Welcome to the Partnership!

"The Home-Based Family Therapy (HBFT) Partnership was launched by the Family Center at Kansas State University (KSU) and Social and Rehabilitative Services (SRS) of Kansas to promote best practices for home-based family therapy. Partnering is key to HBFT.

One level of partnership is between the Community Mental Health Center (CMHC) CBS directors, SRS, Kansas Health Solutions (KHS) and the KSU consultants. The second partnership pairs home-based family therapists with KSU trainers. The third and most critical partnership, between the individual therapist and the client family, is always at the heart of this effort.

The field is moving toward an evidence-based practice framework serving children and families where a member exhibits serious emotional disturbance (SED). Our goal is to help practitioners understand and apply evidence-based principles while inviting input for the development of future evidence-based protocols.

To address these issues and more, the HBFT Partnership offers opportunities through online learning, audio learning companions, core training, and videoconferences."

-HBFTPartnership.com

Our team has compiled all of the data, products, resources, and training materials to give you a glance at what we have accomplished over the course of this contract. This binder includes a look at articles and newsletters, trainings we have hosted, as well as our marketing strategies and some ideas for what we see in the future that best fits the needs of our audience, the HBFT practioner.

Each section begins with an excerpt from our website homepage, *www.HBFTPartnership.com*, which gives a brief introduction to the material to follow. We invite you to take a glance at how far the HBFT Partnership has come and look with us to the future for new developments.

Sincerely,

2012-2013 HBFT Partnership Staff
Nancy O'Conner
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Home-Based Family Therapy Partnership

HOME-BASED FAMILY THERAPY PARTNERSHIP
Purpose of HBFT Partnership

The HBFT Partnership provides multiple opportunities to continue to promote and refine a best practices approach to providing home-based family therapy. As the field continues to seek to improve the effectiveness of services for children and families in which a member has a diagnosis meeting the criteria for serious emotional disturbance (SED), a goal of HBFT Partnership is to assist practitioners incorporating evidence-based principles into their work with families. Such efforts are best facilitated when those actually providing the service have input into the development of evidence-based protocols; thus we seek to continue the collaboration begun in the first two years of the program with the home-based therapists across the state to identify best practice models and interventions that promote successful therapeutic outcomes. In addition, we hope to continue to work with the therapists to identify the core competencies that all home-based therapists should possess. The identification of core competencies provides additional information on best practices in this area. The core competencies enable clinicians to attend to both the ethical and financial aspects of home–based family therapy. Attention to core competencies is embedded in all components of the training including: core training, web-based learning modules, and videoconferences.

The notion of *partnerships* remains key to our work. There are three levels of a partnership incorporated throughout this proposed approach. One level of the partnership is between the Community Mental Health Center CBS Directors, SRS, KHS, and the KSU trainers/consultants/supervisors. A HBFT coordinating committee has been established to serve as a liaison between KSU and SRS/CBS Directors. It is expected that this level of partnership would involve other state contracted agencies seeking home-based family therapy training for their clinicians. The second level of the partnership is between the Home Based Family Therapist and the KSU trainers. The third level of the partnerships between the Home Based Family Therapist and the client family and is central to all partnership levels.

We seek to work together with these contractors to develop a best practices approach to in-home family therapy.

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PUBLICATIONS

Home Based Family Therapy (HBFT) FY 06 Contract Report

This report summarizes our work as trainers and supervisors at the KSU Family Center that has been focused on developing the HBFT Partnership with SRS, Community-Based Services (CBS) directors, supervisors and HBFT therapists in Kansas. This year can best be described as a ***capacity-building*** year. Our attention was focused on understanding the CMHC system and working with those centers currently providing home-based family therapy. The HBFT coordinating committee assisted in helping us to understand the differing needs of the centers and encouraged us to work with those centers that had expressed interest in training for home-based family therapists. This decision resulted in applying our full effort toward the development of the components and resources necessary for building and sustaining an effective partnership.

We have compiled the resources and developed the templates necessary for extending the HBFT partnership and training opportunities including the development of:

- An HBFT Coordinating Committee comprised of representatives from SRS, CBS Directors and the KSU Family Center
    - This committee provides guidance on issues relating to the training contract, prioritizing goals, serving as liaisons with the larger systems of the CMHC's and SRS, and feedback on module development.
- A two-day Core Training introducing the principles guiding the development and sustainment of the HBFT partnership
    - In accordance with our contract, we designed the training to establish a foundation for a yearlong partnership between the CBS Directors; HBFT supervisors, therapists, and families; and us at K-State. Considering that we needed a common starting place for an effective partnership to succeed, we designed the training to provide a model of a *Partnership Culture* reflecting the framework needed for our yearlong work together. We also designed and delivered the training to appeal to the broadest audience of supervisors and therapists of diverse training and experiences. We recognized that to develop a partnership culture with families, supervisors, and therapists, we needed to provide a model of that culture each participant would experience during the training. We are convinced that the modeling during training and the ongoing partnership will have isomorphic effects with supervisors' and therapists' work with their families.
- An HBFT partnership website utilizing the design and programming resources through Kansas State University
    - The website includes: gated user access, tracking, tutorials, accumulated HBFT resources, and evaluations
    - As we became more involved in the development of the modules, it became apparent that the development of a unique website was needed to support the modules. The time and effort devoted to this endeavor was not anticipated, therefore, posting of the final two modules will be delayed until later this summer. It is the opinion of the trainers that this time was essential to the success of the Intervention module and subsequent modules.

- A module template that will guide the development of subsequent modules and facilitate user familiarity with module navigation
    - Recognizing the multidisciplinary audience of clinicians and supervisors, each module will establish a common ground of therapeutic terms and site a clinical example referred to throughout the module. Next, the modules will provide a systemic framework addressing the specific module topic. Finally the modules will facilitate the users' application of module principles with his/her own case examples.
    - Modules will cover 4 primary areas: therapeutic skills, family issues, therapist self-care and supervision
    - The first extended, interactive module entitled "A Process for Developing an Intervention". Family Center staff and faculty tested a beta version. Because of the recommendations from the core training, the decision was made to provide a more in depth experience with interventions
- A clinician supervision plan dividing the state into four supervision groups and involving the 15 centers that have expressed interest in this component of the contract.
    - The delay in the supervision process was impacted by the difficulties we had understanding which centers were providing HBFT and also interested in participating in the supervision. After some time, the coordinating committee encouraged us to base our process on those who had replied to date.
    - A presupervision reporting form has been developed for this group experience to encourage focus of the supervision. Each area will have the opportunity for 1.5 hours of group supervision each month.

Core Training Summary

In preparation for the two-day training for HBFT, therapists and supervisors were surveyed to learn about those who would be attending as well as their needs for training. The survey information revealed that many supervisors and therapists have limited HBFT experience and little awareness of their own culture and its impact on their therapeutic work. After reviewing the participants' evaluations at the end of the first day of training, we discovered that approximately 60% of those attending training had not completed the survey, had no expectations for the training or expected it to be a self-contained two-day workshop. Clearly, very few participants were aware that this was the beginning of a yearlong partnership. In addition, those attending reported having from 0 to 20 years experience providing HBFT. Some attended because they were instructed to while others attended because they were anticipating becoming involved in providing HBFT. It became clear to us that the expectations for such training were varied and therefore confusing.

The information from the evaluations provided us with the opportunity to modify the second day of the training. We began by developing this partnership culture and made overt the areas we learned were of concern to the participants. We addressed the participants' expectations and realized two primary issues were obstacles to building an effective partnership experience: 1) communication and dissemination of information between and within centers is an area of concern for the therapists; and 2) the therapists' expectation that subsequent collaborations will provide them with "ready-to-use" interventions. We simply reported the communication issue to the CBS Directors because it is an area the therapists and supervisors have stated concerns them and the solution is beyond the scope of the K-State contract.

The second issue identified during the training involved the clinicians' expectations for training and their apparent lack of awareness that the training will meet SRS requirements for training and provision of HBFT services. While reviewing the results of the first day survey, we anticipated a gap between supervisor and therapist training, experience and needs. We had not considered that there would be a gap between the administrators and the supervisors/therapists regarding requirements and training needs. We conducted an exercise on the second day to develop an awareness and understanding of those differences and further the partnership culture we were attempting to create throughout the training. The primary expectations voiced in the groups included: the need for ongoing supervisory relationships, therapist self-care, training that accounted for the clinician's level of experience, and assembling a "bag of tools" or interventions.

While the first day of training was received with mixed reviews, in hindsight, we believe the experience was necessary to gain insight into the therapists' expectations and needs and begin the process of gaining their collaboration in this yearlong partnership. It was also evident the therapists have a strong desire to be effective in creating meaningful and lasting change with their families. We are developing the various components of the Partnership Culture to equip supervisor and clinicians to become more versed in the competencies and theoretical foundations necessary for effective Home Based Family Therapy. It is our hope that they will apply their creativity and be increasingly responsive as they develop interventions that successfully meet the needs of the families they serve. Furthermore, we expect that they will recognize their own abilities to develop interventions within the process of therapy, see each other as a supportive network, and be less reliant on a "bag of tools" or a one-size-fits-all intervention framework.

Capacity-Building Experience

In our attempt to learn about the CMHC system as well as the clinicians' needs and expectations, we devoted our time to surveying the partners to further inform our work. In response to the information we learned from the therapist and supervisor surveys from the core training, we did not want to proceed without clear guidance and support. Garnering support in the way we had anticipated proved to be difficult and time-consuming work. The HBFT Coordinating Committee helped us to move forward after months of feeling uncertain. They aided us in understanding the community mental health center system. For example, we arrived to this process with the expectation that all of the centers were in support of this training only to learn that not all centers provide home-based work. This would account for the lack of response to our requests for information. As a result we proceeded in developing the infrastructure necessary for developing the partnerships with those who expressed interest.

In consideration of our vision of this partnership hopefully extending beyond the first year, we paid close attention to developing a system of training that would withstand the test of time. Therefore, we applied the contract resources and devoted our time to the development of the website as the hub of training, collaborations, and resourcing. The structure of the website offers the users a consistent framework that supports their focus on the learning process and relationships with one another. For example, modules will be divided into four primary topic areas and within each module there are five objectives – introduction, establishing a common ground, systemic framework, application, and evaluation. The content of these objectives will coincide with the specifics topic of each module. In addition, threaded discussions, brief surveys, and resources are consistently formatted and the information is catalogued for future reference. The threaded discussion facilitates the connections of clinicians to one another in the hope of mitigating the isolation factor inherent to home-based work.

This same vision of the partnership has been integrated throughout our thinking about the teleconference and supervision. We will be devoting the teleconference to assessment, diagnosis and treatment of disorders identified in the DSM. The threaded discussions, supervision and the HBFT Coordinating Committee will provide information to us regarding specific assessment and diagnostic conditions frequently faced. Treatment is a natural component of this training framework and will be built into each module, teleconference and supervision.

We are currently in the process of developing a larger project team consisting of undergraduate and graduate students as additional collaborators in the further development of components of the contract. Teams of students will be divided between the module categories. Students will be conducting literature reviews; resource management; further website development; module beta testing and editing; and developing outcome evaluations of each component of the contract. We will be encouraging students to develop presentations for poster sessions and roundtables discussions at national organization meetings (e.g., AAMFT and NCFR) and write articles, submitting them to peer-reviewed journal. Finally, we have designated a staff position to specifically attend to the demands of the further development and maintenance of the website.

We have devoted time to learning about the system and the needs of therapists, centers and the state during this capacity building year. These experiences have afforded us with the basic knowledge and opportunity to continue to build these relationships. At the conclusion of this first year, the infrastructure necessary for providing the training components of this contract are in place and there is a clear vision for the future year.

2006/2007 Year End Contract Report

This report summarizes our work as trainers and supervisors at the KSU Family Center during the FY 07 contract year. The previous year was described as a *capacity-building* year that was marked by the development of the first core training, developing the partnership with the CBS Directors, supervisors and HBFT clinicians, increasing our understanding of the CMHS system, and the development of a new website devoted to HBFT training opportunities. This was important to establishing the foundation for the future trainings and establishing a vision for the partnership. We continue to work with the CBS Directors in fostering this partnership and furthering our understanding of the CMHS system.

This contract year could be described as one with a *learning style* focus. We received information about various learning processes and how to integrate these into all aspects of our training. When developing any training, regardless of whether it is face-to-face, by teleconference or solely web-based, we are considering four primary areas:

- **Knowledge and Comprehension**: providing information and asking questions to determine if the participant understands the concepts
- **Analysis**: providing ways of using the knowledge and a means to understand the implications of the new knowledge in the clinicians work
- **Synthesis**: providing opportunities for the participants to integrate the information with current knowledge base and past training and clinical experiences
- **Application:** providing opportunities to use the information and further develop skills to enhance the clinicians work with families. **(**Gagne, R., Wager, W., Golas, K, & Keller, J. 2005)
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We have primarily used a PowerPoint format to develop the modules. Although PowerPoint is a tremendous training guide it does not meet the needs of the web-based learning process. The module development was modified to include a process focused on providing "chunks" of information (instead of bullets of information) in order to provide a more fluid learning process as well as introduce additional learning strategies (journal, survey, threaded discussion, animation, schematics) to appeal to various learning styles. This has then been applied to the development of the teleconference and current modifications to the core training.

Throughout this year we have redesigned the website to make it more functional, created four new modules, created two teleconferences, provided one two-day core training, and began "marketing" the website. We remained available for supervision throughout the year and because of the lack of participation, decided to discontinue this service for the next contract year. Toward the end of the contract year, we have been in touch with Kansas Health Solutions and some of the private home-based family therapy providers discussing the provision of additional trainings and opening the website up for their use.

HBFT Website: There is continued work on the website look and functionality (see attached Home page). We decided to change the website host as the current host was not able to accommodate the changing needs of the modules. The website was completely rewritten and we are very pleased with the outcome. Users are able to register for all training events through this homepage. In addition, the discussion page is available to those who have completed a module, core training, teleconference or for someone simply wanting to respond to discussions or post questions and comments. We encourage people to visit the website and provide us with feedback. Currently, 37 people have registered to the site.

Core Training: The core training was held over two days in November 2006. This year 15 people attended from across the state. Modifications to the core training based on feedback from the first training included the integration of culture throughout the training instead of as a separate section, the discussion of the phases of therapy as they are impacted by culture, therapy focus, supervision, and self-care. In addition, much attention was devoted to the *bridge* from office-based therapy to home-based therapy discussing issues of sensory overload, burnout prevention, and supervision. Attendees participated in role plays based upon the phases of therapy and the application of that *bridge*. The goals, as set forth in the contract were met. Focus on the family as partners in the therapy process, understanding the phases of therapy and the application to home-based work were key growth areas. Participants were able to apply the didactic learning to the role plays and follow this with discussion of their therapeutic style and where in the process they struggle. Again, the bridge is a key source of anxiety for clinicians. Clinicians reported that as they make the transition to the home, their anxiety raised as they were challenged with the sensory overload. As they are able to process the information received, both from observations and verbal report, clinicians felt more confident in maintaining the focus of therapy. They were also able to manage additional information that was more distracting in nature.

Modules: At the start of this contract year we added research teams to enhance the development of all aspects of training. These teams have been hard at work developing the Working with Stepfamilies and Therapist Self-Care modules. In addition, a Crisis Management module was launched and a Supervision module is ready to launch. As the website redesign is now complete, we are able to add the additional modules. As stated previously, we have focused on learning processes and how to connect with different learning styles through each training program, whether it is a web-based learning, teleconference or live presentation. In addition, we have added animation to the modules to connect with a greater number of learning styles. We expect module registrations and completions to substantially increase with the marketing process and access by private contractors to the site. We expect to more fully evaluate module effectiveness as there are additional modules completed in each of the four areas (see attached Discussion page).

Teleconference: The original plan for the teleconference had been to provide one six-hour teleconference focusing on childhood behavioral disorders including: Oppositional Defiant Disorder, ADHD, Conduct Disorder or Childhood Depression. In January, we conferred with our CBS Directors coordinating committee and changed not only the format but the topic in order to meet the needs they had identified. First, the teleconference format was changed to two three-hour teleconferences scheduled as Part One on April 20, 2007 and Part Two on June 22, 2007. Secondly, the topic was changed to Autism Spectrum Disorders with Part One focusing on diagnosis and assessment and the relational aspect of this disorder. Part Two focused specifically on treatment from a home-based perspective. It has been our position, to provide a relational focus for the participants, not focusing on the treatment of the individual. We integrated information from the

Chronic Care Model, Family Systems Illness Model, and the latest research on ambiguous loss. The teleconference was attended by a total of 21 people. Concern was raised as individuals signed up for the teleconference but then did not attend, thus creating unneeded expense for the contract. We have been discussing possible ways of addressing the importance of accountability regarding registration and attendance.

