunity to query the patient regarding his or her rationale for leaving, and it allows peer group members to say good-bye. Patients who discontinue group without warning often leave the group confused with many unanswered questions.

Removing members from group

Removing disruptive patients from group is an extremely difficult process and must be handled in a careful, merciful manner. Later in this unit, we will discuss specific problems patients can bring to group that may call for their removal. Typically, preselection for group will help eliminate potential problem patients from group before beginning. For those who make it through the screening process and must be removed from group, it is recommended an exit interview be conducted to explain to the patient the rationale for his or her removal.

Adding members to group

Just as dropouts and removing patients from group can be very disruptive to the group process, adding a new member can be as well. Often, group members are untrusting of this new, untested group member. There is a bit of a “dance,” if you will, of group members testing the water with the new member. Likewise, the new member may feel ostracized or an outsider from a group of people who have become close. As a perpetual group grows stagnant with members leaving, the facilitator may consider adding new members to inject “life” into the group again. This new member will often bring a new set of issues that inspire or synergize the group. Adding a new member is a rarity in an educational group, unless it is for the purpose of mentoring.

Managing group conflicts

Sooner or later conflict will occur between group members. This can be beneficial if used as a tool to promote self-esteem, to encourage a patient to use conflict resolution techniques, or to encourage a patient to be more self-sufficient. It can also be destructive and polarizing. A group member who overtly or subtly accosts another group member with ridiculing, “inside jokes,” mimicking, and so forth, must be addressed. You, as the facilitator, cannot allow this to go unchallenged. “TSgt Cordell, I’ve heard you make several comments today each time Airman Porter was speaking. Will you tell the group why you have interrupted Airman Porter?” Confront the offender and ask for an explanation. Empower the group to confront aberrant behavior or snide comments. Childish horseplay or immaturity cannot be tolerated in a group setting and must be confronted.

619. Managing problem patients in group

The previous paragraph briefly discussed conflicts in group. We are now going to focus on the individual potential problem patients that can minimize the effectiveness of the group process. Group process? Yes, the group is a process, an ever-evolving process, that requires participation from everyone. If everyone doesn’t participate, there is no process. However, if one patient consistently is overwhelming or nonparticipatory, this can sabotage the group’s effectiveness. The following provides an overview of specific labels or roles patients sometimes assume in group.

The monopolist

This is the patient who will chatter endlessly about anything and everything. He or she has “been there and done that.” He or she will often seize any moment of silence with verbal chatter, often irrelevant to the subject at hand. Ironically, this may be welcomed as filler in the infancy of the group, given many group members are uncomfortable or uneasy with silence. Soon, however, it becomes overwhelming and counterproductive as the monopolist stifles input from other group members. Sometimes, the monopolist may attempt to assume the role of cofacilitator in the group. You must work directly with this individual early on to curtail his or her overwhelming nature.

The silent patient

Equally as challenging as the monopolist is the silent patient. Silence occurs for a variety of reasons, ranging from fear to contempt. Perhaps the patient is fearful of making a fool of himself or herself, is afraid of self-disclosing, fears the perception others may have of him or her if he or she speaks, and so forth. Conversely, the patient may be contemptuous and feel he or she is better than the group or resent being in the group. This typically could be fettered out in the pregroup brief. The best approach for initially dealing with the silent patient is commenting on the nonverbal cues throughout the group, “Airman Thomas, I noticed you rolled your eyes and sighed loudly when Sergeant Johnson finished speaking. What does that mean?” Or by calling on the silent patient periodically to participate, “Sergeant Garza, how would you have handled this situation?”

The schizoid, obsessional, or overly rational patient

This patient may appear aloof, matter-of-fact, isolated, or distant during group. When asked to participate the patient will; but again, very matter-of-factly, and gets to the point with little, if any,

emotional tone. He or she is there, but feels or verbalizes very little emotion. This person can easily become the target of an aggressive narcissist in the group with ridiculing or demeaning comments. To encourage more engagement from the patient, you should actively recruit this participant's involvement as often as possible. "Who was the most helpful in group today Sergeant Johnson?"

The help-rejecting complainer

This is the consummate "yes, but" patient that consistently poses insurmountable problems for the group and then devalues their input by sabotaging the answer or dismissing it as impossible to achieve. This patient uses a lot of the group's sincere energy towards helping a fellow group member and discards their input as impossible to implement. This isn't a one- or two-time event for this individual. He or she consistently uses the "yes, but" phrase to ward off resolution to their problems. This behavior typically elicits one of two responses. Group members sympathize with their peer as they seemed locked in a perpetual hole of negative outcomes, or they become angry and frustrated with what they view as a self-defeating individual. This pattern should be brought to the attention of the "yes, but" patient. Once the behavior is out in the open, the patient may more carefully address issues with the group and become a more productive member.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

614. Identify characteristics of psychotherapeutic groups

1. What is an important aspect psychotherapeutic groups offer?
2. What occurs when there are more than 10 participants in a group?

615. Identify characteristics of educational groups

1. What kinds of groups fit the educational group mold?
2. What is the purpose of conducting a pregroup?

616. Identify common group processes

1. What feelings often mark the beginning stage of group?
2. What occurs when a group member verbally attacks the facilitator?

617. Identify the benefits and contraindications of group participation

1. Identify three benefits of group participation.

2. Identify three contraindications of group participation.

618. Identify common problems in group psychotherapy

1. Who is preferred to address the issue of absenteeism in groups?
2. When a patient discontinues group without warning, what occurs with the remaining group members?

619. Managing problem patients in group

1. What are some reasons why patients may remain silent in group?
2. What role does the “yes, but” patient pose for the group?

Answers to Self-Test Questions

610

1. It is very impersonal and can only make it more difficult to establish rapport.
2. It should be for the benefit of encouraging patients to deepen their level of self-exploration or to enhance the therapeutic relationship.
3. It is not uncommon to feel threatened by the silence and to do something counterproductive to alleviate the anxiety we feel.
4. Growth in problem solving.

611

1. Clarifies which behavior is detrimental, aberrant, counterproductive, and inconsequential.
2. Our regard for ourselves; our mental picture of how we appear to others; our picture of our physical self; our idea of how we present ourselves to others and are judged by them; our personal assessment of our character, personality, skills, abilities, and attributes; and our use of an accumulation of personal scripts from experiences (consciously or otherwise) throughout our lives to dictate how we approach people and situations.

612

1. Initial disclosure.
2. In-depth exploration.

613

1. (1) Cognitive.
(2) Behavioral.
(3) Dynamic or psychodynamic.
2. Psychological disturbances that frequently originate from habitual errors in thinking.
3. (1) I must be liked/loved by everyone I consider significant in my life.

- (2) I must not make mistakes.
- (3) Life must be fair.
- 4. Conventional or traditional categories of mental illness and efforts to treat them are useless; patient insight into his or her past is useless and meaningless; reliving the past has very little, if any, therapeutic value; insight into unconscious conflicts does not lead to behavior change; traditional psychiatry avoids issues related to morality; and conventional therapy fails to teach the patient better behavior.
- 5. Reality therapy.
- 6. The parent, adult, and child.
- 7. I'm OK; you're OK.
- 8. The patient has the capacity to self-regulate in his or her current environment and adjust his or her behaviors and reactions to what is happening around him or her. It emphasizes the patient is responsible for his or her destiny.
- 9. Disqualification, disconfirmation, and incongruent communication.
- 10. Allows the counselor to put forth all the facts for the family in a setting minus the emotional context the problem often carries.
- 11. Consists of an in-depth review of maladaptive behavioral responses that has caused difficulties in the marital, family, social, occupational functioning, or other significant area of your patient's life.
- 12. To abandon all judgments regarding the patient and interact in a neutral, accepting manner.

614

- 1. The ability for the patient to assimilate with other people who are experiencing like problems.
- 2. The group will lose the valuable interaction between group members.

615

- 1. Substance abuse, eating disorder groups, and medical subspecialty groups (i.e., diabetes, multiple sclerosis, smoking cessation, etc.).
- 2. It gives you the opportunity to explain goals, expectations, and rules, and answer questions regarding confidentiality.

616

- 1. Apprehension, dread, anxiety, and sometimes excitement.
- 2. Challenges the validity of you and the group as a whole.