Supervision: Supervision was an area the initial proposal reviewers supported. They appreciated the notion of the therapists being able to continue to consult directly with the trainers throughout their work. However, given state and agency requirements, this is one aspect of the program that has been underutilized. This issue was raised again during the February CBS Directors meeting and the consensus was to continue to offer the service. Since that meeting, we decided to discontinue this service for the next contract year and provide the time in other areas, including offering a third teleconference on ethics next year.

Website Promotion: In addition to the development of the content areas for the website, we are interested in continuing to promote the access and use of the website for continuing education through module completion and as a resource of information. This quarter we presented our work at the March meeting of the CMHC Clinical Directors. We provided the group with the history of the program, the key components of the program (core training, modules, teleconference, and supervision) and provided them with a tour of the website.

Plans for Preparing for the Next Contract Year: We continue to focus on strengthening the partnership with the SRS, CBS Directors, supervisors and clinicians. The website is one system used to strengthen these relationships. During the previous quarter the remaining three modules have been prepared for launch. As the website revisions are completed three modules are scheduled to be launched by September 1st. Work on the 2008 contract proposal outlines the proposed changes to both the content and layout of the work next year. We are excited about what we have begun, is the resources that are in place and our goals for the future. We welcome the inclusion of the private contractors into the partnership.

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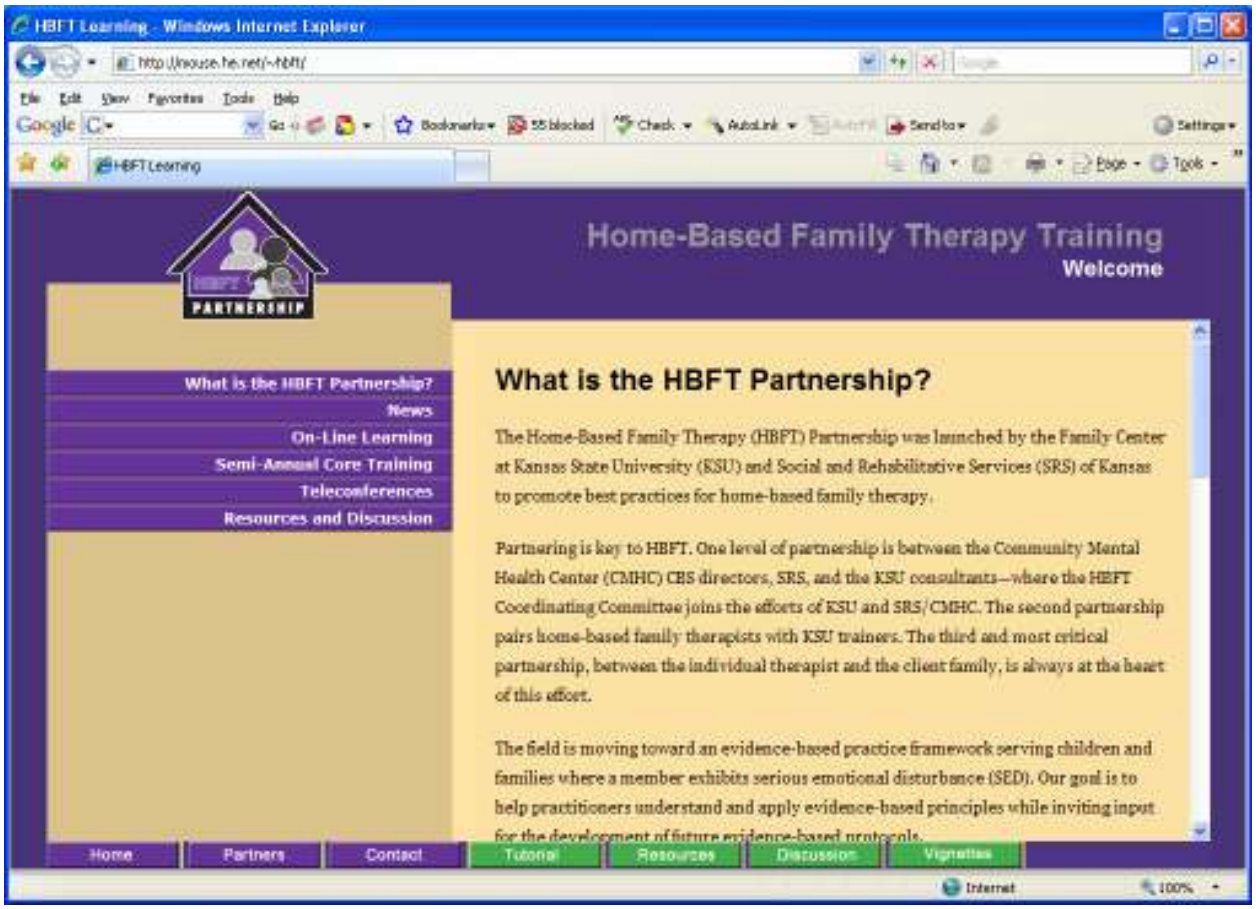
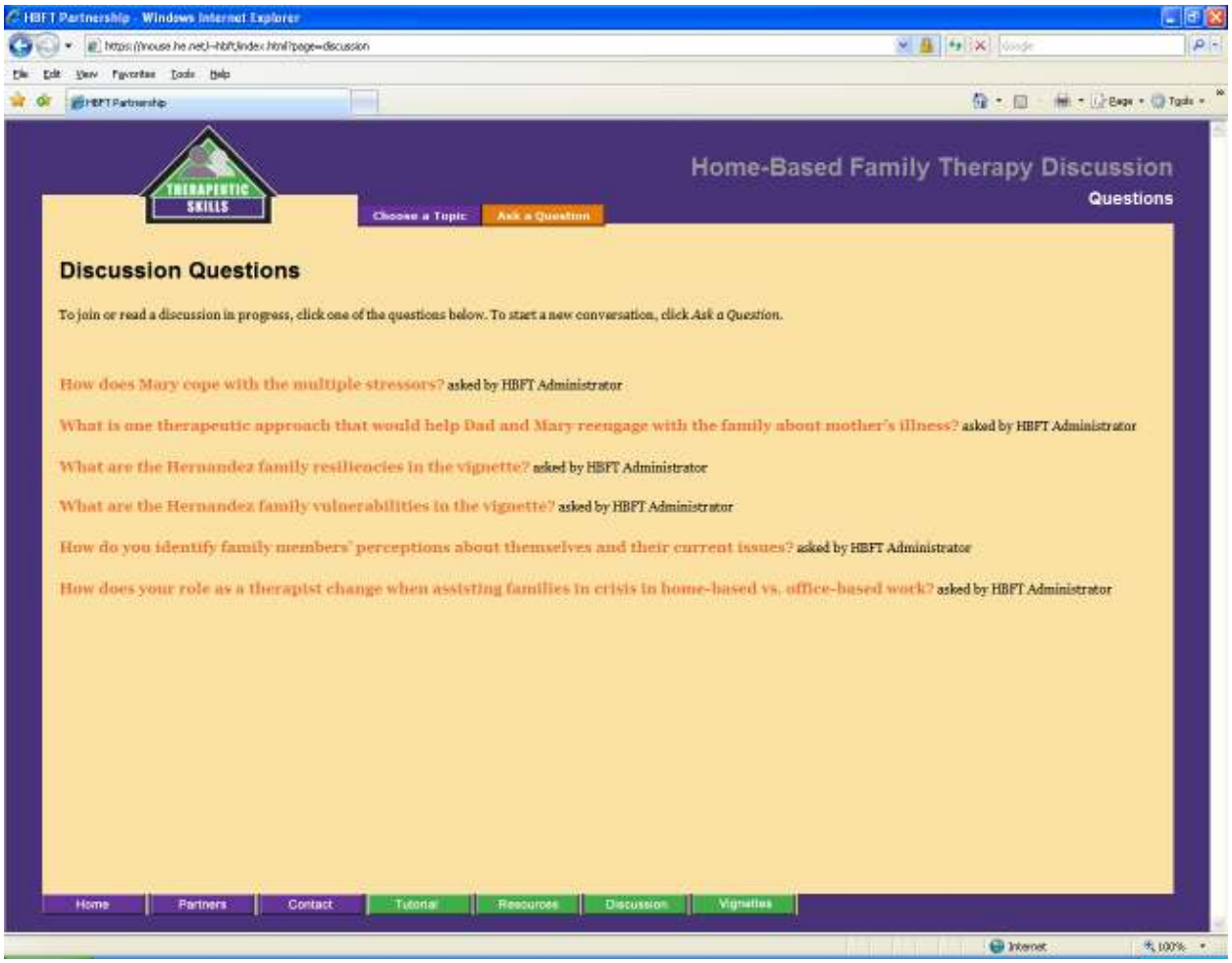
References

Gagne, R., Wager, W., Golas, K, & Keller, J. (2005), Principles of instructional design (5th Edition). Belmont, California: Wadsworth/Thompson

HBFTPARTNERSHIP.COM – REVISED HOME PAGE



HBFTPARTNERSHIP.COM – REVISED DISCUSSION BOARD



Home-Based Family Therapy Partnership

Home-Based Family Therapy
FY08: Final Report
July 17, 2008

This year has been one of change and excitement for the Home-based Family Therapy (HBFT) partnership. The partnership has experienced expanded involvement in core trainings and videoconferences. The website has been redesigned to offer easier user access with the addition of improved administrative editing features. There has also been consistency in the involvement of an expanded HBFT Coordinating Committee with the addition of CMHC Clinic Director representatives and Kansas Health Solutions.

This report summarizes our work as developers and trainers at Kansas State University during the FY08 contract year. We have made great strides in our goal of "cultivating new connections" as we concentrated on further developing the partnership and making numerous resources available to the clinicians, supervisors, directors, and the private contractors. This report will describe the efforts to expand the partnership to reach a greater number of home-based clinicians. Each intended objective and outcome will be specifically addressed.

Contract Objectives:
The general objectives of the contract were described as follows:

- Participants will learn how to operate within a flexible treatment framework that shapes and changes the treatment process based on client families' perceptions of both how change should occur in their family and the nature of the therapeutic relationship – **COMPLETED**.
- Participants will be able to consider the multiple domains impacting the client and collaborating with these systems to enhance the therapeutic relationship –**COMPLETED**.

Participants will work with project personnel to develop a best practices model for home-based family therapy, as well as to identify the core competencies needed to successfully perform this type of therapy –**COMPLETED**.

Objectives specific to the contract components included:

- Participants will be invited to attend two 1-day core trainings will be provided in October 2007 and March 2008. This training will be a launching of the partnership for those who have not had previous access to the partnership – **COMPLETED**.
- SRS contracting agencies will be able to participate in three videoconferences held throughout the contract year. Three 3-hour videoconferences will be completed by May 2008 –**COMPLETED.**

Participants will be invited to participate in four additional web-based on line learning modules will be completed, one in each of the identified categories: Therapeutic Skills, Family Issues, Therapist Self-Care and Supervision – **COMPLETED** based on contract modification.

As we evaluated the feedback from the core trainings and videoconferences, as well as through conversations with home-based clinicians, supervisors, CMHC Clinic Directors, and CBS Directors, we decided it was important to invest time in an exhaustive review of the HBFT literature. *SRS permitted the substitution of this effort in place of two modules.* A report was generated regarding this information and was included in its entirety with the third quarter report. Over 70 articles and books were reviewed and categorized in an effort to inform the redevelopment of the Core Training as well as the other components of the partnership. We engaged in this study to explore answers to the following four questions:

1. How is an office-based practice adapted to work in the home?
2. What does the literature reveal about the common components of home-based practices across evidence-based models?

3. Under which conditions is HBFT indicated or contraindicated?
What are the unique skills and support that HBFT therapists need to provide effective HBFT treatment?

Each clinician signing up to participate in the partnership has received this report and it has been saved as a PDF on our website. Although we could intuitively answer some of these questions (because of our previous research and experience in HBFT), we were committed to addressing these questions from a solid research/evidence-based perspective. We believe this report answers these questions and provides a comprehensive overview of the trends in HBFT and best practice approaches. Our intention was to modify the Core Training and provide more transparency about the research references that have guided its development and presentation. Previous Core Training feedback had specifically requested more references to evidence-based approaches and we believed this exhaustive review was the most efficient way to respond to those requests. In addition, the report has been submitted for publication to the *Journal of Marital and Family Therapy*.

Partnership Participants:
Since 2005, 418 participants have joined the partnership. 92% of the participants have experience with home-based family therapy (HBFT) ranging from 0 to 6 years. Though 36% of participants reported have no active HBFT cases, the remaining reported having an average of 6.41 active HBFT cases. 70% of participants reported making 1-11 HBFT visits per week and 12% reported making 12 or more visits per week. Several respondents who reported making home visits are case managers, therefore, they would be included in the 36% reported having no HBFT cases.

Participants were asked several questions evaluating aspects of their role as a therapist. When asked to evaluate their workload, 36% responded in the range labeled *underutilized to comfortable* while 41% responded to the range *overworked to overwhelmed*. Participants were also asked to evaluate their levels of comfort, satisfaction, and stress associated with their work. Responses ranged from low to high levels. The average responses included: neutral to high on levels of *comfort* (mean level = 2.28), neutral on levels of *satisfaction* (mean level = 2.10), and low to neutral on levels of *stress* (mean stress level = 1.84). On a follow up survey ranging from two months to two years after the initial survey, the average responses of 59 participants reflected significantly higher evaluations of *comfort* (mean 2.51, $p < .05$), *satisfaction* (mean = 2.51, $p < .01$), and *stress* (mean = 1.93, $p < .05$). The mixed results suggest that while these clinicians have become more comfortable in their positions, their levels of stress have grown proportionally. The number of intervening factors make it difficult at this time to determine the degree to which the therapists' involvement in the partnership has influenced any of the differences.

Therapist Responses	**Initial Mean Responses**	**Follow-Up Mean Responses**	**Sig.**
Comfortable doing HBFT (range 1-3)	2.28	2.51	$p < .05$
Level of satisfaction being an HBFT therapist (range 1-3)	2.10	2.51	$p < .01$
Level of stress associated with HBFT (range 1-3)	1.84	1.93	$p < .05$

The HBFT literature reflects the importance of adequate levels of supervision and therapist self-care to support clinicians' work. The therapists reported that they receive an average of 1.39 hours of supervision per week, however, 93% reported that they have never had a supervisor accompany them on a home visit. In addition, 18.5% reported having no supervision. This may be a reflection of not having any home-based cases. Also during the Core Trainings some clinicians report that supervision is an appointment they cancel when they have inadequate time to accomplish their responsibilities. When asked about the frequency of use of therapist self-care activities, 78% of participants reported daily or weekly engagement in self-care activities. Addressing the role strain that often occurs between a therapist's personal and professional lives, 65% reported that they perceive their home-based work impinges upon time with their own families.

The HBFT literature also suggests that the availability of supervision and the use of self-care strategies have a moderating effect on clinicians' stress levels and negative perceptions of their workload. However, based upon analyses of the current data, there were no significant correlations between the frequencies of supervision and self-care activities utilized, caseloads, years of HBFT experience, and therapists' evaluations of their workload. In our future work through the contract, we will develop alternative ways to measure these variables to determine if there may be any correlations.

Component One: Core Training

The Core Training focuses on the many aspects of home-based family therapy and its distinction from traditional in-office therapy services. This core training assists clinicians in understanding the distinctions and ways to use evidence- based principles to meet the needs of the referred families and prevent out-of-home placements.

Outcomes:

- Participants will understand the unique aspects of home-based family therapy
- Participants will explore the importance of cultural competence for successful home-based work
- Participants will learn to integrate a systemic framework into their theoretical orientation
- Participants will explore the phases of therapy (joining, assessment, contracting, intervention and termination)
- Participants will become competent in adapting their skills and competencies to the home-based context

Participants will be able to apply the didactic learning to their clinical work

Evaluation Measurements:

- Survey requesting participant evaluations of training content, integration of theory and practice, and program delivery

Survey requesting participant evaluations of establishment of and expectations for partnership

In addition to providing the two core trainings through the SRS contract, the partnership also contracted to provide 7 additional trainings through Kansas Health Solutions. The evaluations from these trainings clearly support the investment in the development of the literature review, subsequent report and Core Training revision. It has now been offered six times in the new format and the reviews have been excellent. The HBFT team continues to be invested in providing the most effective and educational Core Training possible. The feedback we receive is critical to the ongoing partnership and we are committed to continued engagement with the clinicians, supervisors, and administrators. The Core Training was adapted to specifically address the importance of the partnership, evidence-based practice, self-care, and supervision.

Summary of Core Training Evaluations

The Core Training continues to be a vital component for launching the partnership with clinicians. The additional components provide the necessary follow up and expanded learning when participants engage in the web-based learning modules, videoconferences, and discussion boards. The training is designed for clinicians with 0 - 20+ years of experience providing home-based family therapy. When considering the span of the years of experience, our philosophy and guiding assumption informing the development of the collaborative partnership is that it is quite dynamic. Those with greater experience are able to engage in a "mentoring" type relationship with those new, or relatively new, to provide these services. One core training was rescheduled from January to May due to low registration (8 clinicians had registered). With the support of the HBFT Coordinating Committee, a cancelation policy was developed and posted to the website. Also, at the request of KHS and SRS, the maximum capacity was increased to 50 participants in order to accommodate the anticipated training needs of the KHS constituents. A second Core Training, scheduled for June 12, 2008 was rescheduled due to the tornado that struck the KSU campus that morning. This training will be completed on July 28, 2008.

Since 2005, 325 participants (150 participants through the SRS contract, 173 through the KHS contract, and 2 signifying "Other" affiliation) have completed a total of 11 trainings. During fiscal year 2007/08, 270 participants completed eight Core Trainings: two were offered through the SRS contract and six were offered through the KHS contract. (Due to inclement weather, the seventh and final Core Training was rescheduled on July 28th and is not reflected in this report.) A final evaluation was administered at the end of each Core Training. Responses ranged from disagree to agree.

Based upon the clinicians' feedback after previous Core Trainings, we redeveloped the curriculum. Comparing the

old curriculum used during years 2005-2007 and the new curriculum used in 2008, the participants' responses significantly improved for each question.

Therapist Responses	Old Curriculum	New Curriculum	Sig.
Information was accessible and helpful (range 1-3)	2.36	2.82	$p \leq .001$
Learning objectives were met (range 1-3)	2.55	2.91	$p \leq .001$
Will try new approaches learned during the training (range 1-3)	2.13	2.74	$p \leq .001$
Training increased my skills as an HBFT (range 1-3)	2.10	2.70	$p \leq .001$
Better understanding of unique features of HBFT (range 1-3)	2.31	2.77	$p \leq .001$
Collaborative partnership will support my clinical work (range 1-3)	2.88	2.98	$p \leq .05$

2-28-08 Core training held in Wichita
[+]4-1-08 Core training held in Kansas City
[#]5-8-08 Core training held in Garden City
All other trainings held in Manhattan

Several additional factors may have influenced the improved ratings for each of the clinicians' responses to the Core Trainings after instituting the revised curriculum. The trainers developed a report of an extensive literature review of HBFT that informed the curriculum revision and is provided to all participants. The new curriculum incorporates a greater number of clinical examples from the clinicians' actual cases, more small group work, and in-depth discussions of specific interventions clinicians can use in their work with families.

SRS and KHS requested the maximum number of participants for each core training increase from 30 to 50 to accommodate the expressed needs of the private contractors. Subsequent to this request only two trainings were filled to or near capacity.
[*]

The participants offered additional verbal and written evaluations of the trainings and trainers with specific positive remarks about the collaboration opportunities, research-informed information, experiential components, and the emphasis on self-care and supervision. They expressed appreciation for access to the literature review and the resources made available through the website.

When the HBFT partnership was first developed, the HBFT Coordinating Committee at that time expressed a strong interest in creating an opportunity for home-based clinicians to come together from across the state and engage in a day of education, collaboration, and self-care. It was decided to hold the trainings in a neutral location in Manhattan to fulfill these objectives. In the fall of 2007, we were asked to provide regional trainings in order to be responsive to the needs of the private contractors. The HBFT team expressed concern that regional trainings might inhibit this collaborative atmosphere and that those attending would primarily be from the agency "hosting" the training. In addition, we were concerned that clinicians would attend to work-related issues during the training. This did occur in the Wichita training. Clinicians arrived late after a meeting or left to go to their offices during breaks and lunch and arrived back well after the training had resumed. In two regional trainings that were representative of primarily one agency, we found that the discussions were often less enlightening for the participants and the trainers had to take additional measures to encourage participation. We believe this may stem from the fact that the participants work together every day, may be hesitant to be vulnerable in front of their direct peers, and the lack of networking opportunities during the training. At all trainings, announcements are sent specifically stating that no partial credit will be provided and that each person must attend the entire day. At each training, we also announced

the importance of collaboration and self-care and made the attendance policy explicit. We hoped that this would alleviate the concern about participants leaving early, however, it does not alleviate the concern about clinicians having the opportunity to come together to collaborate and network. We continue to have important discussions with SRS, KHS, and the HBFT Coordinating Committee regarding ways to enhance the collaboration through the partnership.

Component Two: Videoconferences

A. DSM Videoconferences: Project personnel will hold two interactive videoconferences with participating therapists, using the Kansas Regents Educational Communication Center, located in Dole Hall on the KSU Campus. These videoconferences will focus on assessment and diagnosis using the DSM.

Outcomes:

- Participants will become more proficient in recognizing, diagnosing and treating specific diagnoses meeting the criteria of Serious Emotional Disturbance (SED).
- Participants will explore specific connections between of HBFT and SED

Participants will be able to apply the didactic learning to their clinical work

Evaluation Measurements:

Survey requesting participant evaluations of videoconference content, integration of theory and practice, and program delivery.

The DSM videoconference was titled *HBFT Treatment of Children with PTSD and Depression*. The first half of this DSM videoconference was held on February 22nd. Participants were involved from the Manhattan, Wichita, Salina, Dodge City and Overland Park locations. There was a technical problem with the Pittsburg site therefore the videoconference was recorded and those participants received a DVD of the training. The second half of this DSM videoconference was held on April 25th. Participants were involved from the Manhattan, Wichita, Dodge City and Overland Park locations.

Outcomes:

Part I – As a result of attending this videoconference, participants will…

…know the prevalence of the co-morbidity of PTSD and depression in children and adolescents

…identify the features of the family context that contribute to a child's PTSD and depression

…review the diagnostic features of PTSD and depression

…understand a child or adolescent's experiences of the relationship between PTSD and depression

Part II – As a result of attending this videoconference, participants will…

…establish appropriate treatment goals

…develop treatment strategies and interventions to facilitate individual and family change

Evaluation Measurements:

Survey requesting participant evaluations of videoconference content, integration of theory and practice, and program delivery.

The HBFT office staff sent numerous announcements via email and letters publicizing this event in an effort to increase attendance. The participation with each videoconference increased from the past year.

B. Ethics Videoconference: Project personnel will hold a 3-hour videoconference on ethical issues related to home-based work. The Kansas Regents Educational Communication Center located in Dole Hall on the KSU campus will again be used for this work.

Outcomes:

As a result of attending this videoconference, participants will…

- …explore the personal and professional risks associated with neglecting self-care
- …review the correlation between self-care and provider impairment
- …learn to monitor personal and professional boundaries
- …develop strategies for improving self-care and experience overall well-being
- …understand the unique ethical challenges involved in home-based family therapy work

…understand the ethical dimensions of self-care when providing effective home-based family therapy

Evaluation Measurements:

Survey requesting participant evaluations of videoconference content, integration of theory and practice, and program delivery.

The ethics videoconference was titled *The Ethical Implications of Therapist Self-Care* and was held on January 25, 2008. Due to low registration for the original date of October 19th, the videoconference was rescheduled with an extensive marketing effort. Registration for the rescheduled date was positive.

Summary of Videoconference Evaluations
Since 2005, 74 participants have completed a total of six trainings. During fiscal year 2007/08, 48 participants completed three trainings. This reflected a 185% increase in participation over fiscal year 2006-07. A final evaluation was administered at the end of each videoconference asking participants to compare the training with other trainings they have previously attended. The first three responses ranged from less to more informative, engaging, or helpful. The final question asked participants to signify whether none, some, much, or all of the information presented during the training was new to them.

Therapist Responses	**Mean Responses**
How informative was the videoconference? (range 1-3)	**2.42**
Rate your experience of the videoconference (range 1-3)	**2.16**
How relevant was the topic to your clinical work? (range 1-3)	**2.88**
How much of the information was new to you? (range 1-4)	**1.97**

Component Three: Quarterly Web-based Modules
Project personnel will develop and make available to HBFT therapists four quarterly web-based modules. There will be one new module developed from each of the four categories: therapeutic skills, family issues, therapist self-care, and supervision. Each module will conclude with an evaluation that measures participants' knowledge gains. The partnership is using instructional design methods to inform the conceptualization and construction of learning module components (knowledge, comprehension, application, analysis, synthesis, and evaluation) (Bloom, 1984 in Gagne, Wager, Golas, & Keller, 2005).
Outcomes:

- Participants will gain knowledge and skills related to each of the four categories (therapeutic skills, family issues, therapist self-care, and supervision)

Participants will be able to apply the didactic learning to their clinical work
Evaluation Measurements:

- Within-module pre/post surveys measuring participant learning of materials
- Within-module surveys and threaded discussions and post-module follow-up surveys measuring participant application of materials to clinical cases

Survey at the conclusion of the modules requesting participant assessments of module and website functionality

Summary of Online Learning Modules
The research teams have been very active in developing the modules for this contract year. The Therapeutic Skills module, *Models of Cultural Competence* and the Family Issues module, *Families and Chronic Illness* have been completed. In addition two of the existing modules, *Therapist Self-Care and Working with Step-families,* were revised to fit the improved format developed.

Since 2006, when the first Online Learning Modules were available on the HBFTPartnership.com website, only two participants have completed a module. Based on the low participation rate, evaluation figures are not yet available. Since 2006, a total of six Online Learning Modules have been developed. During fiscal year 2007/08, the website and the existing four Online Learning Modules were redeveloped to improve the structure, content and

functionality. An additional two modules were developed with the new framework. During each Core Training provided, clinicians expressed excitement about the addition of a CD Learning companion that the partnership was researching.

Administrative Components

HBFT Website

Modifications and improvements of the functionality of the website were made this year. These modifications continued throughout the contract year. The registration process has been more seamless with increased accuracy. Those registering for events receive a confirmation email and the registrant is automatically added to the event list. There is continued evaluation of the website with modifications made to increase the functionality and allow us to further engage the participant in the content posted. As the modifications have been completed, we have migrated the information to the new site. As of January, any new registrants or information developed was added to the new site making it easier for the users to navigate the site.

We temporarily suspended module access until all the modules were reviewed. We decided this was a good time to review the content of all the modules and to upgrade them based upon what we have learned regarding online learning. The modules have been revised to reflect an improved framework. We continue to encourage participants of the Core Training and readers of the quarterly newsletters to visit the website and provide us with feedback. There continues to be more clinicians registering with the website in an effort to participate in the events, modules, surveys, and discussion boards as well as access the resources posted on the site. Currently there are approximately 390 people registered with the website. This is almost double the number reported last quarter. Additional features are being added to improve the reporting capabilities of all user activities throughout the various components of the partnership.

HBFT Coordinating Committee

This committee has expanded to include KHS as well as representatives from the CMHC Clinic Directors. The committee consists of the following members: Erick Vaughn (SRS), Wes Jones (East Central Kansas Mental Health Center), Jan West (Four County Mental Health Center), Steve Christenberry (Family Service and Guidance Center), Dave Barnum (The Guidance Center), Michele Johnson, (KHS) and Lorna Clark (KHS) and the HBFT Team. This committee has been critical to the development and implementation of trainings and modules that meet the needs of the range of providers involved in HBFT. We have teleconferenced on a monthly basis since January and the committee has provided key guidance for our work and connecting us with other professionals who can offer support for the work. We have become involved in discussions with the CMHC Clinic Directors regarding the referral process for HBFT. We anticipate that our research and knowledge about HBFT can guide the development of referral protocols to be used by the various agencies.

After the literature review and modification of the Core Training, we had extensive discussions with the HBFT Coordinating Committee regarding future trainings. These discussions followed a November 14, 2007 meeting with the CMHC Clinic Directors when we reviewed the progress to-date and presented the ideas for Advanced Core Training, Supervisor training and the CD Learning Companion. The Core Training is the foundational training for the partnership and is provided on a general level. The Clinic Directors were very supportive of the notion that an Advanced Core Training would provide clinicians with continuing education appropriate to more advanced levels experience. Information was provided to the group regarding feedback from the clinicians expressing concern about the supervision experience. The clinicians have described the need for supervision that is more applicable to HBFT because they experienced supervisors with little or no direct experience providing home-based family therapy. The Clinic Directors group supported the development of a specific HBFT Supervisor Training. Finally, the Clinic Directors were supportive of the CD Learning Companion as it is an innovative way of addressing continuing training for clinicians whose schedules require a more flexible method of instruction. We then raised these ideas with the HBFT Coordinating Committee beginning in January 2008. They encouraged us to begin gathering information to develop these three areas. An intern working with us throughout the Spring semester researched and developed the protocols for developing and dissemination of the CD Learning Companion. As a result, when given the administrative support, this aspect is ready for production. KHS assisted us in sending several email blasts to gather participant suggestions regarding content areas for the Advanced Core Training and the Supervisor Training. Those initial surveys provided us with the types of questions we should ask directors and supervisors while developing Advanced Core and Supervisor Trainings.

Collaborative Partnership Promotion

Three issues of the HBFT Newsletter, *The Connection*, were published and mailed in the welcome packet to new members of the partnership. It was also distributed via email to all who have registered with the partnership as well as to the CMHC CBS Directors, Clinic Directors and KHS. Dr. Macchi also provided an article for the KHS newsletter introducing the partnership and highlighting the resources available through the website and the partnership. KHS continues to inform their network about the HBFT partnership and the HBFT team continues to attend meetings discussing the work of the partnership.

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Home-Based Family Therapy Partnership

Home-Based Family Therapy
FY09: Final Report
July 16, 2009

This year has been one of change and excitement for the Home-based Family Therapy (HBFT) partnership. We have looked upon this year as "broadening our training base." The focus of the partnership in this contract year was to develop trainings through the online modules and videoconferences that were more easily transferable to the home environment. These trainings took on a focus of attending to some of the more critical concerns the clinicians face such as safety, self-care, supervision and integrating children of all ages into the therapy process. In addition we continued our coordination with the CMHC's and Kansas Health Solutions.

This report summarizes our work as developers and trainers at Kansas State University during the FY09 contract year. We have made great strides in our goal of "broadening our training base" This report will describe these efforts through describing each objective and outcome.

Description of Contract Components

1. Core Training: Provide Home Based Family Therapy Core Training to Medicaid service providers. Training will provide education on the family-driven approach to working with families in their homes, the many challenges of working in the family home, use of evidence-based principles to meet the needs of families and prevent out-of-home placements, on self-care and supervision. These trainings are limited to 40 participants.

1.1 Two Core trainings will be provided through this contract. **COMPLETED**

- **Outcome***:* Two Core Trainings were held this year through this contract. The first was held on September 18, 2008 in Manhattan, KS and the second was held on April 14, 2009 also in Manhattan, Kansas. In addition (through the KHS contract) two additional regional trainings were held on November 20, 2008 in Emporia, KS and May 5, 2009 in Great Bend, KS. When necessary, wait lists are generated and every attempt was made to fill those slots as they become available.
    - September 18th Training: 40 Clinicians were registered for the event and 8 either canceled or did not attend. Three were added from the wait list for a total of 35 participants. There were 6 CMHC's represented by 10 clinicians, 3 private contractor agencies represented by 18 clinicians, 5 independent providers and 2 participants from SRS.
    - April 14th Training: 40 clinicians registered for the event with 36 Clinicians attending the training and four who did not show or canceled late. There were 7 CMHC's represented by 18 clinicians, 4 private contracting agencies represented by 13 clinicians, 3 who identified themselves as private contractors and 2 who identified themselves as other.
    - November 20th Training: 40 clinicians registered for the event with 37 attending. There were 4 cancelations or no shows. There were 9 CMHC's represented by 28 clinicians, 3 private contractor agencies represented by 8 clinicians, and 1 independent provider.