617

- 1. Any three of the following statements is acceptable:
 - (1) Rejuvenation or generation of hope and optimism.
 - (2) A sense of safety, comfort, and support.
 - (3) Identification of common goals and issues.
 - (4) Exchange of useful constructive information.
 - (5) Interpersonal learning and imitative behavior.
 - (6) The opportunity for verbalization and catharsis.
 - (7) Encouragement and empowerment of participants.
 - (8) Enhancement of one's interpersonal and socializing skills.
 - (9) Unselfish regard for the well-being of others.
 - (10) Prompt and direct feedback about the member's behavior.
- 2. Any three of the following statements are acceptable:
 - (1) Clearly when the person is not motivated to participate in the group process, he or she should not participate.
 - (2) When the person is actively in crisis and other group members are not.
 - (3) When the patient has articulated he or she is actively suicidal or homicidal.

- (4) If the patient is extremely shy or has an unusual aversion to speaking in social settings, he or she should not participate in groups.
- (5) When the patient's interpersonal skills are very poor or the patient has a very limited awareness of his or her feelings or behaviors.
- (6) When the person is acutely manic or his or her need for attention is so great it cannot be managed by the group.

618

- 1. The group.
- 2. Often leaves the other group members confused with many unanswered questions.

619

- 1. Perhaps the patient is fearful of making a fool of himself or herself; the patient is afraid of self-disclosing; the patient fears the perception others may have of him or her if the patient speaks; the patient may be contemptuous; or the patient may feel he or she is better than the group or resents being in the group.
- 2. Poses insurmountable problems for the group and then devalues their input by sabotaging the answer or dismissing it as impossible to achieve.

Complete the unit review exercises before going to the next unit.

Unit Review Exercises

Note to Student: Consider all choices carefully, select the *best* answer to each question, and *circle* the corresponding letter.

24. (610) What is one of the *most* self-defeating beliefs for a beginning counselor?
 - a. We must be perfect.
 - b. We must understand silence.
 - c. We lose ourselves in our patients.
 - d. We are not honest about our limitations.
25. (611) Which is *not* one of the four specific areas that should be addressed in the therapeutic relationship between you and the patient?
 - a. Clear and informed decision-making knowledge and skill.
 - b. Ability to cope with adversity, both personal and environmental.
 - c. Personal barriers (i.e., poor self image or self-defeating attitudes).
 - d. Relational issue, ability to influence, and change relationships in their lives.
26. (611) What is *paramount* to a patient's ability to identify options and alternatives in the face of adversity?
 - a. Denying the problem exists.
 - b. Sharing his or her emotions with others.
 - c. Employing sound insight and judgment.
 - d. Distracting his or her attention from the problem.
27. (612) What refers to the cognitive capabilities or functions displayed by an individual?
 - a. Emotional intelligence.
 - b. Intelligence quotient.
 - c. Affective quotient.
 - d. Common sense.
28. (612) Which is *not* one of the common stages of counseling?
 - a. Initial disclosure.
 - b. Termination of care.
 - c. In-depth exploration.
 - d. Commitment to action.
29. (612) During *this* stage, the patient will gain insight into his or her primary problem and tentatively begin goal setting.
 - a. Initial disclosure.
 - b. Termination of care.
 - c. In-depth exploration.
 - d. Commitment to action.
30. (613) Which cognitive distortion is *best* defined as extreme contradictory qualities (everything is either all good or all bad)?
 - a. Perfectionism.
 - b. Catastrophizing.
 - c. Overgeneralization.
 - d. Dichotomous thinking.

-
-
31. (613) Which cognitive distortion is *best* defined as always making a negative conclusion without supporting information?
 - a. Catastrophizing.
 - b. Arbitrary inference.
 - c. Selective abstraction.
 - d. Magnification/minimization.
 32. (613) Which therapeutic approach forces the therapist to take a stand and often disclose his or her feelings regarding morality, responsibility, and accountability?
 - a. Reality therapy.
 - b. Gestalt therapy.
 - c. Behavior therapy.
 - d. Transactional analysis.
 33. (613) What is *not* one of the Gestalt therapy's five layers of neurosis?
 - a. Lame.
 - b. Phony.
 - c. Phobic.
 - d. Impasse.
 34. (613) In strategic family therapy, what is defined as communication that is intentionally misleading, misunderstood, and inconsistent and often leaves the receiver with an impossible conclusion to an answer?
 - a. Disqualification.
 - b. Disconfirmation.
 - c. Congruent communication.
 - d. Incongruent communication.
 35. (613) In strategic family therapy, what is defined as denying or invalidating hurtful or demeaning statements to protect the sender's self-image?
 - a. Disqualification.
 - b. Disconfirmation.
 - c. Congruent communication.
 - d. Incongruent communication.
 36. (613) In what stage of behavior therapy is the patient encouraged to take control of his or her internal anxiety-provoking physiological responses?
 - a. Relaxation training.
 - b. Desensitization proper.
 - c. Hierarchy construction.
 - d. Graded participant model.
 37. (613) In what stage of behavior therapy is the patient walked through the *least* anxiety-provoking events to gradually increasing levels of events through imagery?
 - a. Relaxation training.
 - b. Desensitization proper.
 - c. Hierarchy construction.
 - d. Graded participant model.
 38. (614) What group permits patients to join and finish at different times?
 - a. Open-ended.
 - b. Close-ended.
 - c. Psychotherapeutic.
 - d. Psychoeducational.

39. (614) How many group participants can one facilitator *effectively* manage?
- a. 6 to 8.
 - b. 8 to 10.
 - c. 10 to 12.
 - d. 12 to 14.
40. (615) Which group usually is structured in nature and time-limited for a specific number of sessions, and typically has a closed membership?
- a. Psychotherapeutic.
 - b. Educational.
 - c. Support.
 - d. Social.
41. (615) What is always considered a *primary* concern when you discuss group participation?
- a. Confidentiality.
 - b. Apprehension.
 - c. Anxiety.
 - d. Dread.
42. (616) During which stage of the group process should you establish the basic ground rules for participation in group?
- a. Conflict and controversy.
 - b. Initiation.
 - c. Termination.
 - d. Beginning.
43. (616) During which stage of group has the “birthing” process of merging personalities subsided?
- a. Conflict and controversy.
 - b. Working and cohesion.
 - c. Termination.
 - d. Initiation.
44. (616) During which stage of group will dependencies between group members and the facilitator emerge or group members will attempt to introduce new “bombshell” material?
- a. Conflict and controversy.
 - b. Working and cohesion.
 - c. Termination.
 - d. Initiation.
45. (617) Regarding group participation, which term would be used to describe the extremely shy patient?
- a. Contraindication.
 - b. Termination.
 - c. Relapse.
 - d. Benefit.
46. (618) What common problems tend to occur the longer group continues?
- a. Removing members from group.
 - b. Adding members to group.
 - c. Absenteeism.
 - d. Drop-outs.

47. (618) Conflict can be beneficial if used as a tool in group if it is used to do all of the following *except*
- a. promote self-esteem.
 - b. encourage a patient to be more self-sufficient.
 - c. encourage a patient to use conflict resolution techniques.
 - d. polarize group members.
48. (619) The group member who can easily become the target of an aggressive narcissist in the group is the
- a. monopolist.
 - b. silent patient.
 - c. schizoid patient.
 - d. passive-aggressive patient.

Student Notes

Unit 3. Case Management, ADAPT, and Population Health

3–1. Case Management	3–1
620. Identify and plan community resources	3–1
621. Identify base-level community resources	3–6
3–2. Alcohol and Drug Abuse Prevention and Treatment Program.....	3–9
622. Identify key aspects of the treatment team	3–9
623. Evaluation of civilian employees.....	3–10
624. Substance counselor certification process	3–11
625. Clinical supervision	3–14
3–3. Air Force Population Health	3–16
626. Key aspect identification of population health, health care optimization, and behavioral health optimization	3–16

CASE management uses all of the treatment planning needs you have already identified and places them under one “umbrella.” Each patient will not need every resource listed below, but knowing how and when to access each will prove beneficial.

3–1. Case Management

As we discussed in an earlier volume, you must know your limitations as a mental health journeyman. Your desire to help others will sometimes place you in situations for which you are not qualified to perform. Knowing when to recognize this will not only attest to your maturity to acknowledge your limitations but will also benefit the patient as he or she will acquire confidence in your ability to point him or her in the right direction when needed. Case management reiterates your limitations and allows you to say, “I’m not the expert in financial management, but I know who is.” Your ability to network and establish rapport with each of your potential resources will make your job much easier and the patient’s treatment appear seamless as he or she navigates through treatment.