- May 5th Training: 24 Clinicians registered for the event and 21 attended. There were 2 cancelations or no shows. There were 4 CMHC's represented by 12 clinicians, 3 private contractor agencies represented by 4 clinicians, and 5 who identified themselves as other or independent.
- **Evaluations**:
  - We continue to spend a considerable amount of the afternoon portion of the core training focusing on self-care and supervision. The core training is an opportunity to assist the clinicians in encouraging them to work with their supervisors and peers in collaborative ways. Stamm (2002) developed a tool called the Professional Quality of Life (ProQOL R-IV) to measure helping professionals' experiences associated with providing care to others. We use this measure to assist clinicians with developing a greater awareness of their overall well-being relating to their work. The assessment measures three domains of experience: compassion satisfaction, burnout, and compassion fatigue/secondary trauma. Compassion satisfaction reveals the degree to which a clinician experiences pleasure from doing the work of therapy. Burnout reveals the degree of hopelessness and helplessness a clinician experiences due to the pressures of work-related stress and/or lack of support for their work. Compassion fatigue/secondary trauma measures the degree to which the clinician is experiencing stress as a result of exposure to clients' trauma experiences and stories. We encourage clinicians to complete this assessment often and have conversations about the assessments with their colleagues.

Summary of Core Training Evaluations:
With 436 participants responding, we have continued to see improved responses to the Core Training since revising the curriculum in 2008. Participants continue to provide favorable responses to the presentations, content, training exercises, and applicability.

Therapist Responses (*range 1-3*)	**Old Curriculum**	**New Curriculum**	**Sig.**
Information was accessible and helpful	2.36	2.82	$p < .000$
Learning objectives were met	2.55	2.89	$p < .000$
Will try new approaches learned during the training	2.13	2.69	$p < .000$
Training increased my skills as an HBFT	2.10	2.68	$p < .000$
Better understanding of unique features of HBFT	2.31	2.75	$p < .000$
Collaborative partnership will support my clinical work	2.52	2.76	$p < .000$

2. Videoconferences: Provide videoconferences to educate and train providers of Medicaid funded services for children with Severe Emotional Disturbance (SED). Topics for Videoconferences will be 1) diagnosis and assessment using the DSM and 2) Ethics.

2.1 Diagnosis and Assessment Videoconference:

2.1.1 Project personnel will hold two (2) interactive videoconferences with participating therapists, using the Kansas Regents Educational Communication Center, located in Dole Hall on the KSU Campus. Therapists will be able to participate through sites located

across the state. **COMPLETED**

- **Outcome**: The DSM videoconference for this contract year was titled "Addressing ADHD in HBFT."
    - Part 1 was held on January 30, 2009 with the following objectives:
        - Identify the child and other family member experiences of Attention-Deficit Hyperactivity Disorder (ADHD)
        - Review the context of ADHD along the continuum of behavior disorders
        - Review the diagnostic criteria of ADHD and the varying presentations of the diagnosis
        - Identify common co-morbidities associated with ADHD
        - Develop greater awareness of the controversies associated with the diagnosis of ADHD
            - There were 15 clinicians registered for this event and 12 attended. Clinicians were located in Manhattan, Overland Park, Wichita and Dodge City.
    - Part 2 was held on March 27, 2009 with the following objectives:
        - Explore effective individual and family-focused treatments for ADHD
        - Understand the suspected and known *treatment* side-effects
        - Review ways to collaborate with medical and school officials to help families manage the effects of ADHD
        - There were 18 clinicians registered for this event and 9 attended. There was a "freak" spring snowstorm that resulted in the closure of the Dodge City, Colby and Salina sites. In addition, one person canceled due to illness. For those who attended Part 1 and could not attend due to the snowstorm, we have offered a copy of the videotape with a pre and post-test so they may complete the DSM requirements for their professional license.

<u>2.2 Ethics Videoconference:</u>

2.3 Project personnel will hold a 3-hour videoconference on ethical issues related to home-based work. The Kansas Regents Educational Communication Center located in Dole Hall on the KSU campus will again be used for this work. **COMPLETED**

- **Outcome**: The ethics videoconference titled "The Ethics of Confidentiality" was held on October 17, 2008. The objectives of this videoconference were as follows:
    - Understand the ethical dilemmas unique to home-based work
    - Learn ways to proactively address ethical issues with families
    - Learn ways to collaboratively work with families to determine how to minimize the impact of ethical dilemmas on therapy progress and client well-being
    - There were 21 clinicians registered for this event with 19 attending (2 cancelations, 2 no shows, and 2 attended without prior registration). Thirteen agencies were represented at six videoconference locations (Manhattan, Wichita, Hays, Dodge City, Overland Park, and Salina). There were 5 CMHC's represented and 8 private agencies. The evaluations were positive with participants commenting on how important it was for them to consider the many challenges to HBFT especially in rural settings and appreciating the small group exercises that allowed them to discuss their own challenges to confidentiality while applying the framework to evaluate the strategies discussed in the videoconference.

Summary of Videoconference Evaluations

- Since 2005, 142 participants have completed a total of twelve trainings. During FY2009, 38 participants completed three trainings. This reflected a 26.6% increase in participation over FY2008. A final evaluation was administered at the end of each videoconference asking participants to compare the training with other trainings they have previously attended. The first three responses ranged from less to more informative, engaging, or helpful. The final question asked participants to signify whether none, some, much, or all of the information presented during the training was new to them.

Therapist Responses	**Mean Responses**
How informative was the videoconference? (*range 1-3*)	2.17
Rate your experience of the videoconference (*range 1-3*)	2.48
How relevant was the topic to your clinical work? (*range 1-3*)	2.66
How much of the information was new to you? (*range 1-4*)	2.06

3. Web-based Learning Modules: KSU Project personnel will develop and provide web-based learning modules to educate and train providers of Medicaid funded services for children with Severe Emotional Disturbance (SED). One new module will be developed each quarter.

3.1 One new module will be developed each quarter, for a total of 4 new modules, one from each of the four categories: 1) therapeutic skills, 2) family issues, 3) therapist self-care, and 4) supervision. **COMPLETED**

- *Outcomes:*
  - As the HBFT team considered the needs identified by the clinicians throughout the partnership it was determined that the modules developed would address critical areas of safety, self-care and integrating children into the therapy process. By December 2008 the Supervision module was completed specifically *"Utilizing Supervision in HBFT."* The objectives of this module are
    - …learn the ways that supervision assists and guides therapists.
    - …develop greater awareness of points of view of the supervisory relationship and a supervisor's varied roles.
    - …determine when the therapist should request additional supervision.
    - …know how supervision addresses varying needs at different levels of clinical experience.
    - …explore ways to utilize the supervisory oversight to improve clinical outcomes.
    - …identify ways to use supervision to address issues arising within therapy that are specific to home-based work.

- The Family Issues module, *"Families and Domestic Violence"* was also completed in December 2008. The objectives of this module are:

  The prevalence of abuse.

    - The effects of abuse on women, children, and society.
    - The forms and signs of domestic violence, including physical, emotional and sexual.
    - The patterns of abuse that typically exist in intimate partner relationships.
    - How to assess for abuse.
    - How to help families dealing with domestic violence develop a safety plan.

- The two remaining modules for the year were completed by the end of the contract. The Therapeutic Skills module *"Using Play Therapy in the Home"* focused on
    - Theoretical foundation from which play therapy was developed
    - The stages of play therapy and assessment processes
    - Models of play therapy
    - Issues and ideas for integrating play therapy into the home setting
    - Examine the role of the therapist in the play therapy process
    - Applying play therapy with a common family
- The final module, *"Maintaining Personal and Professional Boundaries"* in the Therapist Self-Care category focused on Identify personal self-care issues that need to be addressed in your life and clinical practice
    - Utilize a unifying framework to examine your own self-care
    - Assess areas of your practice and life that contribute to personal or professional self -awareness regarding stress and self-care
    - Identify personal cases that have the potential to stir feelings of countertransference
    - identify self-care techniques, that other clinicians have found useful, and integrate them into your therapeutic practice
    - Develop your own *program* of self-care that will lead to increased balance for both your personal and professional life
- These modules were specifically selected to provide both skill based information as well as address safety, therapist self-care and supervision issues in practical information and assisting clinicians in becoming more self-aware of their strengths and limitations. Our conversations with clinicians in the Core Trainings and Videoconferences as well as through the evaluations provided, suggest that the clinicians struggle most with issues of safety and burnout and the implications these issues have for the work provided.

Summary of Online Learning Modules: It is the expectation of the partnership that once the modules are converted into CD Learning Companions (the expectation for FY10) that we will see an increase in the web-based learning component of this contract.

Partnership Participants:
Currently, there are 565 persons registered with hbftpartnership.com. There was an increase of 147 new people registered with the website. We have registered with "Google Analytics," a website tracking service, to track the following website activity: number of visits, number of pages visited and viewed, average time on the site, and percentage of new visits (see attached report). As a result, we are beginning to see that others beyond the partnership are visiting the site from various places around the world. As the amount of data increases, we will describe and analyze the types of activity. Eventually, the data will help us to determine the pages of most and least interest and to monitor the effects of our marketing efforts to increase traffic to specific areas of the website.

Administrative Components
HBFT Website
Modifications and improvements of the functionality of the website were made this year. These modifications continued throughout the contract year. There is continued evaluation of the website with

modifications made to increase the functionality and allow us to further engage the participant in the content posted. The website has several new features that will assist us in providing more detail regarding the work we are providing. There are enhanced reporting features that will allow us to track individuals participating in events as well as agency involvement. We strive to make the website the "go-to" site for anyone wanting information regarding the partnership. We created a priority list for the year that included such enhancements as user notification when a module/training is published, creating an informed consent guaranteeing user privacy, fields that would allow us more detailed attendance records, and the ability to embed animations. The new "google analytics" will track number of visits, number of pages visited and viewed, average time on the site, percentage of new visits, etc. The resources section continues to grow and, whenever possible, all articles are in PDF format or with active links to the source. Currently, there are 565 persons registered with hbftpartnership.com.

We continue to encourage participants of the Core Training and readers of the quarterly newsletters to visit the website and provide us with feedback. There continues to be more clinicians registering with the website in an effort to participate in the events, modules, surveys, and discussion boards as well as access the resources posted on the site.

Collaborative Partnership Promotion

Three issues of the HBFT Newsletter, *The Connection*, were published and mailed in the welcome packet to new members of the partnership. It was also distributed via email to all who have registered with the partnership as well as to the CMHC CBS Directors, Clinic Directors and KHS. In addition, the three HBFT Newsletters were also published in Spanish. The third newsletter focused on clinician safety when working with domestic violence in the home. This was a significant shift in the newsletter from an emphasis on what is happening in the partnership to an emphasis on relevant clinical topics. It is our intention to continue this focus.

Plans for FY 2010

We are excited about the contract submitted for next year. The CD Learning Companion is an addition to the partnership that should help the HBFT clinician access the resources and continuing education opportunities in a more user friendly way. The staff member who developed the protocols for this venture will remain with the project to ensure the quality of this endeavor.

In addition, we anticipate exploring in a more formal way the effectiveness of the trainings through the use of the data that continues to be collected. We have been in conversations with SRS and KHS to specifically determine the effectiveness of this partnership throughout the coming year.

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Home-Based Family Therapy Partnership

FY 10: HBFT Fourth Quarter Report

This report summarizes our work as trainers and supervisors at the KSU Family Center during the fourth and final quarter of the FY 10 contract year. We have designated this year as one of "resource expansion." As agencies need to make tough economic decisions and be more creative in the utilization of resources, our focus is on providing the clinician with increased opportunities to access training and information as well as complete relevant continuing education. Our modules and videoconferences attend to some of the more critical concerns clinicians are facing such as safety and integrating children into the therapy process. The ethics videoconference addressed the importance of collaboration and the DSM videoconference topic focused on Fetal Alcohol Syndrome.

HBFT Website: The website serves as the primary information source for the partnership. Enhancements are an ongoing process and we are pleased with how it is developing. There are several enhancements on the agenda for FY 11. The number of persons registered with the partnership/website continues to increase with the current total at **744**.

Core Training: There were two core trainings held during this quarter. The April Core Training was held in Manhattan on April 14, 2010. There were 40 persons registered for this training and 38 attended (one registrant from Comcare and one participant from St. Francis did not attend). We then traveled to Pittsburg, KS for the final Core Training of FY10 on May 5, 2010. There were 22 persons registered for the training and all attended. In collaboration with KHS, the decision was made to move the training from Great Bend to Pittsburg in order to serve those clinicians in southeast Kansas, an area we have not previously provided training. A comment report for all Core Trainings is attached to this final report.
The core training is truly a launching of the partnership with follow up continuing through the web-based learning modules, CD Learning Companions, videoconferences and discussion boards. During these two trainings we highlighted the opportunities for clinicians through the website. A display was created and each clinician received the Domestic Violence CD and other handouts such as the newsletters and resource guide. The HBFT Handbook was also displayed

Modules: The web-based modules have been replaced this year with the CD Learning Companions. Three CD's were created this contract year.

Modules: The web-based modules have been replaced this year with the CD Learning Companions. Three CD's were created this contract year.

CD Learning Companions: When developing these CD's much consideration was given to

ways of maintaining attention of the driver while encouraging them to attend to driving. Not an easy feat!

The first CD, ***Families and Domestic Violence***, was completed in the fall. The final two. The final two CD's were also completed***. Challenges to Therapist Self-Care*** is available and we are awaiting the receipt of ***Working with Stepfamilies*** any day now. When each CD is made available we meet with the CBS Directors and Clinic Directors providing each group with 200 CD's.

The graphics are very well done and are a great resource for the listener for a visual of many of the concepts being discussed. Clinicians are referred to the online module for more detailed information as well as additional resources. In addition, we have sent letters to all the private contractors and agencies regarding distribution. We have also responded to over 70 requests from private providers. The availability of the CD's are announced on the hbftpartnership.com website, on our Facebook page, and in our newsletter.

Videoconference: There were no videoconferences provided this quarter. The next videoconference will be held in September or October 2010. We are considering the ***Ethics Involved in Working with Domestic Violence*** as the topic.

Collaborative Partnership Promotion: The HBFT staff continues to disseminate information about events and resources available through the partnership. A new "therapist spotlight" was posted. In addition we have changed the schedule for the newsletter publication to include one published in the late summer to highlight the fall events (ethics videoconference and core training).

The team created an HBFT Partnership Facebook page. The HBFT Partnership Facebook page was launched in an attempt to reach out to more of our users and those who may be interested in learning more about the resources that the partnership has to offer. The HBFT Partnership group is an open group, which allows anyone to join, view our page and links, and allows them to join a discussion and send messages to us as well. The group also provides upcoming news (videoconferences, core trainings, cd availability) and has a link that takes you directly to the HBFTPartnership.com website. We are in the process of announcing the page to our users.

The team has created a resource guide that includes all of our CEU opportunities. This guide has been distributed at the CMHC CBS Directors' meeting and will be handed out at our core trainings, and sent to our videoconference participants.

Finally, we expect to distribute CD Learning Companions at all training events in the future.

Special Project – The Home-Based Family Therapy Handbook: Each year the HBFT team is fortunate to have undergraduate interns work with us. This year Emily Hatch, a senior in Family Studies and Human Services was on our team. Emily was responsible for the two newsletters published this year. In addition, Emily had a special project involving the development of a handbook to help therapists alleviate their clients' fears and concerns about therapy by providing information about home-based therapy in a material form. The primary purpose of this handbook will always be to incorporate therapists' ideas and knowledge into written form to aid

them in working with clients. The handbook is titled *What to Expect from Home-Based Family Therapy: Your Guide to HBFT*.

Emily sent a survey via email to all the past participants of the core trainings posing a variety of questions including their preference of title, education level of their clients, which visual and informative qualities they thought handbook should possess, and frequently asked questions they have received about home-based therapy.

The survey was sent to approximately 300 Kansas home-based therapists on February 10, 2010 and received a 30% response rate. The handbook contains the following content areas: "What to Expect from HBFT", "How to Get the Most out of Your Therapy Session", and "Frequently Asked Questions". The handbook also includes a statement of commitment that each member of the family will read and sign. The purpose of this statement is to help clients experience a sense of responsibility for the therapy process, and hopefully increase their participation.

The handbook contains a section for personal stories or testimonials from previous clients who have received therapy. Finally, the handbook incorporates reflection questions and solution-focused therapy quotes throughout the various sections.

The response from the therapists regarding the handbook has been predominantly positive. One therapist stated, "It would make family therapy in homes more consistent among the agencies in explaining to families what will happen, how it works, and what to expect." Another therapist commented, "I like this idea as I have not seen this done before and it is needed with as much home-based work clinicians do."

A main objective for developing this handbook is to support therapists as they work with clients. Therefore, their input and feedback was an essential component. Their responses from the survey make up the entire handbook. The back cover of the handbook contains a link to a survey that both the clients and therapists can access. This survey will ask for comments and suggestions about the handbook so it can continue to be improved. The complete handbook is attached to the final report. The handbook is in it's print format therefore, the pages will appear to be out of order. However, when printed and folded, the handbook is in correct format.

Plans for the FY 11: The HBFT partnership will provide two Core Trainings sponsored by SRS and two Core Trainings sponsored by KHS. The KHS trainings will be held in Kansas City and Hutchinson. We continue to focus on strengthening the partnership with the SRS, CMHC Clinical Directors, CBS Directors, supervisors, clinicians, KHS and the private contractors. The website is one system used to strengthen these relationships. We believe the CD Learning Companions will be another way of strengthening the partnership. CD's will be distributed to all the CMHC's through the Clinical Directors' and CBS Directors' meetings this year. CDs will also be available at the Core Trainings and upon request. At each Core Training, participants will receive a copy of all available CD's, the handbook, resource guide and newsletters. We are planning a focus group of local clinicians and KSU interns to obtain feedback on our first two CD learning companions. This information will contribute to the development of future CD Learning Companions.

HBFT is sensitive to the budget cuts the CMHC's are experiencing and intend to be available and responsive to innovative training ideas for the centers. We are considering a pilot project involving several centers working with the directors to determine innovative ways to support therapists in light of the recent budget cuts.

Nancy T. O'Conner, M.S., LCMFT
Project Co-Administrator

C.R. Macchi, Ph.D., LCMFT
Project Co-Administrator

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- Dashboard
- Intelligence Beta
- Visitors
- Traffic Sources
- Content
- Goals

Custom Reporting

My Customizations
- Custom Reports
- Advanced Segments
- Intelligence Beta
- Email

Help Resources
- About this Report
- Conversion University
- Common Questions

Export Email Advanced Segments: All Visits

Dashboard

Apr 1, 2010 - Jun 30, 2010

Visits Graph by:

Site Usage

510 Visits

1,308 Pageviews

2.56 Pages/Visit

63.14% Bounce Rate

00:02:42 Avg. Time on Site

35.49% % New Visits

Visitors Overview

234 Visitors

view report

Map Overlay

view report

Traffic Sources Overview

Direct Traffic
500.00 (98.04%)

Search Engines
9.00 (1.76%)

Referring Sites
1.00 (0.20%)

view report

Content Overview

Pages	Pagevie	% Pageviews
/welcome.php	659	50.38%
/~hbft/learning.html	84	6.42%
/contact.html	53	4.05%
/~hbft/learning-bodyFrame.	43	3.29%
/~hbft/welcome.php	30	2.29%

view report

FY 2010 – HBFT Core Training Post Evaluation Comments: Wichita, Manhattan, & Pittsburg

11. What resources do you need to further support your home-based work?

- As an independent therapist any collaborative resources would be appreciated
- Live examples (video)
- On-going training
- Specific strategies for dealing with clients that become extremely upset/violent while in the home setting
- Maybe an example checklist to help with safety form those who have done this for a while
- More training (advanced)
- More clinical training
- Different ideas on how to do therapy/ things that work
- Case examples and interventions are always helpful
- Tips and techniques to handle paperwork
- Community partners
- Training – web materials will be helpful
- Evidence based practice research – feedback from colleagues
- More interventions
- More interventions and strategies on how to do HBFT differing from office based therapy
- Reading materials
- Presentations
- Specific interventions tailored for the family as opposed to individuals
- More supervision times
- Access to free online CEUs
- Continue to use resources from partnership, love the CD idea for CEUs
- Books, website
- A variety of interventions and strategies
- Knowing when to terminate
- None, very complete
- Strategies to engage entire family including young children/interactive activities
- Specific tools/activities to bring to HBFT families
- Ways to let parents discover their self-defeating behaviors
- On-going updated information and ideas
- On-going contact will be helpful
- Continued collaboration & partnerships, rationings and supervisions
- I will look at the website

- Information about techniques to incorporate very young children and their unique needs into HB work
- Sample treatment plans
- Play therapy
- More ideas for creative ways to engage families
- More therapeutic techniques

- The CD's and discussion board are new to me and interested to see how I can use it for support
- Would like to hear about various activities and supplies for in-home therapy
- The resource I will use a lot is the website and its content
- Contracting with education and professional support
- Examples of assessment tools
- Examples of treatment plans
- Regular availability of literature/materials regarding new techniques
- Therapeutic techniques with foster children not likely to be reintegrated with their family
- Maybe more examples of therapeutic strategies to involve families and get them on task
- Ideas from colleagues are always helpful
- Managing mandated reporting vs. messy house
- More support and resources, or assistance with resources/tools/items that can be used in sessions from the agency I work with
- Resources to work with a large age range in the home and all be involved
- Time! Time to prepare for sessions – time to attend trainings – time to read books, articles, etc.

12. What additional resources could we provide to support your ***self-care***?

- I would have like some experiential activities
- Access to information. More training/skills of taking care of self.
- Spend more time on this topic during training opportunities
- Increase resources – creative ideas for self-care
- More local trainings
- I am looking forward to accessing your online journal articles on treatment modalities
- A list of self-care helpers (massage therapists, spas, recreational parks) in various MHC areas
- Discussion of more ideas of how to make time for yourself in the day; setting hours (not working all evenings/weekends, etc)
- I have always done well with self-care and utilize my recreation and free time to the fullest extent

- At this point in my practice, I need to work on my own self-care skills – including creating resources that are beneficial to me
- Continued updates in the field
- Stress ball
- Additional trainings to increase HBFT techniques
- Resources on self-care
- Information given was thorough
- On-going training, education @ low cost
- ProQOL is a good resource
- Articles and studies
- Discounts or partial reimbursements or coupons for mental health clinicians at self-care facilities (ie – massage therapists)
- Any other good self-care manuals/books
- Vacation funds!
- Great job – thank you for all areas you are addressing in self-care!
- Organization of providers
- The ProQOL is a good tool and I hope to continue to use it to "check myself"
- I really like the MP3 audio training

- Links to services provided by therapists who work with therapists! (therapy for therapists)
- How do I get support from family & friends while maintaining client confidentiality
- Spa treatments!
- Articles and functions to see other professionals
- Has staff made any suggestions on what supervisors can do to support in self-care?
- You all did great
- Retreat!
- A listing of independent providers for referrals
- A brief training on self care
- Burnout training
- Wellness programs
- Encouragement to therapists to take time off, attend trainings, retreats, etc.

13. What additional resources could we provide to support your **use of supervision**?

- Resources for finding outside supervision/support if not available at your agency
- On-going brochures, reading materials
- More strategies for creating a relationship with your clinical supervisor if they are also the person who does your administrative supervision as well

- My frustration is that my agency does not provide adequate supervision. The agency utilizes supervision to remind you of what you need to do to increase billable time. There is no worker/clinical support or growth (DCCCA)
- I will use the HBFT in my private practice, so w ill not have a supervisor. Is there such a thing as a free non agency "supervisor"? (James Sommer)
- Provide training to my agency. I don't feel that I get the time/one on one attention that I need
- Further process on different types/degrees of supervision
- Additional supervision focusing exclusively on HBFT
- Specific trainings on providing supervision to supervisees
- Don't know, have a well established connection with colleagues in the field for peer review when needed
- Ideas on how to conduct supervision in a manner that benefits me as a therapist
- I don't use supervision but I do talk with colleagues/peers
- Importance of supervision to supervisors
- How to best prepare ourselves as a clinician before going into meaningful supervision sessions
- Information and education
- Concrete checklist or format for additions to the supervision routine
- Helpful information on ways to get the most out of scheduled supervisions
- Notification of trainings
- Group self-care activities
- Questionnaires, etc to provide discussion starter points

- A resource list of people state wide with experience and willingness to provide supervision
- I have a MSW and looking for clinical supervisor for LSCSW outside of agency
- How to use my agency supervisor and how to use clinical supervisor
- "Supervision tool" that helps provide a supervision experience that includes evaluating self-care, personal biases & how they relate to working with particular clients
- Resources for supervisors to know what to ask during supervision
- LCPS's available in my area
- Providing information to them that explains that assessments should be completed before they are assigned to do therapy – not forcing therapy on the family
- Ways to not reschedule supervision

Additional Comments

- Would appreciate a list of other independent therapists for networking
- I greatly enjoyed the training

- The whole training was good and needed for the KHS certification, which our agency is just beginning this process
- Due to trends with insurance/company/agency demands the productivity requirements and time for self care and supervision meetings decline. Reimbursement rate increase would help, broadened practices would assist
- Very good! Really enjoyed and look forward to our partnership
- I am always looking for new topics to create CEU lessons on
- Open to new therapeutic approaches
- Very interested in teaching opportunities (Phelicia Livingston)
- Always seeking partnership and other colleagues
- Great job and passion expressed – thank you!
- Overall great job! I really enjoyed this! Great learning experience!
- General suggestions – provide parking instructions in email, larger print on handouts and slides. Thanks!
- Great job!
- Have videoconferences more often or have them as modules. Once a year is not available enough
- I enjoyed learning about how different perspectives can skew the process and how each therapist adds a little bit more to the client case
- Please do your best to block/redirect those participants that monopolize the discussions
- As a program director, guiding my staff to your resources will be very helpful in my supporting them. Thank you!
- Larger print on the PowerPoint presentation and handouts for us "old people"
- Both presenters' energy and enthusiasm added so much to the workshop. It was very obvious how passionate both presenters are in the HBFT are. Their "sense of self" added to the presentation.
- Although there were opportunities to network through the BafaBafa exercise, and opportunity to introduce ourselves to the whole group would be a way to identify supports and contacts of people who do work in the same area we work.
- Thank you! Great training! Feels good to share experiences and information with fellow therapists coming from various agencies
- The continued emails will be a nice reminder of these things
- Thanks for your support of the clinicians
- The pictures and examples shown on the overhead were too small to see. It might be helpful to blow the pictures up/make them bigger
- It was tough to read the slides
- To promote discussion avoid allowing 1 or 2 people to dominate
- More small group discussion

- Very interesting and good ideas to apply to future sessions

- This is my first training with HBFT Partnership. The ongoing support concept and numerous resources are a new idea for me and I look forward to utilizing these resources – Lindsay Mills
- The slides that were so small print – had hard time reading them. Would be helpful if they could be emailed and we could access them
- This is the best training I have been to in a very long time. The information was presented in a manner that was informational and engaging
- This was one of the best trainings I have ever attended. Where is US Toys?
- "This training was great, but it wasn't new info to me, as I have been doing in-home for 12 years, have previously done MST training and another home based training – and I tried to convey that prior to coming today. But the presenters did a great job and presented the material very effectively. So, it was a good review." – Jerald Payne
- More time to talk to others/network about what works for them when doing HBFT
- Good training! I think a training for our supervisors is a GREAT idea!

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Please visit HBFTPartnership.com to access a link to a survey about this handbook.

Your feedback is very important and greatly appreciated!

This handbook was created by Emily Hatch, a Family Studies and Human Services major at K-State, as an internship project. Emily is currently a graduate student at Friends University studying Marriage and Family Therapy.

Kansas State University

Spring 2010

Your Guide to Home-Based Family Therapy

What to Expect from Your Experience with Home-Based Family Therapy

2010 © HBFT Partnership

This handbook was created through the support of a contract with the Kansas Department of Social Rehabilitation Services, Division of Disability and Mental Health Services.

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PLEASE USE THE FOLLOWING PAGES TO WRITE DOWN ANY THOUGHTS, QUESTIONS, OBSERVATIONS, OR TOPICS OF DISCUSSION FOR YOUR NEXT THERAPY SESSION.

The Home-Based Family Therapy Handbook

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"Healing may not be so much about getting better as about letting go of everything that isn't you - all of the expectations, all of the beliefs - and becoming who you are."
- Rachel Naomi Remen

What to Expect from HBFT

Home-Based Family Therapy (HBFT) is a process used in homes to help families function at their best. Family therapists are caring professionals who enjoy working with families. Here are the steps used in HBFT:

Referral– Therapists may receive referrals for therapy from family members, doctors, judges, psychiatrists, etc. Once a referral is made, the therapist will contact the family to set up an initial session. It is important to schedule a time that all family members can attend and will fit into the family schedule for the long-term.

Initial Session– This is the first time the therapist and family meet. This session will be used to fill out intake paperwork and get a better idea of what the family feels the problem is. The therapist will suggest what forms of therapy they think will benefit the family, for example, couples therapy for the parents or play therapy with the children.

> "You don't choose your family. They are God's gift to you, as you are to them."
>
> -Desmond Tutu

REFLECTIONS

- How would I describe my relationship with my family therapist?
- How have I helped my family reach our treatment goals?

6. Don't Fix the Blame, Fix the Problem

Trying to figure out whose fault it was rarely solves the problem.

7. Always Go for Win-Win

No one wants to be a "loser". Work towards a solution where everyone wins.

8. Never Threaten– Physically or Emotionally

Once a threat is made, it cannot be taken back. Threatening "I'm leaving" is emotional blackmail.

9. Don't Bring Up Issues Before Bed

Do not try to resolve large, difficult issues right before bedtime. Issues seem worse when people are tired.

10. Don't Involve Others

Involving others causes the fight to grow. They are usually not told when the issue is resolved so they still have a negative impression of the situation.

Rules for Fighting Fair

1. Choose Your Battles
Before beginning an argument, decide what you are *really* fighting about and if it is worth fighting for.

2. Speak Quietly And Respectfully
Most people react negatively and defensively when they feel attacked.

3. Choose Your Words Carefully
Think before you speak, especially if you are angry or upset. Words can hurt deeply and are usually remembered forever.

4. Don't Bring Up the Past
EVERYONE has an imperfect past and NO ONE can change their past. Dwelling on the past prevents you and your family from moving forward.

5. Allow for Time-Outs
It is important to take a break and calm down if frustrations are high. Remember to come back together to finish the discussion. Do not leave it unresolved.

> "The only rock I know that stays steady, the only institution I know that works is the family."
>
> -Lee Iacocca

REFLECTIONS

- How do I feel about Family Therapy?
- What worries or fears do I have about Family Therapy?
- What do I want my therapist to know about me?

Beginning Sessions– The purpose of these first few sessions is to become comfortable with the therapist in the family home. Therapists are guests in the home and respect the family's private space. They are there to observe and help, not to judge the appearance of the family's home.

Treatment Phase– Once the family and therapist are comfortable with each other, they work together to establish goals for the family and discuss the treatment plan. These sessions are also known as the working phase because it is when the therapy and family work take place.

Termination– Once the therapist and parents feel that progress has been made and treatment goals have been met, they can discuss ending therapy, or termination. Therapists will discuss how to continue the work the family is doing once therapy has ended. The time it takes to reach termination varies for each family.

Provided by Amanda Mazouch,
M.S. in Marriage and Family Therapy

How to Get the Most Out of Your HBFT Experience

Build a therapeutic relationship with your family therapist

Help make goals for the family

Have all members of the family present

Turn off TVs and phones!

Be Honest–
your therapist is there to help you, not judge you.

Ask Questions

Practice the skills you have learned

Have everyone fed before the session begins

Keep a journal and complete the homework assignments your therapist gives you!

- Create a safe environment by not using threats, weapons, or violence
- Be open-minded and open to change
- Plan ahead with my family before each session

I have read these guidelines and agree to follow them to the best of my ability.

_____

_____

_____

_____

_____

_____

_____

"Other things may change us, but we start and end with the family."
-Anthony Brandt

"Change is inevitable, growth is optional"
-Anonymous

LETTER OF COMMITMENT

I promise to:

- Be honest with my therapist and myself
- Participate fully in the therapy process
- Understand that this process will not work unless I am fully committed
- Ask questions when I do not understand
- Remove anything that will distract me during sessions
- Be positive even when I feel frustrated
- Help set family goals
- Attend all of the family therapy sessions
- Complete the homework assignments given to me by my therapist
- Respect others even when I do not agree with them

"In every conceivable manner, the family is link to our past, bridge to our future."
-Alex Haley

Do not allow guests or visitors during your family session

Plan Ahead with your family before your next therapy session–
Do you have questions for next time?
What things do you want to discuss?