620. Identify and plan community resources

Case management seeks to identify and coordinate all available community multidisciplinary activities. Due to your unique role as a technician working in the Mental Health Clinic, family advocacy, or alcohol and drug abuse prevention and treatment (ADAPT) program as a certified Alcohol and Drug Abuse Counselor (CADAC), you have the “know-how” to gain access to many resources your patient might not otherwise be aware of or be afforded the opportunity to initiate. Your effort is a piece of a much larger puzzle and requires all available support systems working together to compliment the patient’s treatment.

Staffing a case

“Staffing a case,” as it is referred to universally in the treatment world, involves you presenting the patient to the provider in a logical, smooth flow of information. This lesson will identify key areas you will need to address as you present your case.

Do’s of presenting a case

Staffing the case is meant to allow you to briefly identify key aspects of why the patient is at your clinic. Generally, you will staff the case immediately following your intake interview with the provider on call (clinics may designate a provider or it may be the first available provider). You should present this in a structured manner that flows logically with minimal repetition and overlap. Much emphasis was placed on covering a broad range of information during the intake interview; all of the information will not be relevant for the provider when you are staffing a case. Remember, you

will be documenting your interview, and the provider will have ample occasion to peruse your documentation at that time.

Your presentation is meant to be a summary. Many new journeymen will want to cover every aspect of the interview and inadequately present irrelevant information as it pertains to the patient's clinic visit. The summary is intended to briefly introduce the patient and highlight the main clinical features. For example, "Technical Sergeant Gary Jones is a 30-year-old, married male, assigned to the 1st Medical Operations Squadron, who presents with depressive symptoms related to marital discord." You would then continue describing what kind of neuro-vegetative symptoms are associated with TSgt Jones's depressive symptoms. You would also identify specifically what aspects of his marriage are causing him concern.

You will want to provide a brief overview of the Subjective/Objective Assessment Plan (SOAP) format as it relates to the patient's presenting problem. The subjective area is briefly shown in the previous example of TSgt Jones. The objective, assessment, and plan should be presented with the same brevity, but be careful to not exclude relevant information. Always comment on suicidal or homicidal ideation despite how irrelevant you may feel it is to the presenting problem.

The provider may ask for clarification or inquire about an area you have briefed during your staffing. This is common and should be expected. The provider is merely attempting to complete a picture of what the patient's presenting problems are currently.

Don'ts of presenting a case

Some of you may recall a police sitcom a good number of years ago that repeatedly used the mantra "just the facts, ma'am." This is true when staffing the case as well. Sometimes, new technicians and, for that matter, veteran technicians will adopt an unfortunate approach of editorializing while staffing a case. Editorializing will distract from the patient's presenting problem, and the provider may disagree with your comments upon seeing the patient. This will result in a loss of confidence in your abilities. Stick with the facts and present them as such.

Don't align yourself with a patient by promising to keep secrets. If a patient has revealed a criminal act, threatened suicide or homicide, participated in or revealed any form of family maltreatment, it must be reported. You can be held legally responsible for failing to report the aforementioned items.

Do not lie to the provider! If you failed to ask the patient whether he or she was experiencing suicidal or homicidal ideation, tell the provider you didn't ask. Don't deny the patient has any suicidal or homicidal ideation when, in fact, you never asked.

Don't embellish or minimize the patient's problems. This goes back to editorializing, but don't make the patient's problems appear much larger or dismiss his or her problems as whining. This is not for you to decide. If the patient feels it is a problem, it's a problem.

Consultation and referral services

Rarely does a client enter the Mental Health Clinic with a clear cut answer to what issues they are dealing with at the moment. There are typically many issues the client is trying to resolve at any given time. While we have many resources at our disposal, the client may have a question about his or her financial situation, a medical issue, or education questions. At that point, you might have to tell the patient, "Let me find out what I can about that topic and get back with you." The issue may be so complicated it would be more appropriate for the client to go directly to the source and talk to the advisor themselves. These are both examples of consultation and referral.

Definition

According to the 12 Core Functions of a substance abuse counselor, consultation and referral are very similar but have distinctly different goals. We will discuss all of the 12 core functions later in this unit, but for now we will discuss only two:

1. Consultation – Relating with in-house staff or outside professionals to assure comprehensive, quality care for the client.
2. Referral – Identifying the needs of the client that cannot be met by the counselor or agency and assisting the client to use the support systems and community resources available.

Again, consultation is the counselor going out and getting information the client needs and bringing it back to the client. Referral is the counselor assisting the client in getting the information for them. Using these definitions, if a client wanted to find out where the local Alcoholics Anonymous (AA) meetings were, we might use consultation or referral to help them. In consultation, I might go out and find a list of meetings and bring it back to the client. Through referral, I might assist the client by giving them the phone number to the local AA chapter and let the client get the information on their own.

Explain rationale for consultation/referral

Often, patients may voice concern or discomfort in being referred to another agency or person. For that matter, they are uncomfortable when you inform them that you must staff their visit with a provider. If you tell the patients of the procedures up front, it will help clear up any misunderstandings or suspicion they may have later.

Many patients feel they have shared their problems with you and they don't want others to know or become involved. Making the patient aware of your limitations of expertise in the clinic and that the referral is simply to help him or her receive better care will often put the patient at ease.

A large part of developing rapport with a client is open communication and trust. You don't have to sit back and pretend like you as the technician are the expert on every topic. It is very easy to let the client know that you are interested in getting them every answer and access to every resource you can. To do this, you are going to have to seek information out or send them to another person who is an expert in the area they need assistance in. Surely you wouldn't tell a client the solution to his or her dental care if he or she said his or her hurt tooth was creating a lot of stress because he or she is constantly distracted. You would obviously need to consult/refer this client to another expert.

Finally, you should let the client know you will let the consultation/referral agency know as much or as little about his or her particular case and, especially in the case of consultation, make it as anonymous as possible.

Identify and match consultation/referral needs

After you have identified the issue and explained to the client your need to consult with someone else or refer them to another professional, you should match the correct issue with the right solution. You wouldn't send someone with medical issues to finance, and you wouldn't send someone who wanted to find out his or her educational options related to a bachelor's degree over to the gym.

Consultation and referral sources

A client does not know all of the available resources that he or she can use; if he or she knew the resources, he or she probably wouldn't need to be coming to mental health. Since we are one of the many helping agencies in the local community, it will be up to us to know what the most appropriate sources are for our clients. The activities that form the core components of case management are:

- Mental health treatment.
- Substance abuse treatment.
- Crisis response services.
- Health care.
- Financial support and entitlements.
- Peer support.

- Family Advocacy Program (FAP).
- Family support.
- Organizational support.
- Spiritual/religious support.

Mental health treatment

Ongoing mental health for patients requiring it should be an easily managed event. Ongoing outpatient care can be arranged via the base Mental Health Clinic. The dually diagnosed patient who is referred from ADAPT can also be coordinated within the same work section typically. It may be necessary to provide a Standard Form (SF) 513, Medical Record–Consultation Sheet, or like referral material to the provider.

Military dependents or retirees may not have the option of participating in on-base mental health treatment. In this case, your familiarity with local resources will be required. Knowing your personal limits regarding your knowledge of rules involving insurance coverage and third-party liability is equally important. If you don't know, ask. Do not promise patients coverage or payment for services when you are not sure. Always consult your local Beneficiary Services Office/Tricare if you have questions or your patient has questions you cannot answer.

Substance abuse treatment

The mental health patient who requires substance abuse education or treatment should be referred to the ADAPT program. Again, mental health and ADAPT, in the military setting, work in tandem with each other. Familiarize yourself with referral procedures from the Mental Health Clinic to ADAPT personnel. A referral may necessitate an SF 513 or like referral material. Knowing the referral process and familiarizing yourself with Air Force Instruction (AFI) 44-121, *Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program*, will also assist you when medical providers, commanders, first sergeants, or other referral agencies contact the Mental Health Clinic seeking to refer someone for an evaluation.

Crisis response services

Despite sometimes prolonged and intense mental health or substance abuse treatment, patients tend to have crises. Some providers, counselors, and technicians have gone to great lengths to be available to patients 27/7. I use the term 27/7 facetiously to point out that some journeymen must learn when to disengage from work and not attempt to put in more hours than are available in a given workday. This can and often does lead to burnout and is counterproductive in maintaining an empathetic approach or attitude.