Make your "Therapy Room" in your house comfortable.

Everyone needs to participate

Be open to change!

REFLECTIONS

- What have I learned so far in family therapy?
- What changes have I noticed in myself?
- What do I need to remember to talk to my therapist about in our next session?

Frequently Asked Questions

How long is this going to take?

This depends on how long it takes to reach the goals the family has established with the therapist and how much effort is put into the process. The more participation there is, the faster it goes!

Will my therapist talk to other people about what I say?

Your session with your therapist is confidential. However, they are required to report if someone intends to hurt themselves or another person. They must also report any abuse that has not been previously revealed. Your therapist will go over the confidentiality guidelines with you.

Can the therapist fix my child/family?

Families are not broken and therefore do not need to be "fixed". The therapist is there to provide information and tools to help the family function more effectively.

Why does the whole family need to be here?

A family works together as a team, and what happens to one person affects the rest of the family. It is important that the entire family is there for all of the therapy sessions so that everyone is on the same page and moving in the right direction.

REFLECTIONS

- What progress have I seen in myself?
- What things do I still need to work on?
- How would I describe my home-based family therapy experience?

Why is the therapist coming to my house?

The best way for the therapist to help a family is to work in the environment where the issues are happening. In-home family therapy gives you privacy and convenience during treatment!

How is my therapist related to the child welfare system?

Your home-based family therapist is not related to the child welfare system and their purpose is not to take children away from their homes. This is an opportunity to learn more about your family, parenting practices, and what would help your family move past the struggles you are currently having.

Does my house have to be clean?

Your therapist is there for *you*, not to judge your home. However, it will make the therapy process go smoother if the designated "therapy room" is safe, comfortable and quiet. Do not have any weapons in the room and turn off any distractions such as cell phones and TVs.

Contact Information

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Partnership is Key

The Home-Based Family Therapy (HBFT) Partnership was launched by Social and Rehabilitative Services (SRS) of Kansas and the Family Center at Kansas State University (KSU) in 2005 to promote best practices for home-based family therapy.

HBFT also partners with Association of Community Mental Health Centers of Kansas, Inc. (ACMHCK) and Kansas Health Solutions (KHS).

Partnering is key to HBFT.

Home-Based Family Therapy Partnership

Kansas State University

2010-2011 Resource Guide

HBFTPartnership.com
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2010-2011 HBFT Resource Guide

www.HBFTPartnership.com

Core Training (6 CEUs)

The beginning of our journey to bridge the gap between office and home-based work.

Core Training is a key event in the HBFT partnership, identifying aspects of home-based family therapy that are distinct from traditional, in-office therapy.

Large and small group experiential exercises provide participants with the opportunity to interact with one another through sharing experiences, resources and ideas.

The result is a network of providers from across the state in various agency settings and from various theoretical perspectives engaged in a rich learning environment **Attendance is only required at one core training.**

Visit the **Discussion Board** and contribute to clinician challenges, or comment on other clinician's discussions through the website.

Online Learning (2 CEUs)

Interactive modules will offer wisdom on topics that include:

Evaluating Models of Cultural Competence

Integrating Play Therapy in the Home

Understanding and Working with Stepfamilies
CD available

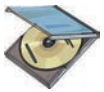
Families and Domestic Violence
CD available

Challenges to Therapist Self-Care
CD available

Balancing Professional and Personal Lives

Utilizing Supervision

Now Available!
CD Companions on Therapist Self-Care, Working with Stepfamilies, & Families and Domestic Violence



The CD Learning Companion is complementary to online learning. HBFT clinicians can listen to a CD in their car and apply those skills when they arrive at client families' homes. Pre and post tests allow clinicians to earn CEUs (2).

Ask your agency Director or contact HBFT for more information on obtaining your CD.

Videoconference (3 CEUs)

Encourage sharing between clinicians from all over Kansas.

Videoconferences are offered at 8 sites throughout Kansas: Colby, Dodge City, Hays, Manhattan, Overland Park, Pittsburg, Salina & Wichita.

DSM videoconferences include two 3-hour sessions. Part 1 is on diagnostic criteria of a DSM disorder; Part 2 focuses on home-based therapeutic adaptations.

Ethics videoconferences address the unique ethical challenges involved in home-based family therapy.

Find downloadable articles, book references, supervision forms, and links in the **Resources Area** on the website.

HOME-BASED FAMILY THERAPY PARTNERSHIP
FY2011: Final Report
July 15, 2011

This report summarizes our work as trainers and supervisors at the KSU Family Center during the FY2011 contract year. As stated in the initial report for FY2011 the focus was on ***networking, networking, networking***! We are continuing to distribute *Learning Companions* (formerly referred to as *CD Learning Companions* since the MP3 format is also available online) to clinicians throughout the state and we have developed a functioning network of social media. We have attended the CBS Directors and Clinical Directors meetings to discuss the resources available through the HBFT Partnership and distribute updated brochures, newsletters, *Learning Companions*, and *Group Training Kits*. During our meetings with the CMHC Directors we have experienced a positive response to our efforts to meet the needs of clinicians in an economically conscientious way.

Contract Objectives

General objectives of the contract can be described as the following:

1. Participants will learn how to operate within a flexible treatment framework that shapes and changes the treatment process based on client families' perceptions of both how change should occur in their family and the nature of the therapeutic relationship.
2. Participants will be able to consider the multiple domains impacting the client and collaborating with these systems to enhance the therapeutic relationship.
3. Participants will work with project personnel to develop a best practices model for home-based family therapy, as well as to identify the core competencies needed to successfully perform this type of therapy.

Description of Contract Components

1. **Core Training:** Provide Home Based Family Therapy Core Training to Medicaid service providers. Training will provide education on the family-driven approach to working with families in their homes, the many challenges of working in the family home, use of evidence-based principles to meet the needs of families and prevent out-of-home placements, and on self-care and supervision.

   1.1. Two Core trainings were provided through this contract. In addition (through the KHS contract), two regional trainings were held on October 5, 2010 in Hutchinson, KS and on April 12, 2011 in Kansas City, KS. **COMPLETED**

   Outcomes:

   - October 5, 2010 Training: 22 clinicians registered for the training and 20 attended.
   - November 16, 2010 Training: 24 clinicians registered for the event and 22 attended.
   - April 12, 2011 Training: 32 clinicians registered for and attended the training.
   - May 10, 2011 Training: 31 clinicians were registered for and attended the event.

Summary of Core Training Evaluations:
An initial survey administered prior to the events requested participant evaluations of their perceptions of their HBFT work, level of experience and past training for providing HBFT, use of self-care and supervision to support their work, expectations for the training, a description of a current stuck case, and responses to the 30-item Professional Quality of Life (ProQOL-IV) measure. During the trainings, we use this information to address specific participants' questions, concerns, and requests. Participants are also encouraged to review two table displays presenting information about the partnership and demonstrating ways a clinician can access resources needed to bring play therapy into the home.

The evaluations of the training content, integration of theory and practice, and program delivery continue to be high. On a scale of 1-5 each trainings received primarily 4's and 5's in the areas of dissemination of information as well as the content of the trainings. There continues to be a strong emphasis on networking and resource development.

2. **Videoconferences:** Provide videoconferences to educate and train providers of Medicaid funded services for children with Severe Emotional Disturbance (SED). Topics for Videoconferences will be diagnosis and assessment using the DSM and Ethics. Project personnel will hold two (2) interactive videoconferences with participating therapists, using the Kansas Regents Educational Communication Center, located in Dole Hall on the KSU Campus. Therapists will be able to participate through eight possible sites located across the state.

2.1. Diagnosis and Assessment Videoconference**:** **COMPLETED**

*Outcome*s: On February 11, 2011 and March 11, 2011 the DSM videoconferences were held. The DSM videoconferences are broken up into two parts of three hours each. The topic for this DSM videoconference was ***Juvenile Bipolar Disorder***. Part 1 covered assessment and diagnosis and Part 2 covered treatment and in-home therapeutic considerations of this disorder. There were 33 registered attendees at Part 1 and 29 registered attendees at Part 2.

The learning objectives for Part 1 were the following:

- Review the prevalence of Bipolar Disorder (BPD) and, more specifically, Juvenile Bipolar Disorder (JBP)
- Explore the diagnostic criteria and assessments of the varying presentations of Bipolar Disorder (BPD) in children and adolescents
- Discuss differential diagnosis and most common co-morbid disorders in children and adolescents
- Examine the controversies associated with a diagnosis of BPD in children and adolescents
- Review an alternative diagnosis of Temper Dysregulation Disorder with Dysphoria (TDD) proposed for inclusion in the DSM-V
- Discuss a case scenario and an assessment and diagnosis of an 8 year old girl

The learning objectives for Part 2 were the following:

- Review the factors associated with an effective assessment and diagnosis of JBD

- Explore evidence-based treatments that address JBD
- Examine the role of monitoring to raise individual and family awareness and skills for improving treatment effectiveness
- Discuss a case scenario involving treatment implications for a 12 year old girl with JBD

Summary of Videoconference Evaluations:

- A survey requested participant evaluations of videoconference content, integration of theory and practice, and program delivery. This videoconference series, by far, was the best attended of all the videoconferences provided to date. The overall evaluation of the videoconference was positive and many attendees commented that the information was helpful and relevant to their current clinical work.

2.2. Ethics Videoconference**:** **COMPLETED**

Project personnel will hold a 3-hour videoconference on ethical issues related to home-based work. The Kansas Regents Educational Communication Center located in Dole Hall on the KSU campus will again be used for this work and therapists will be able to participate through eight possible sites located across the state.

Outcomes: The Ethics Videoconference titled, ***Ethical Issues Associated with Working with Domestic Violence in the Home*** was held on October 29, 2010. There were problems with the distribution of the videoconference notification, therefore, only 8 clinicians participated. This situation has been rectified and there has already been a substantial increase in the response to the upcoming DSM videoconference.

The learning objectives for the videoconference were for practitioners to:

- …review the underlying virtues of ethical codes of practice.
- …learn about the prevalence of domestic violence.
- …learn ethical dimensions of assessing for intimate partner violence.
- …explore the tension between a therapist's duty to protect and client's right to self-determination and autonomy.
- …learn about and apply an ethical decision-making model.

Summary of Videoconference Evaluations:

- A survey requested participant evaluations of videoconference content, integration of theory and practice, and program delivery. Though the responses to the material and the presentation was generally positive, several participants commented on their disappointment that there were so few attendees. Participants reported wanting more specific case scenarios and interventions used by the presenters. We are currently reformatting our videoconference planning process to include these components.

Group Training Kits: This project was not part of the original task orders but added. It grew out of a meeting with the CMHC in Hutchinson when the clinicians asked about availability of in-house group training. We have developed a training kit available to agencies across the state to provide in-house trainings. This product enables a group of clinicians at an agency to gather at work and receive training on a topic previously presented as an HBFT videoconference. The kits are offered for a one-time nominal fee

of $25 and can be used indefinitely. A center that sends 5 people to a videoconference would spend $125 for registration fees plus travel. The additional time away from the office for travel could also incur approximately a 10-hour reduction of billable hours (2 hours per person). A center's use of the *Group Training Kits* minimizes the time and expenses associated with a clinician's absence from the office.

The staff members complete a pretest, watch the DVD, engage in discussions on specific issues identified by the material, and complete a posttest. A designated staff person facilitates the training and verifies the participation of the staff. The staff who complete the process receive 3 CEUs. This is intended to support agencies addressing the current economic struggles while continuing to sponsor staff attendance at continuing education functions. This enables staff to economically obtain ethics and DSM CEUs needed for licensure renewal. The group training format encourages collaboration among practitioners and supervisors at each agency. An agency can train any number of clinicians for the cost of one.

The *Group Training Kits* have been created and distributed to CMHC Clinical Directors and CBS Directors for the two videoconferences offered during this contract year. Additional kits of past videoconferences will be developed and distributed in the coming months.

3. **Online Learning Modules:** KSU project personnel will develop and provide web-based learning modules to educate and train providers of Medicaid funded services for children with Severe Emotional Disturbance (SED).

   3.1. *Learning Companions* to existing Web-based Learning Modules **COMPLETED**

   Two CD/MP3 Learning *Companions* were developed based on two existing online modules.

   Outcomes: The first CD and MP3 of this contract year (fourth overall), ***Integrating Play Therapy into the Home,*** was delivered in January 2011. Approximately 260 *CD Learning Companions* were distributed. CDs are also included in every packet provided to those attending the Core Trainings as well as distributed to agencies as we meet with staff.

   The CD and MP3, ***Utilizing Supervision to Support HBFT,*** has been received and is scheduled to distributed at the next CMHC Directors meetings. A mass email has been sent out to all registered users regarding the availability of this CD and MP3.

   During this contract year there were approximately 1,200 *CD Learning Companions* were distributed. Overall approximately 3,000 *CD Learning Companions* have been distributed to those registered on the website and at each of the CBS Directors and Clinical Directors meetings.

   Evaluations

   - Within-module pre/post surveys measuring participant learning of materials.

- Within-module surveys and threaded discussions and post-module follow-up surveys measuring participant application of materials to clinical cases.
- Survey at the conclusion of the modules requesting participant assessments of module and website functionality.

Administrative Components

HBFT Website

Currently there are 932 persons registered with the HBFTPartnership.com website. This is an increase of 102 users since the start of this contract year on July 1, 2010. Attached is a description of the users from our Google Analytics account that tracks website visits and usage. During this contract year, the website has had 2,729 visitors of which 43.06% were new visitors to the site. Based upon the increased distribution of marketing materials and the availability *Learning Companions*, 98.83% of users are accessing the site directly and increasing their time on the site accessing information through our learning modules and resources section.

Collaborative Partnership Promotion

We developed and distributed three newsletters throughout this contract year. Each newsletter focused on the topic related to new products available through the partnership. The fall newsletter focused on *Play Therapy*, the winter newsletter focused on *Juvenile Bipolar Disorder*, and the summer newsletter *Clinical Supervision* (attached). Each newsletter is distributed electronically to all who are registered with the website (932 users). We are using the newsletters to highlight topics of upcoming events and products and to promote utilization of the available resources.

Special Projects

Social Networking

The spring 2011 undergraduate internship project goal was to develop a functioning network of social media for the HBFT Partnership so program users can have easy, reliable, up-to-date knowledge of the goals of the partnership, upcoming events, and available resources. To achieve this goal, the intern divided goal completion into three phases: research, implementation, and maintenance. The implementation and maintenance phases were completed May 15, 2011.

Reviewing articles, literature, and websites during the research phase allowed for a better foundation of knowledge to move into implementing specific strategies. Finding a way to integrate the knowledge gained from researching social media/networking and the goals of the HBFT partnership was an important part of the research phase.

Overall, social networking and social media are becoming a part of every aspect of life. The immediate need for information in a fast, readable, easy-to-access way is something HBFT needs to catch on to, or get lost in the massive amounts of media. The three social networking sites have been implemented for HBFT are *Facebook*, *LinkedIn*, and *Twitter*. Having a specific purpose for each of our sites will help HBFT achieve its original goals as a partnership, while facilitating easier access to information and resources for therapists, clinical directors, and

other agencies. We are looking forward to seeing how the research and the chosen sites can benefit our partnership as we move into the future. Attached is a report of the project and a description of the purpose for each social networking site.

Evaluation of Task Orders

As agencies in Kansas continue to provide home-based family therapy training, the evaluation process will concentrate on those clinicians participating in the HBFT partnership experience. The trainings offered through this contract emphasize a client-centered approach congruent with the SRS Plan, cultural competency, and the evidenced-based practices of HBFT reflected in the current literature.

The *Core Training*, *Videoconferences*, *Group Training Kits*, *Online Learning Modules, & Learning Companions* each utilize a pre/post evaluation to assess the impact of the material on the therapist conceptualizations of current cases. In addition, we have utilized evidenced-based instructional methods (Gagne, Wager, Golas, & Keller, 2005) in the development of the modules with specific questions evaluating module effectiveness and to assess clinicians' ability to apply the information to their specific experiences. (Creswell, 2003; Dillman, 2000; Patton, 2002). The data generated from each component of the contract will contribute to the development of subsequent components.

We have developed a Logic Model for the HBFT Partnership (attached) to review the work of the overall project as well as to focus our evaluations on the individual components. This model serves as a guide for the partnership as each aspect of the contract is developed and implemented. It also serves as a guide for the completion of the quarterly and final reports submitted to SRS.