The primary goal of managing a crisis is to ensure safety and quickly respond in assisting the patient to resume his or her previous level of adaptive functioning. Depending on the crisis, it may be manageable by a simple reassuring phone conversation, or it may be as life threatening as suicidal or homicidal ideation. What are your local procedures for crisis management? Are recruiters, maintenance personnel, security forces, and so forth at geographically separated units (GSU) informed of resources available in the civilian community? Commanders and first sergeants at GSUs should be provided information they can access anytime. All patients should be provided with resources available 24 hours a day that have a live person they can interact with rather than an answering machine. Periodically check the resources yourself at any given hour to ensure you are providing patients, commanders, and first sergeants with reliable information.

What are the procedures for admitting a patient? What are the unique differences with the admission of an active duty member versus a retiree or a civilian dependent? Familiarize yourself with resources, contacts, and local procedures for admitting a patient. No, you will never personally admit the patient, but, as a 5-level 4C0, you may be asked by a newly assigned provider to assist with the procedures he or she should follow. Many clinics maintain a continuity book for this very reason.

Health care

Severely diagnosed psychiatric patients, as well as patients with a substance abuse/dependence diagnosis, have much higher mortality rates than the general population. The patient's disregard for his or her physiological well-being, either from having limited mental faculties or from years of physical neglect due to substance abuse, can become a primary treatment issue depending upon the diagnosis. Familiarize yourself with the resources you have available at your facility.

We, in the military, have the luxury of many medical treatment options available. Knowing where to begin, how to make the referral, and how to guide the patient will be challenging. Some patients may be resistive or need care they do not feel they need. Referring a patient to a dietician or to the Health and Wellness Center (HAWC) may seem unnecessary. You, having experience and knowledge of the ravages and physical toll substance abuse or dependence can exact, are pursuing a more productive and healthier lifestyle for your patient. Another way of looking at it is you are looking at the patient's overall health, but the patient may only be concerned with his or her immediate needs. The patient may resent or resist any help you may offer that he or she perceives isn't needed to resolve his or her immediate need.

Financial support and entitlements

Patients with financial problems present themselves in all spheres of the mental health/substance abuse world. The patient's reasons for financial difficulty may range from gambling or drinking away his or her income, to a tragic story of multiple, unexpected financial blunders. In either case, knowing where the patient can begin to get help can create a domino effect in a positive manner for other problems the patient may be experiencing. Many options are available on most bases, ranging from the Personal Financial Management Program (PFMP) to Air Force Aid (AFA), along with many others. Find out what the Airman and Family Readiness Center (AFRC) offers for financial assistance or budgeting. Is there a retiree support office on base?

Entitlements are constantly changing, and you may be more confused than your patient in this area. You aren't expected to know the answers to every nuance of a patient's entitlements, but you should know the resource where he or she can obtain the information.

Peer support

The greatest influence besides our family, and sometimes more so, is peers. For those of you who are single, have been deployed, or served a remote, you quickly learn your peers are very much your temporary family. Find out which of the patient's peers are willing to support the patient in a meaningful, positive manner; however, this may not always be possible. If the patient is an alcoholic, all of his or her peers may be abusing substances as well. Attempt to connect the patient with activities or organizations that will promote positive peer interaction and mentoring.

Family Advocacy Program

The number of family maltreatment cases involving alcohol is disproportionately tilted towards the substance abuser. The FAP provides an array of services for the military family. Prevention is the focus of family advocacy, with assessment and treatment services available if a maltreatment incident has already occurred. Familiarize yourself with the services offered by the FAP and ensure you use this resource when appropriate.

Family support

The patient's family should have been engaged long before case management or discharge planning has begun. Like peers, the patient's family can be extremely supportive and an excellent source of ongoing daily encouragement. The family is often an excellent resource as it relates to psychiatric follow-up. Everyone in the family is anxious for his or her loved one to return to a previous level of functioning and is usually willing to assist. However, this cannot be said for the substance abuse or dependence patient. The patient's family may be leery of the patient's sincerity and commitment to sobriety. Many "bridges" may have been burned in the past, and the reception from the patient's

family may be tepid at best. The other aspect to keep in mind as you prepare your patient to return home is he or she may be returning to a substance-abusing spouse or partner. This is the least ideal situation and will not offer much sanctuary for the recovering substance abuser or dependent.

Organizational support

The stigma the patient may feel, often associated with seeking help for mental health or substance abuse issues, can be exacerbated by disinterested leadership. Case management and discharge planning with the patient's commander and supervisors should begin long before you have met the patient. Psychiatric admissions or outpatient care can often breed suspicion or labeling from the patient's commander, who is often uncomfortable with these issues. Patients who self-refer or are command-directed to participate in ADAPT will need the support of their commander and supervisor.

Educating, networking, and remaining engaged with the command structure will solicit not only confidence in you and what you are doing, but also organizational support for your patient.

Spiritual/religious support

This is another venue that you should have made contact with prior to case management or discharge planning. This resource may be considered an optional resource based upon the patient's beliefs. For the substance abuser, the belief in a higher power is not only therapeutic, but essential to treatment. This said, it doesn't necessarily mean the belief in a god of some nature. With few exceptions, the employment of religion should be initiated or suggested by the patient. Don't assume a patient "needs" religion or "salvation!" Spiritual or religious leaders can provide vital support to the psychiatric or substance abuse patient, when appropriate.

621. Identify base-level community resources

The "town hall" meetings many of which your base commanders conduct, as well as a variety of other venues for voicing concerns, are addressed and articulated for resolution in the Community Action Information Board (CAIB) and the Integrated Delivery System (IDS). If resolution cannot occur at the base level, it is forwarded to the major command (MAJCOM) and on up the "chain" for possible resolution. These efforts are reflected by numerous base agencies coming together and voicing concerns they or their patients have articulated.

There will be times when patients, or even you, discover support resources are not available when a need exists in the Air Force community. The issue could be an appropriate matter for the base CAIB to address, particularly if by resolving the issue, it would enhance readiness. Review the following lesson to learn the role of both the CAIB and IDS.

Community Action Information Board

The role of the CAIB is outlined in AFI 90-501, *Community Action Information Board and Integrated Delivery System*. This cross-functional group may be a venue to address resource availability, or lack thereof, in the community. The CAIB was created to identify, resolve, or elevate those installation or community issues that impact readiness or affect quality of life for Air Force members or their families. The emphasis will be on positive actions and programs that strengthen force readiness through a sense of community and assist AF members and civilians, their families, and communities to thrive and successfully manage the demands of military life.

Effective functioning of the CAIBs at all levels will require grassroots input on the issues affecting individuals, families, installations, and communities. Effective CAIBs will function as a forum to give the total AF community an opportunity to have their concerns addressed in a cross-functional setting.

Every installation has a CAIB, chaired by the installation commander, and its membership composition is:

- Support group commander.

- Medical group commander.
- Operations group commander.
- Maintenance group commander.
- Staff judge advocate.
- Senior chaplain.
- Civil engineering commander.
- Public affairs officer.
- Services squadron commander.
- Mission support squadron commander.
- Comptroller squadron commander.
- Security forces squadron commander.
- Air Reserve component commanders.
- Command chief master sergeant.

Other community members, such as commanders of major tenant units, school personnel, spouses, and teens, may be invited to participate, when appropriate.

The board meets quarterly and is focused on bridging any gaps in services. The board is a forum that can be addressed by individuals, families, or communities.

At all levels, the CAIB will take a strategic, cross-functional look at quality of life, personal readiness, and community issues to formulate long-term solutions. The CAIB approach to community problem solving will take a broad perspective to integrate and synergize efforts to address community concerns.

At the installation level, the role of the CAIB will be to:

- Use a variety of approaches (focus groups, surveys, town meetings, interviews, etc.) to identify individual, family, installation, and community concerns.
- Develop and implement cross-organizational solutions to problems that cannot be resolved by individual CAIB organizations. Promote collaboration among helping agencies, identify gaps in service, and reduce duplication of effort.
- Forward issues and concerns that cannot be resolved at the installation level or have broader AF-wide implications to the MAJCOM CAIB.
- Review the results of AF community needs assessments and other quality of life surveys and determine implications for the installation and necessary follow-up actions.
- Approve an installation Community Action Plan every two years to guide the CAIB's activities and to establish priorities for the organizations participating on the CAIB.

Issues addressed at the CAIB requiring research or feasibility of implementation are forwarded to the IDS.

Integrated Delivery System

As a journeyman, you likely may be called upon in some capacity to participate in the base IDS. Like the CAIB, the IDS is guided by AFI 90-501. Specific IDS membership is:

- Family member program flight chief.
- Family advocacy outreach manager.
- Sexual assault prevention and response coordinator.
- Mental health officer.