Plans for FY 2012

HBFT Supervision

Throughout the past five years of providing training to HBFTs we have engaged in numerous conversations about their work. We have repeatedly received positive comments and expressions of appreciation for the ways that the partnership provides guidance and resources specific to home-based work. We have explored ways that they receive ongoing support through their agencies and, more specifically, through supervision.

Two years ago we conducted an analysis of the data about supervision from those registered with the partnership. At that time, we found no significant connections between supervision and HBFTs experience of stress, comfort and satisfaction associated with their home-based work. In February 2011 we analyzed the data from 230 respondents who addressed supervision and provided responses to the Professional Quality of Life (ProQOL-IV) measure. This measure includes information about three domains: compassion satisfaction, burnout, and compassion fatigue associated with providing therapeutic services. Again, we discovered no significant relationship between supervision and those three domains. Subsequent to the findings of those two studies, we determined that we needed to know more about the type of

supervision the HBFTs receive to determine if certain aspects are more effective and helpful than others.

In February 2011, we began a study examining the available literature on clinical supervision to determine the critical components necessary for effective guidance and support. Despite an extensive review, we were unable to find any literature that specifically addresses clinical supervision of HBFT.

For the past year, during our conversations with Clinical Directors as well as clinicians, we have repeatedly heard that there is a need for increased training and greater support of clinical supervision. At recent meetings with the Clinical and CBS Directors, we discussed the methodological difficulties of determining the direct effects of HBFT training on client care. However, we determined that increased training opportunities for clinical supervisors hold promise for improving client care.

In April, we began designing a survey to explore the clinical supervision offered at the CMHCs and private contractors. We began by interviewing two Clinical Directors to explore possible variables to include in the survey. Once completed, we distributed the survey via email to 946 people including those from the following four types of positions: CMHC Clinical Directors and CBS Directors, clinical supervisors, therapists, and case managers. To-date we have received responses from 198 respondents. The online survey will remain open until early August 2011.

Using conditional branching to provide different questions to each type of respondent, the survey addresses the following issues related to providing home-based work:

- Availability of supervision – types, frequency, purpose
- Current caseloads – number of active cases, frequency of visits, and number of treatment plan review cases
- What are the most common supervision issues related to the unique factors associated with providing HBFT?
- Are there agency policies that present barriers for providing HBFT? If so, please describe.
- Do clinical supervisors experience difficulties addressing HBFT-specific issues? If so, please describe.
- What training needs would best support clinical supervision of HBFT?
- How do clinical supervisors support therapist/case manager self-care?
- Do you experience difficulties addressing HBFT-specific issues with your clinical supervisor? If so, please describe.
- What are your clinical supervision needs that, if addressed, would better support and improve your home-based work?
- Frequency of engaging in 16 specific clinical supervision activities (e.g., reflecting on the current state of the supervisory relationship, discussing the use of self in therapeutic process, reviewing case notes and reports)

- ProQOL-IV (30 questions related to compassion satisfaction, burnout, compassion fatigue)

In the coming months, we will be developing a training plan proposal to address the issues, concerns, and objectives addressing clinical supervision of HBFT.

It has been a successful contract year and we are looking forward to the submitting a proposal in response to SRS's upcoming RFP for next year. We have developed a HBFT Resource Binder as a reference for clinical directors that includes all of the products and trainings that have been developed since the initial contract in 2006. Copies will be distributed to SRS with our proposal.

Nancy T. O'Conner, M.S., LCMFT
Contract Co-Administrator

C.R. Macchi, Ph.D., LCMFT
Contract Co-Administrator

HOME-BASED FAMILY THERAPY PARTNERSHIP
FY2011: 4th Quarter Extension Report
July 20, 2012

This report summarizes our work as trainers and supervisors at the KSU Family Center during the fourth quarter extension of the FY2011 contract year. The focus of our work during this extension is ***creative flexibility***! Recognizing the fluid nature of state mental health policies and programming, we have focused on continuing to provide agencies and clinicians with the resources and services necessary for minimizing any disruptions associated with those changes. We are continuing to distribute *CD Learning Companions* to clinicians throughout the state. We continue to communicate with the Clinical Directors to discuss the resources available through the HBFT Partnership.

HBFT Website

Currently there are 1,133 persons registered with the HBFTPartnership.com website. This is an increase of 60 users since the start of this contract extension on January 1, 2012. Attached is a description of the users from our Google Analytics account that tracks website visits and usage. During this quarter, the website has had 360 unique visitors of which 51.65% were new visitors to the site. Based upon an average of just over 3:03 minutes on the site, it appears that most visitors are using the site to access information and register for events.

Core Training

One training was presented this quarter on May 16, 2012 in Hutchinson, KS (see attached evaluation summary). Participant evaluations of the presentation deliver, subject matter, responsiveness to participants' questions, and materials remain high at an average of 4.6 on a 5.0 scale. Overall, 86% of participants indicated that they either *Agree* or *Strongly Agree* that the Core Training was accessible and helpful to them.

Modules

The web-based modules task has been replaced with the *Learning Companions*, however, we continue to research topics for future web-based modules. We have completed research and development of a new module titled, *Families and Financial Stress* that has been posted to our website as an additional resources for the users.

Learning Companions (CDs and MP3s)

Additional CDs and MP3s are available to those logging onto that module or to the Resources section of the website. Overall 1,700 *CD Learning Companions* have been distributed to those registered on the website and mental health agencies in general.

Videoconference

We offered a videoconference titled, *Reactive Attachment Disorder (Part II): Treatment Goals and Interventions*, on April 20, 2012. Thirteen participants joined the videoconference from the following sites: Colby, Manhattan, Overland Park, Pittsburg, Salina and Wichita. Evaluations of the presenters and the presentation reflected were mostly rated as satisfied or extremely

satisfied.

Group Training Kits

We have developed training kits for use within the agencies across the state. This product enables a group of clinicians at an agency to gather at work and receive training on a topic previously presented as an HBFT videoconference. A center's use of the *Group Training Kits* minimizes the time and expenses associated with a clinician's absence from the office and serves as a means to connect staff through shared training time.

The kits are offered for a one-time nominal fee of $25 and can be used indefinitely. A center that sends 5 people to a videoconference would spend $125 for registration fees plus travel. The additional time away from the office for travel could also incur approximately a 10-hour reduction of billable hours (2 hours per person).

The kits are sent to clinical directors who have made a request via email or phone message to the HBFT office. The kits include detailed instructions describing the following process: staff members complete a pretest, watch the DVD or stream an MP4 directly from our website, engage in discussions on specific issues identified by the material, and complete a posttest. A designated staff person facilitates the training and verifies the participation of the staff. The staff who complete the process receive 3.0 CEUs. These kits are intended to support agencies addressing the current economic struggles while continuing to sponsor staff attendance at continuing education functions. The kits also enable staff to minimize costs while obtaining the ethics and DSM CEUs needed for licensure renewal. The group training format encourages collaboration among practitioners and supervisors at each agency. An agency can train any number of clinicians for the cost of one kit.

Special Projects

We have developed a ***HBFT Resource Binder*** that includes information about each of the products the HBFT Partnership has developed since its inception in 2006. The binder has been designed to be a quick reference intended for distribution to all SRS project officers, KHS Project Officers, CMHC Clinical Directors, and private contractor directors. The binder includes detailed descriptions of each product as well as the training materials that were previously distributed for all trainings including: PowerPoints, *CD Learning Companions*, newsletters, and brochures. This resource is intended to increase the awareness of the HBFT Partnership resources on directors' bookshelves while also providing easy access to the available materials for those planning staff trainings and support.

We have conducted a study through online surveys of the registrants of the HBFT Partnership website. We are awaiting a response of a manuscript that we submitted for publication to the *Journal of Marital and Family Therapy* (see attached article below). The abstract states:

> "The present study examined whether home-based family therapists' workloads and clinical experience were associated with therapists' professional quality of life. Hypotheses were tested using structural equation modeling with a sample of 225 home-based therapists. Results suggested that therapists' workloads and clinical experience significantly predicted therapists' professional quality of life.

> These associations between therapists' workloads and clinical experience were partially mediated through participation in self-care and frequency of clinical supervision. Implications for improving therapists' quality of life are discussed as a function of therapists' workloads, clinical experience, self-care, and supervision."

The training implications of this study suggest that we further explore ways to support HBFT therapists' use of a sustained program of self-care and clinical supervision to improve professional quality of life.

FY2013 Contract Proposal

Research from our three studies informed the development of our response to the RFP proposing to offer an advanced training for HBFT clinical supervisors and provide specific guidance for therapist self-care during FY2013.

Nancy T. O'Conner, M.S., LCMFT
Contract Co-Administrator

C.R. Macchi, Ph.D., LCMFT
Contract Co-Administrator

Google Analytics

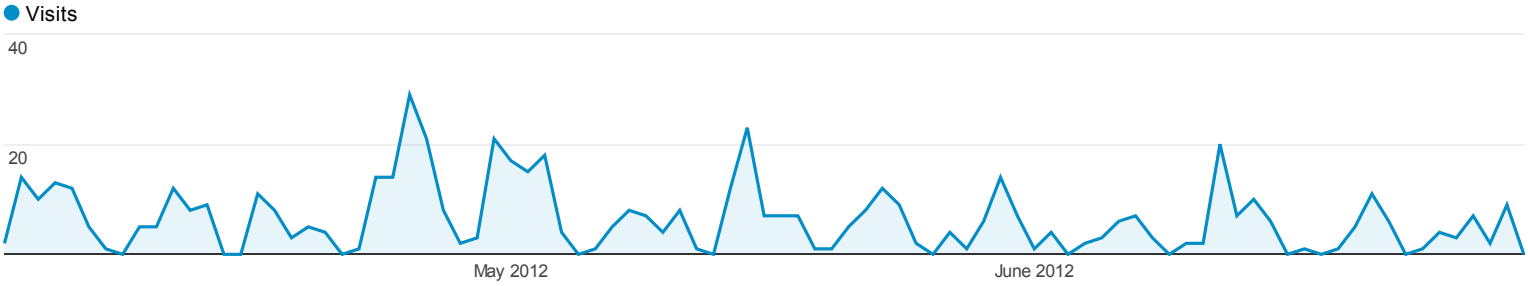
http://www.hbftpartnership.com - htt...
www.hbftpartnership.com [DE...

Visitors Overview

Apr 1, 2012 - Jun 30, 2012

% of visits: 100.00%

Overview



360 people visited this site

Visits: 577

Unique Visitors: 360

Pageviews: 1,924

Pages / Visit: 3.33

Avg. Visit Duration: 00:03:03

Bounce Rate: 47.66%

% New Visits: 51.47%

51.65% New Visitor
298 Visits

48.35% Returning Visitor
279 Visits

	Language	Visits	% Visits
1.	en-us	541	93.76%
2.	en	7	1.21%
3.	zh-tw	4	0.69%
4.	de-de	3	0.52%
5.	es	3	0.52%
6.	fr	3	0.52%
7.	ar	2	0.35%
8.	en-gb	2	0.35%
9.	ja	2	0.35%
10.	ko	2	0.35%

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Home-Based Family Therapy Training
Kansas State University
Nancy T. O'Conner, MS, LCMFT
C.R. Macchi, PhD, LCMFT

CORE TRAINING

Today's Date: May 16, 2012 Training Location: Hutchinson, KS

Average scores for each trainer

1=Low satisfaction and 5=High satisfaction		
	Nancy O'Conner	C.R. Macchi
Effectiveness of delivery	4.5	4.6
Knowledge of the subject matter	4.7	4.7
Responsiveness to participants	4.6	4.6
Organization of material	4.7	4.7

What resources do you need to further support your home-based work?

- How to establish a strong therapeutic relationship as opposed to a friendship
- More supervision
- Interventions that I can pull out of what is in the home
- More intervention ideas
- Collaborative case conceptualization
- Handouts, work sheets and games to use with clients
- More real-life experiences by the presenters
- More specific techniques and strategies to work with families in the home
- Online resources and websites to refer to
- How to engage clients who are resistant to services
- Therapeutic play with all ages of clients
- Refresher courses

What additional resources could we provide to support your *self-care*?

- Recommend readings and articles
- Ways to record thoughts and feelings other than traditional journaling
- Excited for the web-based application
- Provide short trainings on specific self-care activities and relaxation techniques
- Provide current and new ways therapists can support themselves through self-care
- Provide ways to balance my schedule
- Where/who is appropriate to seek out for personal therapy (especially in a small town)

What additional resources could we provide to support your *use of supervision*?

- Supervision forms that address self-care too
- More research and literature would be interesting and helpful
- More focused supervision (my supervisor is a stay at home mom with children)
- Checklist/guidelines for supervision
- A handout to utilize in supervision to cover all you mentioned
- Supervision handbook to share with supervisor
- Ways to encourage better supervision to supervisor in a non-attacking way
- Specific topics to discuss or activities that may help initiate communications during supervision
- Easy ways to track post-therapy sessions to facilitate bringing them up in supervision session

PLEASE PROVIDE ANY ADDITIONAL COMMENTS THAT WILL HELP US TO PARTNER WITH YOU AND SUPPORT YOUR WORK:

- More activities, less lecture
- I didn't feel like there was any new material presented
- Liked the idea of stress tracker and thinking about your thoughts/values affect your work with families
- I would be interested in hearing more ideas on therapeutic strategies and techniques
- Would like information on domestic violence
- Recommend books of activities to use with families that don't require much financial strain
- The room was too cold – difficult to maintain focus
- Please be more clear about the start and end time of the training – please show respect for our time
- Location difficult to find – sign outside would have been helpful
- Difficult to hear presenters at times
- Love the new self-care focus

Demographics
79% of participants completed our pre-survey; among those who completed the survey:

-38.2% indicated social worker as their primary license
-11.8% indicated marriage and family therapist as their primary license
-17.7% indicated psychologist as their primary license
-23.5% indicated counselor as their primary license
-11.8% indicated other as their primary license

Overall, 86% of participants indicated that they either *Agree* or *Strongly Agree* that the Core Training was accessible and helpful to them.

Summary of RAD Part 2 Videoconference Survey (April 20, 2012)

13 out of 13 participants responded. Here is a summary of the questions asked.

Did the videoconference meet your expectations? Yes or No
100% Yes
Comments:
- It clarified questions I had about RAD and over-diagnosing. Treatment information was very helpful.
- The topic is such a complicated and controversial one, but the facilitators did a great job of discussing/addressing the issues
- Often there was too much commenting from the same person in the main group with C.R.
- I was very pleased with the conversations and comments which resulted from the videoconference.
- Good discussion about the topic
- The direct links to Zeanah's articles were very helpful to me.

What did you like about this training?
- Liked the information regarding therapies being used.
- It was very informative.
- I liked that they were upfront about there not being any empirically-validated assessments or treatments, but discussed possibly resources.
- The atmosphere was very relaxed. It was helpful to hear suggestions and comments from those who have worked closely with RAD children.
- The open discussion.
- Very well organized
- Hearing from other practitioners and then hearing the research material from the academics.
- cost interaction across the state location
- Opportunity to discuss.
- Like the handout and how I will be able to refer back to this in my practice.
- To learn more about what others feel about the research that has been done in relation to this topic.
- I especially liked the topic because the majority of my work is with children and do have a few clients diagnosed with RAD. I also liked the feedback and examples from other people attending the videoconference.
- 20 miles from my home. 1/2 day is nice.

What would you like to see improved?
- When registering for the conference after you register I would like a confirmation page right then to tell me that the registration went through and may on that page have again when and where the conference is and also where payment needs to be sent so you have something to print for your records or your agencies records.
- I can think on nothing other than starting session after five minutes of waiting for participants to show up.
- More informed treatment providers presenting rather than a literature search.
- Often there was too much commenting from the same person in the main group with C.R.

- Presentation format that is more engaged between the two co-facilitators.
- The room in the basement is always stuffy/warm The presentation/training-nothing to improve, just continue offering relevant, reasonable cost trainings re: HBFT
- More treatment modalities discussed...
- More sites to have the conference or even online access (convenience), I do like it was available in my city.

How did you hear about the videoconference?

Announcement on HBFTPartnership.com website	2 (15.38%)
Flyer	1 (7.69%)
E-mail	5 (38.46%)
Word of mouth (supervisor or other colleague)	4 (30.77%)
HBFT Newsletter "The Connection"	1 (7.69%)
Other:	1 (7.69%)
N/R	0 (0%)

Please answer the following questions about your registration process.