- Health promotion manager.
- Airman and family readiness flight chief.
- Wing chaplain.
- Air Reserve component representatives.

Other organizations, such as the staff judge advocate, wing financial analysis officer, and civil engineering; individuals from private organizations, such as enlisted councils, spouses groups, and teen groups; and others may be invited to participate when an issue of concern to their specific group is under discussion.

The IDS meets monthly and seeks implementation of recommendations from the CAIB. The IDS also provides recommendations and solutions for problems to the CAIB.

At all levels, the IDS will function as the action arm of the CAIB and will develop a comprehensive, coordinated plan for integrating and implementing community outreach and prevention programs (e.g., financial management; violence awareness, intervention, and prevention; sexual assault prevention; suicide prevention; substance abuse prevention; domestic violence prevention; health promotion; tobacco cessation, etc.). The IDS will improve the delivery of human service programs by establishing a seamless system of services through collaborative partnerships and coordinated activities.

Responsibility for chairing and convening the installation of the IDS shall rotate among the member organizations with each serving a two-year term. The chair will be appointed by the installation commander and will designate an office to serve as the office of record. The IDS chair and CAIB executive director will not be from the same organization.

Some of the more well-known functions of the IDS include monitoring basewide suicide statistics; developing and providing suicide prevention programs; and implementing and marketing base-wide outreach and prevention programs. The IDS is also responsible for conducting the biennial community needs assessment.

Coordinating multidisciplinary activities

It might be up to you, as the mental health journeyman, to help coordinate multidisciplinary activities. Getting as many minds together from different disciplines within the mental health, medical, and base community can be vital to seeing a “big picture” and giving a client the best advice/resources to achieve success for their particular situation. Again, we in the clinic will have access to all of the potential resources for a client. If the client knew about all the resources available to them, they might not take the time to come see us and go directly to the source.

It is beneficial to have all members of the mental health team (psychiatry, psychology, social work, nursing, and technicians) meet to discuss different cases. This will be discussed further in another objective, but the ability to have everyone meet and discuss different cases helps provide both quality clinical care and a great training experience for all involved. The same benefits are met when other medical disciplines are involved. Finally, getting different members of the base team together (CAIB, IDS, etc) will give an even larger perspective of options available.

Once you have all of the options available for your client, then you have a good foundation for discussing consultation or referral for your client.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

620. Identify and plan community resources

1. What is the purpose of the summary you provide to the clinician after your interview?

2. What must you always comment on in the summary to the provider?
3. Give the definitions for consultation and referral.
4. What is the primary goal of managing a crisis?
5. What is the focus of the Family Advocacy Program?

621. Identify base-level community resources

1. How often does the CAIB meet?
2. What does the IDS seek from the CAIB?

3-2. Alcohol and Drug Abuse Prevention and Treatment Program

As you learned in the apprentice course, you will have the opportunity to participate in many facets of the ADAPT Program. Knowing the lingo and what purpose some of these aspects of ADAPT serve will be identified in this area.

622. Identify key aspects of the treatment team

When an individual is referred to ADAPT for a substance-use-related incident, or a substance is suspected to have been involved as the reason for referral, an assessment is conducted. Following the assessment, the CADAC or provider will formulate a recommendation to present to the treatment team (TT) regarding a disposition for the member. This can range from no intervention in a case where alcohol was clearly not a factor in the referral, to inpatient treatment for a patient who has severe substance-related needs.

The composition of the TT is specific, and its membership is intended to have all of those individuals who can make key decisions related to the member's treatment in place. The ADAPT Program manager (ADAPTPM) chairs the TT and determines the clinical course of treatment for patients in the ADAPT Program. The membership of the TT includes:

- Patient's commander and/or first sergeant.
- Patient's immediate supervisor.
- ADAPTPM (or a privileged provider with oversight of the ADAPT Program).
- CADAC (or provider).
- Medical consultant(s), as needed.
- Any therapist concurrently involved in the care of the individual.
- Other individuals deemed necessary by the ADAPTPM.

- A flight surgeon, if the patient is on flight status.

Commander, first sergeant, and supervisor involvement in the TT process is vitally important. The commander must concur with treatment recommendations by the ADAPTPM. The first sergeant and supervisor support is vitally important in the successful implementation of the treatment plan. Specifically; commanders, first sergeants, and supervisors must be involved in the TT during program entry and termination, and anytime there are significant treatment difficulties with the patient. A few examples of this could include the patient refusing to participate or a relapse or subsequent incident. The commander must be briefed on the patient's status at least quarterly by ADAPT personnel.

The specificities of treatment plans were discussed earlier in the CDCs. The primary purpose of the treatment plan in substance abuse is to establish the framework for the patient's treatment and recovery. The ADAPTPM, after consulting with the TT, makes a treatment decision within 15 duty days of the referral to the ADAPT office. Reasons for any delay must be documented in the outpatient record (OPR) and in the mental health record. The commander must also be notified of the delay and the reasons why.

Following the TT, you must ensure the events and decisions discussed are documented. Remember, if it isn't documented, it didn't happen. You should document extensively in the mental health record, and simply document the occurrence and the outcome of the TT in the OPR.

623. Evaluation of civilian employees

Conducting a substance abuse evaluation of a civilian employee is a different process than with a military person. You should be familiar with the procedures involved in conducting such an evaluation. When we refer to civilian employees, keep in mind we are referring to civilian employees employed under the civil service program, which does not include contractors or nonappropriated fund (NAF) employees.

Referring a civilian employee for a substance abuse evaluation entails very specific instructions with which you should become familiar prior to directing instructions for supervisors to follow. AFI 36-810, *Substance Abuse Prevention and Control*, provides specific guidelines for referring civilian employees.

The civilian employee can receive a one-time evaluation free of charge. Follow-up that may be required must be done using resources available in the community. The civilian employee must understand the information gathered during the assessment cannot be provided to his or her supervisor unless the civilian employee signs a consent form authorizing this communication. Whether the employee was referred by his or her supervisor, or self-referred, any crime or criminal conduct the employee reports (excluding personal drug use or addiction) must be reported to the proper authorities.

If the civilian employee diagnostically meets the criteria for substance abuse or dependence, and requires additional treatment, the ADAPT clinic personnel will advise the employee of the findings. The ADAPT clinic will also inform the employee of the nature of health problems associated with substance abuse and the availability of assistance with community resources. Providing this information allows the employee to make an informed decision about how to deal with the problem.

Civilian employees are highly encouraged to sign a consent form allowing the ADAPT staff to speak with the employees' supervisors. The benefits of signing the release include:

- Enabling the supervisor to better consider a request for the use of leave for future counseling or treatment sessions.
- Making rehabilitation more effective by involving the supervisor in the problem-solving process.
- Telling the supervisor the employee is trying to correct the problem. The supervisor needs to know this if other corrective action is under consideration.

- Helping destigmatize the problem, which helps toward dealing with the problem as an illness.

The ADAPT staff must tell the employee the consequences of not signing a consent form. Consent forms used by civilian employees must conform with the requirements outlined in Public Law 93-282, *Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act*, part 2, subsection 2-11 (k), as directed by the Secretary of Health and Human Services. The consequences for not signing a consent form are:

- The signed statement is the only way for the employee to authorize the counselor to communicate with the supervisor or any other relevant individual.
- Unless the supervisor knows the employee is getting help, the supervisor must proceed with corrective action.
- If the employee entered the program after his or her on-base driving privileges were revoked or suspended under the alcohol and drug countermeasures program of AFI 31-204, *Air Force Motor Vehicle Traffic Supervision*, those privileges are not reinstated until the ADAPT clinic (or rehabilitation committee) determines the employee is sufficiently rehabilitated and is no longer a driving safety risk. If the employee refuses to sign a release, ADAPT has no way of communicating with the security forces. Therefore, the employee will not be allowed to drive on base.

Some civilian personnel are in sensitive positions, which do not afford them the confidentiality other civilian employees enjoy. Those exceptions are:

- Any position that requires bearing and using a firearm as a deadly force as authorized under AFI 31-207, *Arming and Use of Force by Air Force Personnel*, or Air Force Policy Directive (AFPD) 71-1, *Criminal Investigations and Counterintelligence*.
- Any position that involves responsibility for developing or approving war plans, major or special war operations, or critical and extremely important items of war; or requiring access to sensitive compartmented information.
- Any position requiring access to classified information or material as prescribed in AFI 31-401, *Information Security Program Management*.
- Any position that involves control of, access to, or authorization to grant access to nuclear weapons or weapon systems, when the performance of duties could result in an unauthorized launch, detonation, or release of an operational nuclear weapon.
- Any position that requires regular or frequent contact with the President of the United States, or access to presidential facilities, transportation, or operational and administrative support of activities as prescribed in appropriate directives.

You should peruse AFI 36-810 and the references identified above for specific guidance and to gain a better understanding of this program.

624. Substance counselor certification process

This process can be intimidating if you are unprepared. Your familiarity with the process will help eliminate this unnecessary worry. Your role in the certification process likely will be that of the certification applicant since you will be accumulating the necessary hours of internship during this time. If you are completing this 5-level CDC for the first time, you most likely do not have the amount of clinical time under your belt to become certified, but you probably know about the certification process and are actively pursuing certification.

History

In March of 1985, the Department of Defense (DOD) gave the AF and other services two years to establish standardized criteria for selection and certification of personnel who serve in clinical roles as alcohol and drug abuse counselors.

It was decided that licensed medical personnel are not required to be certified; however, they are required to receive additional training in chemical dependency. In 1988, the AF joined the International Certification Reciprocity Consortium/Alcohol and Other Drugs of Abuse (ICRC/AODA) to conform to the DOD directive.

Why Certification?

Reasons to require certification include:

- Set proficiency standards
 - What must I be proficient at to get certified?
- Ensure continual learning/education
 - 60 hours of continuing education units (CEU) every three years
- Establish credibility
- Enforce professional/ethical standards

Proficiency standards

The profession of substance abuse counseling is a relatively new career and has changed to accommodate its growth and maturity. Measurements were developed to ensure that new alcohol and drug abuse counselors were qualified to perform their jobs. Proficiency is not assumed because an individual completes a training program. Certification is task oriented.

Continual learning/education

Competence in a rapidly changing and highly complex field demands constant upgrading of skills and knowledge. To maintain certification, counselors must attend intermittent education programs. Sixty CEUs are required to retain certification during each three-year certification.

After obtaining the certification, the member is awarded six CCAF credit hours as follows:

- Three semester hours in “Overview of Addiction Counseling.”
- Three semester hours in “Application of Addiction Counseling.”

These hours may be used toward a mental health services associate degree program and credit for civilian college degree programs is also possible.

Establishes credibility

Commanders expect and deserve well-trained people in all positions. The professional standards used in the military to measure competency are often identical to the standards used in the civilian community. Commanders and clients have more confidence in someone who is well-trained and has met stringent criteria as specified by a professional organization. Having your certification gives you the “letters” behind your name to give you more authority when you are telling a commander that their troop has a diagnosis. Instead of automatically looking over at your ADAPTPM, they will understand you have gone through a thorough process of obtaining your certification.

Enforces professional/ethical standards

When groups of people come together to form an organization, ethics soon become a focus. A code of ethics protects clients and serves as a behavioral guide to counselors. The Air Force has a formalized code of ethics for the CADAC. This code of ethics protects both the client and the counselor.

Certification prerequisites

The applicant must attend six hours of ethics training and sign a code of ethics statement. He or she must complete a minimum of 270 hours of formal classroom education (i.e. 3-level *Mental Health Service Apprentice* course). The applicants must have supervised practical training—a minimum of

300 hours of documented supervised practical training, by a certified counselor, with a minimum of 10 hours in each core function. For work experience the applicant must have three years internship (6,000 hours) with clients with a minimum one year working with alcohol/drug abuse clients. One year of experience can be waived if the applicant has a bachelor's degree in one of the following behavioral sciences: psychology, counseling, sociology, social work, or addiction studies. Additionally, the applicant must have the supervisor's recommendation to apply to the certification process.

Twelve core functions

The twelve core functions are considered to be the basic skill/knowledge areas that a counselor must be competent in to be considered a quality counselor. For certification purposes, they are talking about substance abuse specifically, but in reality a quality mental health technician should be competent in all of the 12 core functions as well.

1. **Screening:** The process by which a client is determined appropriate and eligible for admission to a particular program.
2. **Intake:** The administrative and initial procedures for admission to a program.
3. **Orientation:** Describe the following to the client: general nature and goals of the program, rules governing client conduct that may lead to disciplinary action or discharge from the program; for nonresidential program, the hours services are available, treatment cost, if any, and client rights.
4. **Assessment:** The procedures by which a counselor/program identifies and evaluates an individual's strengths, weaknesses, problems, and needs for the development of the treatment plan.
5. **Treatment Planning:** Process by which the counselor and the client identify and rank problems needing resolution; establish agreed-upon immediate and long-term goals; and decide on a treatment process and the resources to be utilized.
6. **Counseling:** The utilization of special skills to assist individuals, families, or groups in achieving objectives through explanation of a problem and its ramifications; examination of attitude and feelings; consideration of alternative solution; and decision making.
7. **Case Management:** Activities that bring services, agencies, resources or people together within a planned framework of action toward the achievement of established goals. It may involve liaison activities and collateral contacts.
8. **Crisis Intervention:** Those services which respond to an alcohol and/or other drug abuser's needs during acute emotional and/or physical distress.
9. **Client Education:** Provision of information to individuals and groups, concerning alcohol and other drug abuse and the available services and resources.
10. **Referral:** Identifying the needs of the client that cannot be met by the counselor or agency and assisting the client to use the support systems and community resources available.
11. **Reports and Record Keeping:** Charting the results of the assessment and treatment plan, writing reports, progress notes, discharge summaries, and other client-related data.
12. **Consultation:** Relating with in-house staff or outside professionals to assure comprehensive, quality care for the client.

Written exam

The written exam is aligned with the revised Technical Assistance Publication Series (TAP-21), *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* publication from the Substance Abuse and Mental Health Services Administration (SAMHSA) and is based on job-task analysis. The test includes 137 multiple choice questions, a two-page case history that must be read, and then 13 questions tied to that case which require higher levels of thinking

skills. On average testers take five to eight minutes to read the case history. Total test time allowed is 3.5 hours. Knowledge for the test will be attained through OJT and research. The 13 questions following the case history assess the analysis, synthesis, and evaluation skills of the test taker. The previously mentioned 12 core functions are addressed in seven of the eight practice domains identified in TAP-21, which include:

1. Clinical Evaluation.
2. Treatment Planning.
3. Referral.
4. Service Coordination.
5. Counseling.
6. Client, Family, and Community Education.
7. Documentation.
8. Professional and Ethical Responsibilities.

MAJCOMs notify applicants of final results upon receipt of official notification of the written exam results from ICRC. If awarded certification, the period of certification is three years. The applicant has 10 duty days upon receipt of the certification letter to file an appeal of the “no pass” decision. Applicants must request, in writing, to retake the test. The written request must be made within six months. Applicants will be allowed three attempts to pass.

625. Clinical supervision

The responsibilities your supervisor has are certainly broad. However, one thing that must be certain is the specific responsibilities you have as a 5-level. To understand why your supervisor seems to be evaluating you and ensuring your six-part folder is current all the time, we will briefly cover some of the areas of supervision of clinical activities and what you may expect to inherit, as you become a supervisor. This lesson will provide an overview of these topics. You should educate yourself as well.

Job description

What exactly is your job description? Understanding what your job description greatly impacts the quality of work or product on which you will be evaluated. If you don’t understand the purpose and use, then the final product (your hard work) is not going to meet a specific standard.

Establishing performance standards

All of us at one time or another have had a troop that we felt did not “make the grade” or “failed to meet standards.” How exactly do you know that they do not meet standards? Simply saying you have a “gut feeling” that the troop isn’t cutting it isn’t an acceptable response. You must be able to demonstrate not only to the troop, but also to your supervisor, where exactly the standards are not being met.

CADAC scope of practice/supervision

AFI 44-119, *Medical Quality Operations*, specifically outlines not only the education and certification requirements for the CADAC, but also the required supervision.

With the exception of the initial assessment, development or changing of a treatment plan, and crisis intervention, the core functions may be performed, independent of supervision as judged by the ADAPT program manager. “Independent of supervision” simply means the client doesn’t need to have an “eyes-on” contact by the licensed provider in the instances listed above.

Supervision for CADACs must involve some direct observation and a review of all patient charts. The ADAPT Program manager is ultimately responsible for the clinical practice of all CADACs. IAW AFI 44-119, the ADAPT Program manager is responsible for maintaining all the CADAC’s

training records and competency assessments. To ensure ongoing training and competency, the ADAPT Program manager, or designee, must observe the CADAC providing individual or group treatment/counseling at least 2 hours monthly. The competency assessment must be performed two times per month and will be documented in the CADAC's training record.

Noncertified 4C0's who are in training may conduct the 12 core functions but only under the supervision of a CADAC or credentialed provider. This requires an "eyes-on" approach throughout the entire client contact.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

622. Identify key aspects of the treatment team

1. What is the primary purpose of the treatment plan?
2. Where do you document the treatment team meeting?

623. Evaluation of civilian employees

1. How many times can a civilian employee be seen in the clinic for an evaluation free of charge?
2. What are four benefits of having a civilian employee sign a consent form?
3. What are three consequences for the civilian employee if he or she does not sign a consent form?

624. Substance counselor certification process

1. In what year did the DOD give the AF and other services two years to establish standardized criteria for selection and certification of personnel who serve in clinical roles as alcohol and drug abuse counselors?
2. What organization did the AF join with to conform with the DOD directive?
3. How many hours of ethics training must be completed as a prerequisite towards certification?
4. The 13 questions on the written certification exam cover which eight practice domains?

625. Clinical supervision

1. What does AFI 44-119, *Medical Quality Operations*, outline for the CADAC?
2. Who is ultimately responsible for the clinical practice of all CADACs?

3-3. Air Force Population Health

As we are making substantial advances in abilities, technology, and delivery of healthcare, we must remain conscious of the cost of health care. In the early 1990s, the Air Force was not efficiently using its resources when it came to health care. In all cases, excellent care was being given, but more emphasis needed to be placed on prevention along with treatment of disease.

626. Key aspect identification of population health, health care optimization, and behavioral health optimization

To get a better handle on making health care more efficient and effective, we need to identify the key aspects in three areas of health care—population health, health care optimization, and behavioral health optimization.

Identify key aspects of population health

Prevention and disease management are tools to improve the overall health of the entire military beneficiary population and make excellent financial sense. It has been shown that for every dollar spent on childhood immunizations, the DOD saves approximately 16 dollars. Have you heard the saying “An ounce of prevention is better than a pound of cure?” It couldn’t be any truer today. And more importantly, think about the human factor involved. Have you ever suffered through an illness and then found out, if you had been immunized, taken the appropriate medication, or washed your hands, your chance for contracting that illness would have been greatly reduced? Would you do things differently if you had that knowledge? Would you want anyone you love to go through it if it could have been prevented? Childhood immunizations are just the tip of the iceberg. Our population is living longer, and we are demanding a better quality of life, in addition to longevity.

The Air Force has adopted the population health focus to meet the unique needs of our service. Population health concepts address three of the Air Force medical service’s (AFMS) greatest challenges:

1. Providing a healthy, fit, and ready force.
2. Improving the health status of our enrolled population.
3. Managing an effective and efficient health care delivery system.

The objectives of population health activities within the AFMS are to achieve measurable gains in the health status of our enrolled population and improve the efficiency and effectiveness of the delivery system while helping to build healthy communities in which to live, work, and play. An integrated, collaborative approach that incorporates population health concepts into everyday operations forms the basis for implementation and sustainment of the activities required to be successful.

To measure our success with the population health focus, the AFMS has established six critical success factors (CSF):

1. Describe the demographics, needs, and health status of the enrolled population.
2. Appropriately forecast and manage demand capacity.
3. Proactively deliver preventive services to the enrolled population.

4. Manage medical and disease conditions.
5. Continually evaluate improvement in the population's health status and the delivery system's effectiveness and efficiency.
6. Energize a total community approach to population health.

Identify key aspects of health care optimization

So how do we manage all of this? Step one is the creation of health care optimization (HCO). We can sum up HCO with the phrase "Deliver the RIGHT CARE...by the RIGHT PEOPLE...at the RIGHT TIME." HCO is the study and practice of using resources. In this case, we are referring to the use of the provider and the support staff to maximize the number of patients an individual provider can see, and take advantage of the population health principles of preventative services.

HCO helps the AFMS establish guidelines for use. Factors that are considered in the process are readiness skills of the provider and staff, available resources, and knowing the health of the population. Many of our providers support wartime critical services; thus, the more current they are with their training, the more efficient they become. Likewise, the support staff is driven to stay current with their skills. In the end, it benefits the patients with more efficient services and the potential for better clinical outcomes. The right allocation of resources (e.g., providers, nurses, technicians, and equipment) is necessary to adequately provide for the patients. If the providers are not properly supported, they will not be able to meet the needs of their patients. When the medical facility has a deep understanding of the patient population's total medical needs, it can accurately forecast the needed resources. Resources can also be shifted according to the need of the facility.

This balance of provider, support staff, and patients is handled differently according to the particular type of clinic and the services offered. Currently, HCO has developed a program for primary care and, in the near future, will be bringing online a program for specialty care and inpatient care.

Identify key aspects of behavioral health optimization

Up to this point, you may have been wondering where mental health fits into the scheme of population health and HCO. Although people don't think of mental health as frontline medicine for acute care, research has shown repeatedly that a patient's mental status plays a significant role in his or her overall health. Nearly half of all formal mental health care and 75 percent of all psychotropic drugs are provided by primary care managers. It's easy to see that primary care plays one of the most important roles in mental health. Additionally, many people with diagnosable mental illnesses will never seek help for their mental health, but they continue to see a primary care provider. It's crucial for the health status of the entire population that we capture this point of access to mental health.

Many health-related issues are connected to behavior. Thus, they fall into the realm of mental health. Smoking cessation, stress management, and weight loss are three critical areas, and that's just a start. Our biggest problem in marketing these services has been and continues to be convincing people to come to the Mental Health Clinic. People are afraid of the stigma attached to mental health and often refuse to seek out services based on the perception that they will be branded as "crazy."

The Behavioral Health Optimization Project (BHOP) seeks to address these issues, as well as provide an excellent resource to the medical provider in the clinic. The BHOP model strives to increase access to behavioral health by integrating behavioral health consultants (BHC) into the primary care clinic. The BHC is usually either a psychologist or a social worker. The role of the BHC is to provide consultative services to the primary care provider and assistance to the patient without any extensive specialty mental health care.

BHOP was begun as a pilot program in 1997 at Tinker AFB, Oklahoma, and it has slowly branched out from there. A study is being conducted to determine efficacy of this program, but early results are very positive for improvement in patients' overall health. In the future, we may see this program more comprehensively integrated into the primary care clinics. It is an exciting prospect that we will be able to intervene with a population of patients that in the past we would not have seen.

Self-Test Questions

After you complete these questions, you may check your answers at the end of the unit.

626. Key aspect identification of population health, health care optimization, and behavioral health optimization

1. What three concepts addressed by population health are considered the greatest challenge?
2. What are the six CSFs?
3. What is HCO?
4. HCO helps who establish guidelines for use?
5. What examples of health-related issues are connected to behavior?
6. What does the BHOP model strive to do?

Answers to Self-Test Questions

620

1. To briefly introduce the patient and highlight the main clinical features.
2. Suicidal or homicidal ideation despite how irrelevant you may feel it is to the presenting problem.
3. Consultation – Relating with in-house staff or outside professionals to assure comprehensive, quality care for the client. Referral – Identifying the needs of the client that cannot be met by the counselor or agency and assisting the client to use the support systems and community resources available.
4. To ensure safety and quickly respond in assisting the patient to resume his or her previous level of adaptive functioning.
5. Prevention.

621

1. Quarterly.
2. Implementation of recommendations.

622

1. Establish the framework for the patient's treatment and recovery.
2. Extensively in the mental health record, and document the occurrence and outcome in the outpatient record.

623

1. Once.

2. (1) It enables the supervisor to better consider a request for the use of leave for future counseling or treatment sessions.
 (2) It makes rehabilitation more effective by involving the supervisor in the problem-solving process.
 (3) It tells the supervisor that the employee is trying to correct the problem. The supervisor needs to know this if other corrective action is under consideration.
 (4) It helps destigmatize the problem and helps toward dealing with the problem as an illness.
3. (1) The signed statement is the only way for the employee to authorize the counselor to communicate with the supervisor or any other relevant individual.
 (2) Unless the supervisor knows that the employee is getting help, the supervisor must proceed with corrective action.
 (3) If the employee entered the program after his or her on-base driving privileges were revoked or suspended under the Alcohol and Drug Countermeasures Program of AFI 31-204, those privileges are not reinstated until the ADAPT clinic (or rehabilitation committee) determines the employee is sufficiently rehabilitated and is no longer a driving safety risk. If the employee refuses to sign a release, ADAPT has no way of communicating with the security forces. Therefore, the employee will not be allowed to drive on base.

624

1. 1985.
2. International Certification Reciprocity Consortium/Alcohol and Other Drugs of Abuse (ICRC/AODA).
3. Six.
4. (1) Clinical evaluation.
 (2) Treatment planning.
 (3) Referral.
 (4) Service coordination.
 (5) Counseling.
 (6) Client, family, and community education.
 (7) Documentation.
 (8) Professional and ethical responsibilities.

625

1. Not only the education and certification requirements for the CADAC, but also the required supervision.
2. ADAPT Program manager.

626

1. (1) Providing a healthy, fit, and ready force.
 (2) Improving the health status of our enrolled population.
 (3) Managing an effective and efficient health care delivery system.
2. (1) Describe the demographics, needs, and health status of the enrolled population.
 (2) Appropriately forecast and manage demand capacity.
 (3) Proactively deliver preventive services to the enrolled population.
 (4) Manage medical and disease conditions.
 (5) Continually evaluate improvement in the population's health status and the delivery system's effectiveness and efficiency.
 (6) Energize a total community approach to population health.
3. The study and practice of using resources.
4. Air Force Medical Service.
5. Smoking cessation, stress management, and weight loss.
6. Increase access to behavioral health by integrating behavioral health consultants into the primary care clinic.

Unit Review Exercises

Note to Student: Consider all choices carefully, select the *best* answer to each question, and *circle* the corresponding letter. When you have completed all unit review exercises, transfer your answers to ECI (AFIADL) Form 34, Field Scoring Answer Sheet.

Do not return your answer sheet to AFIADL.

49. (620) When you present a case for staffing, in what format do you provide the overview?
- a. Bullet.
 - b. Narrative.
 - c. Subjective.
 - d. Subjective/Objective Assessment Plan (SOAP).
50. (620) What is *not* one of the core components of case management?
- a. Peer support.
 - b. Family support.
 - c. Recreational support.
 - d. Crisis response services.
51. (620) Who is the *greatest* influence in our lives besides family?
- a. Peers.
 - b. Clergy.
 - c. Supervisors.
 - d. Commanders.
52. (621) Who is responsible for conducting the biennial community needs assessment?
- a. Community Action Information Board (CAIB).
 - b. Integrated Delivery System (IDS).
 - c. Family Advocacy Program (FAP).
 - d. Airman and Family Readiness Center (AFRC).
53. (622) Who chairs the treatment team (TT) meetings?
- a. Alcohol and Drug Abuse Prevention and Treatment Program manager (ADAPTPM).
 - b. Certified Alcohol and Drug Abuse counselor (CADAC).
 - c. Patient's commander.
 - d. Flight surgeon.
54. (622) How many duty days does the Alcohol and Drug Abuse Prevention and Treatment Program manager (ADAPTPM) have to make a treatment decision for a new referral to the ADAPT office?
- a. 5.
 - b. 7.
 - c. 15.
 - d. 21.
55. (623) How many visits for evaluation are civilian employees authorized free of charge at the base substance abuse clinic?
- a. One.
 - b. Two.
 - c. Three.
 - d. Four.

-
-
56. (624) Which of the following agencies did the AF join forces with to conform to the DOD directive to establish standardized criteria for selection of personnel who serve in clinical roles as alcohol and drug abuse counselors?
- a. International Certification Reciprocity Consortium/Alcohol and Other Drugs of Abuse (ICRC/AODA)
 - b. Air Force Substance Abuse Counselor Certification Board (AF SACCB).
 - c. Alcohol and Drug Abuse Prevention and Treatment (ADAPT).
 - d. Air Force Medical Support Agency (AFMSA).
57. (624) How many continuing education units (CEU) are required to retain certification during each three-year certification?
- a. 30.
 - b. 40.
 - c. 45.
 - d. 60.
58. (624) Which of the 12 core functions is described as the administrative and initial procedures for admission to a program?
- a. Screening.
 - b. Intake.
 - c. Orientation.
 - d. Reports and record keeping.
59. (624) Which one of the 12 core functions is described as relating with in-house staff or outside professionals to assure comprehensive, quality care for the client?
- a. Referral.
 - b. Consultation.
 - c. Client education.
 - d. Case management.
60. (624) Who notifies the applicants of the results of the Certified Alcohol and Drug Abuse Counselor (CADAC) written examination?
- a. International Certification Reciprocity Consortium/Alcohol and Other Drugs of Abuse (ICRC/AODA)
 - b. Air Force Substance Abuse Counselor Certification Board (AF SACCB).
 - c. Base medical group commander.
 - d. Major command (MAJCOM).
61. (625) Understanding which of the following greatly impacts the quality of work or product which you will be evaluated by?
- a. Career field education and training plan (CFETP).
 - b. Job description.
 - c. Performance standards.
 - d. Qualification training packages (QTP).
62. (625) Which Air Force Instruction (AFI) specifically outlines *not* only the education and certification requirements for the certified alcohol and drug abuse counselor (CADAC), but also the required supervision?
- a. AFI 40-301, *Family Advocacy Program*.
 - b. AFI 44-119, *Medical Quality Operations*.
 - c. AFI 44-120, *Drug Abuse Testing Program*.
 - d. AFI 44-121, *Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program*.

63. (625) The certified alcohol and drug abuse counselor's (CADAC) competency assessment must be performed how many times per month and documented in their training record?
- a. 1.
 - b. 2.
 - c. 3.
 - d. 4.
64. (626) What is *not* one of the critical success factors?
- a. Appropriately forecast and manage demand capacity.
 - b. Energize a total community approach to population health.
 - c. Provide sufficient staffing to provide care for all beneficiaries.
 - d. Proactively deliver preventive services to the enrolled population.
65. (626) What percentage of *all* formal mental health care is provided by primary care managers?
- a. 10.
 - b. 25.
 - c. 50.
 - d. 75.

When you complete this course, please complete the student survey on the Internet at this URL:
<http://www.maxwell.af.mil/au/afiadl/>. Click on Student Info and choose 9502 Survey.

Glossary

Abbreviations and Acronyms

AA	Alcoholics Anonymous
ACOA	Adult Children of Alcoholics
ADAPT	Alcohol and Drug Abuse Prevention and Treatment
ADAPTPM	Alcohol and Drug Abuse Prevention and Treatment program manager
AF SACCB	Air Force Substance Abuse Counselor Certification Board
AFA	Air Force Aid
AFI	Air Force Instruction
AFMS	Air Force Medical Service
AFMSA	Air Force Medical Support Agency
AFPD	Air Force Policy Directive
AFRC	Airman and Family Readiness Center
BHC	behavioral health consultant
BHOP	Behavioral Health Optimization Project
BTZ	below-the-zone
BX	base exchange
CADAC	Certified Alcohol and Drug Abuse counselor
CAIB	Community Action Information Board
CCAF	Community College of the Air Force
CCT	client-centered therapy
CDC	career development course/child development center
CEU	continuing education unit
CISD	Critical Incident Stress Debriefing
CSF	critical success factor
DOD	Department of Defense
DWI	driving while intoxicated
EOD	explosive ordinance disposal
FAP	Family Advocacy Program
GA	Gamblers Anonymous
GSU	geographically separated unit
HALT	hungry, angry, lonely, and tired
HAWC	Health and Wellness Center
HCO	health care optimization

ICRC/AODA	International Certification Reciprocity Consortium/Alcoholism and Other Drugs of Abuse
IDS	Integrated Delivery System
IQ	intelligence quotient
LOR	letter of reprimand
MAJCOM	major command
MOPP	mission-oriented protective posture
NA	Narcotics Anonymous
NAF	nonappropriated funds
OCD	obsessive-compulsive disorder
OJT	on-the-job training
OPR	outpatient record
PCS	permanent change of station
PDG	Professional Development Guide
PFMP	Personal Financial Management Program
REBT	rational emotive behavior therapy
RET	rational emotive therapy
SAMHSA	Substance Abuse and Mental Health Services Administration
SF	standard form
SFT	strategic family therapy
SOAP	Subjective/Objective Assessment Plan
TA	transactional analysis
TDY	temporary duty
TT	treatment team
UCMJ	Uniform Code of Military Justice
WHO	World Health Organization

Student Notes

AFSC 4C051
4C051N 04 0906
Edit Code 03