9.1 I could easily find the online registration form

Strongly disagree	0 (0%)
Disagree	2 (15.38%)
Agree	2 (15.38%)
Strongly agree	9 (69.23%)
N/R	0 (0%)

9.2 I had no trouble using the online registration form

Strongly disagree	0 (0%)
Disagree	4 (30.77%)
Agree	4 (30.77%)
Strongly agree	5 (38.46%)
N/R	0 (0%)

9.3 I received confirmation of my registration in a timely fashion.

Strongly disagree	0 (0%)
Disagree	2 (15.38%)
Agree	5 (38.46%)

Strongly agree	6 (46.15%)
N/R	0 (0%)

9.4 The site location was conveniently located to my office.

Strongly disagree	0 (0%)
Disagree	2 (15.38%)
Agree	1 (7.69%)
Strongly agree	10 (76.92%)
N/R	0 (0%)

9.5 I was provided a sufficient amount of information to find the site location.

Strongly disagree	0 (0%)
Disagree	0 (0%)
Agree	3 (23.08%)
Strongly agree	10 (76.92%)
N/R	0 (0%)

Have you been to a clinical and/or professional videoconference before?

Yes	12 (92.31%)
No	1 (7.69%)
N/R	0 (0%

Please rate C.R. Macchi (Facilitator) on the following:

11.1 Effectiveness of delivery

Extremely Dissatisfed	0 (0%)
Dissatisfied	2 (15.38%)
Satisfied	4 (30.77%)
Extremely Satisfied	7 (53.85%)
N/R	0 (0%)

11.2 Knowledge of subject matter

Extremely Dissatisfed		0 (0%)
Dissatisfied		1 (7.69%)
Satisfied		6 (46.15%)
Extremely Satisfied		6 (46.15%)
N/R		0 (0%)

11.3 Responsiveness to participants' questions

Extremely Dissatisfed		0 (0%)
Dissatisfied		0 (0%)
Satisfied		4 (30.77%)
Extremely Satisfied		9 (69.23%)
N/R		0 (0%)

11.4 Organization of material

Extremely Dissatisfied		0 (0%)
Dissatisfied		0 (0%)
Satisfied		6 (46.15%)
Extremely Satisfied		7 (53.85%)
N/R		0 (0%)

Please rate Jurdene Ingram (student facilitator) on each of the following:

12.1 Effectiveness of delivery

Extremely Dissatisfied		0 (0%)
Dissatisfied		0 (0%)
Satisfied		6 (46.15%)
Extremely Satisfied		7 (53.85%)
N/R		0 (0%)

12.2 Knowledge of the subject matter

Extremely Dissatisfied		0 (0%)
Dissatisfied		0 (0%)
Satisfied		8 (61.54%)
Extremely Satisfied		5 (38.46%)
N/R		0 (0%)

12.3 Responsiveness to participants' questions

Extremely Dissatisfied	0 (0%)
Dissatisfied	0 (0%)
Satisfied	4 (30.77%)
Extremely Satisfied	9 (69.23%)
N/R	0 (0%)

12.4 Organization of material

Extremely Dissatisfed	0 (0%)
Dissatisfied	0 (0%)
Satisfied	4 (30.77%)
Extremely Satisfied	9 (69.23%)
N/R	0 (0%)

Rate your feelings on the following statements:

13.1 The PowerPoint slides helped to facilitate the learning process during the videoconference

Strongly disagree	0 (0%)
Disagree	0 (0%)
Agree	4 (30.77%)
Strongly agree	9 (69.23%)
N/R	0 (0%)

13.2 The PowerPoint handout will be helpful for my clinical work

Strongly disagree	0 (0%)
Disagree	0 (0%)
Agree	6 (46.15%)
Strongly agree	7 (53.85%)
N/R	0 (0%)

13.3 The PowerPoint slides were easy to read

Strongly disagree	0 (0%)
Disagree	0 (0%)
Agree	2 (15.38%)
Strongly agree	11 (84.62%)
N/R	0 (0%)

13.4 The reference list on the HBFTpartnership.com website will be helpful for my clinical work

Strongly disagree	0 (0%)
Disagree	0 (0%)
Agree	5 (38.46%)
Strongly agree	8 (61.54%)
N/R	0 (0%)

Do you plan to attend future videoconferences offered through the HBFT Partnership? Please provide us with topic areas of interest to you that we will consider covering in future videoconferences.

Yes	13 (100%)
No	0 (0%)
N/R	0 (0%)

Predictors and Processes Associated with Home-Based Family Therapists' Professional Quality of Life

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ABSTRACT

The present study examined whether home-based family therapists' (HBFT) workload and clinical experience were associated with therapists' professional quality of life. Hypotheses were tested using structural equation modeling with a sample of 225 home-based therapists. Results suggested that therapists' workload and HBFT experience significantly predicted therapists' professional quality of life. These associations between therapists' workload and HBFT experience were partially mediated through participation in self-care and frequency of clinical supervision. Implications for improving therapists' quality of life are discussed as a function of therapists' workload, clinical experience, self-care, and supervision.

Keywords: home-based family therapy, self-care, supervision, therapists' professional quality of life.

Clinical work can have a negative emotional and psychological impact on therapists. Therapists' interactions with families and exposure to their descriptions of stress and trauma can produce feelings of depression, anxiety, and burnout (Farber & Heifetz, 1982; Rosenberg & Pace, 2006; Sprang, Clark, & Whitt-Woosley, 2007). Thus, it is imperative to understand the factors that can protect against these negative outcomes. Therapists who do not adequately attend to their own self-of-the-therapist concerns are less likely to provide their clients with quality service (Durtschi & McClellan, 2010). Furthermore, theoretical descriptions of home-based therapy have repeatedly suggested that providers engaging in these services face additional demands related to their unique roles and responsibilities (Macchi & O'Conner, 2010).

Maintaining a high professional quality of life is important because it is believed to relate to the quality of service provided to clients. Although a great deal of literature has been written describing home-based family therapy and the impact of this service on therapists (Boyd-Franklin & Bry, 2000; Cortes, 2004; Snyder & McCollum, 1999; Woods, 1988), much of this past work has been theoretical speculation about these processes. We extend previous research on therapists' professional quality of life by quantitatively testing the direct effects from therapists' home-based family therapy (HBFT) experience and perceived workload on their professional quality of life. Second, we examined self-care and frequency of clinical supervision as potential mediators of the association between clinical experience and perceived workload.

Professional Quality of Life

Professional quality of life is defined as "the quality one feels in relation to their work as a helper" (Stamm, 2011) and is comprised of three domains: 1) compassion satisfaction, 2) burnout, and 3) compassion fatigue. Compassion satisfaction reflects the degree to which therapists experience satisfaction and fulfillment from their work and the services they provide.

Burnout is a gradual process of experiencing stress over time that results in therapists' feelings of depletion and dissatisfaction in their work. Compassion fatigue is similar to experiencing symptoms of post-traumatic stress disorder (PTSD) resulting from therapists' exposure to clients with a history of trauma. Several work-related factors have been found to impact the levels of each domain.

Several studies have determined that workload and years of experience have been found to impact the domains of professional quality of life. The effects of clinicians' increased workload can result in a more negative perceived professional quality of life (Deighton, Gurris, & Traue, 2007). Clinicians' increased workload, defined as the number of hours per week with families, results in lower rates of compassion satisfaction and higher rates of compassion fatigue and burnout (Craig & Sprang, 2010; Lawson & Myers, 2011; Sprang et al., 2007). More years of experience has predicted increased compassion satisfaction (Craig & Sprang, 2010), whereas less years of experience has revealed higher levels of compassion fatigue and burnout (Sprang et al., 2007). Thus, clinicians with less experience appear to be at greater risk, compared with more seasoned clinicians. Whereas these other studies have examined several factors affecting the individual domains of professional quality of life separately, our study advances past work by examining the effects on professional quality of life as a unified construct.

Unique Demands Associated with Providing Home-Based Work

Home-based family therapists are especially at risk for burnout due to travel demands, experiencing isolation due to spending long periods away from the office without contact with other professionals, working in unfamiliar communities, and managing caseloads heavily laden with high-risk, multiproblem families (Macchi & O'Conner, 2010). Furthermore, therapeutic progress with multiproblem families is often subtle and slow. Clinicians providing many hours

of home-based services while observing subtle client change may assume that their therapeutic efforts are inconsequential, thus contributing to increased feelings of burnout (Meyers & Cornille, 2002). The stress associated with the high demands of working with complex cases contributes to therapists' risk for distress or impairment. Furthermore, Kagan and Scholsberg (1989) suggest that navigating unfamiliar home environments and surrounding communities and monitoring personal safety may place an additional burden on therapists that can lead to increased levels of stress.

Mediating Effect of Therapist Self-Care

Despite therapists' common assumption that self-care improves professional quality of life, this has been assumed far more than it has been demonstrated. Much of the literature on self-care is no more than speculation, and these assumptions should also be empirically evaluated. Professionals dedicated to helping others in need tend to have high levels of caring, compassion, and empathy and are often willing to put aside their own needs to care for others (Meyer & Ponton, 2006). However, Barnett and colleagues (2005) suggest that "the very nature of our [clinical] work requires us to focus on the needs of others, and we may fall into the trap of overlooking our own needs" (p. 259). The association between perceived workload and professional quality of life, and the association between clinical experience and professional quality of life are proposed to be mediated by the effects of therapist self-care. Several articles opine the need for home-based family therapists to engage in a regular program of self-care to manage work related pressures (Meyer & Ponton, 2006; Woodford, Bordeau, & Alderfer, 2006; Woolston, Berkowitz, Schaefer, & Adnopoz, 1998). Involvement in regular self-care may enable the therapist to be more fully aware of personal needs in relation to the effects that their home-based work has on their professional well-being (Baker, 2003).

Eastwood and Ecklund (2008) examined the relationship between self-care practices and levels of compassion fatigue with a sample of residential treatment center childcare workers. They discovered that positive self-care practices such as engaging in a hobby, reading for pleasure, and taking pleasure trips have a significant effect on reducing the risk for compassion fatigue. Similarly, Lawson and Myers (2011) examined "career sustaining behaviors" reflecting such self-care practices as: spending time with family, maintaining a sense of humor, maintaining balance between professional and personal lives, and maintaining professional identity. They discovered that these behaviors had a significant effect on increasing counselor compassion satisfaction and reducing compassion fatigue and burnout.

Mediating Effect of Clinical Supervision

The association between perceived workload and professional quality of life, and the association between clinical experience and professional quality of life are also proposed to be mediated by the frequency of clinical supervision. Several articles address the instrumental role clinical supervision has on the work of the home-based family therapist (Lawson & Myers, 2011). While these conceptual pieces describe the invaluable role of clinical supervision, there is actually very little empirical support for the potential effects of supervision on professional quality of life. Lawson and Meyers (2011) noted that respondents placed a lower priority on receiving regular supervision than other self-care practices. Despite the lower level of interest in clinical supervision, clinical supervision is widely believed to support and strengthen home-based family therapists. However, prior assumptions on the role of supervision in improving clinicians' professional quality of life have yet to be empirically examined.. This study aims to shed light on the expected positive effects of clinical supervision on professional quality of life.

The Current Study

This paper examines the effects of home-based family therapists' clinical experience and perceived workload on therapists' professional quality of life. Although there is initial evidence to suggest that having a higher workload and being less experienced can result in a lower professional quality of life, the underlying mechanisms for this relationship are not well understood. This study will examine two potential mechanisms: frequency of self-care and supervision. This paper contributes to the literature by providing a more sophisticated data analysis of variables affecting therapists' quality of life, in a relatively large sample of home-based family therapists. Additionally, prior studies have examined each sub-domain of professional quality of life separately, but have yet to examine how workload and experience influence this more complete conceptualization of professional quality of life as a whole.

We make the following hypotheses based upon the results of previous studies examining the relationships among our variables of interest. Our *first hypothesis* suggests that increased workload will be related to lower levels of professional quality of life (Craig & Sprang, 2010; Lawson & Myers, 2011; Sprang et al., 2007). Our *second hypothesis* posits that therapists' increased level of home-based family therapy (HBFT) inexperience will be associated with lower levels of professional quality of life (Craig & Sprang, 2010; Deighton et al., 2007; Sprang et al., 2007). Our *third hypothesis* proposes that therapists' increased use of self-care will mediate the effects of workload and experience on professional quality of life (Eastwood & Ecklund, 2008). Finally, our *fourth hypothesis* is that therapists' increased use of clinical supervision will mediate the effects of workload and in-home clinical experience on professional quality of life (Lawson & Myers, 2011).

METHOD

Sample

The survey was emailed to 831 licensed clinicians who were currently delivering home-based family therapy, representing each of the mental health professions in a Midwestern state (i.e., psychologists, social workers, marriage and family therapists, professional counselors). The current sample is comprised of 225 licensed therapists who responded (27% response rate) to an email inviting respondents to complete an online survey prior to attending a training workshop. Completion of this state-sponsored workshop was required to receive the certification necessary for billing Medicaid reimbursement of home-based family therapy services. Over 85% of the clinicians in the current study were women. Licensed social workers comprised 59% of the sample, 19% were licensed marriage and family therapists, 11% were psychologists, and 10% were counselors. In terms of experience, 47% of the clinicians in this study had less than one year of HBFT experience, 28% had between one and three years of experience, 20% had four to 10 years of HBFT experience, and 5% had more than 10 years of experience. The clinicians reported working in different settings, including: 26% in community mental health centers, 57% with private contractors, and 16% in private practice. On average, the clinicians had 8.96 active HBFT cases (*SD* = 7.60) and 71% had never received any formal training in home-based family therapy.

Measures

Perceived workload. One item was used to measure perceived workload: "How would you describe your workload related to the amount of clients you have?" Response categories ranged from 1 = *underutilized – I could use more work*, 2 = *comfortable – I have enough work, but do not feel overloaded*, 3 = *unsure*, 4 = *slightly overworked – I need a small decrease in my*

workload, 5 = *overwhelmed – I have more work than I can handle*. Higher scores indicated a higher perceived level of workload.

Less HBFT experience. One item asked respondents to indicate the number of years they have been specifically practicing home-based family therapy. Response categories ranged from 5 = *less than one year* to 1 = *more than 10 years*.

Frequency of self-care. One item was used to measure engagement in self-care activities: **"**How often do you engage in activities that you consider as self-care?" Response categories ranged from 1 = *rarely*, 2 = *monthly*, 3 = *weekly*, 4 = *daily*, and 5 = *several times per day*.

Frequency of supervision. One open-ended item was used to measure the frequency of supervision: **"**How many hours of supervision do you receive per week?" Participants wrote in the number of hours of supervision received. Responses ranged from less than 1 to 4 hours per week.

Professional quality of life. The Professional Quality of Life Scale, fourth revision (ProQOL R-IV; Stamm, 2005) was used to measure professional quality of life. The ProQOL R-IV contains the following subscales: 1) compassion satisfaction, 2) burnout, and 3) compassion fatigue. Examples of the items comprising compassion satisfaction included, "I get satisfaction from being able to help people" and "I am pleased with how I am able to keep up with helping techniques and protocols." Sample items from burnout included, "I have beliefs that sustain me" (reversed) and "I feel overwhelmed by the amount of work or size of my caseload I have to deal with." Sample items measuring compassion fatigue/secondary trauma included, "I am preoccupied with more than one person I help" and "I avoid certain activities or situations because they remind me of frightening experiences of the people I help." The items within each subscale were averaged to maintain the original metric of the scale (0 = *never*, 1 = *rarely*, 2 = *a*

few times, 3 = *somewhat often*, 4 = *often*, and 5 = *very often*). This measure has not been subjected to rigorous analyses of its psychometric properties, but is a widely used measure of professional quality of life in over 200 peer reviewed manuscripts (for a complete bibliography, see www.proqol.org). Alpha reliability coefficients for each subscale of the ProQOL in the current study were α = .84 for compassion satisfaction, α = .72 for burnout, and α = .79 for trauma/compassion fatigue. The burnout and trauma/compassion fatigue subscales were reverse coded and a latent variable of professional quality of life was created with these three subscales. Higher scores on the professional quality of life latent construct indicate higher levels of professional quality of life (i.e., lower burnout and trauma/compassion fatigue and higher compassion satisfaction).

Control variables. Therapist gender, professional affiliation, average HBFT caseload, and formal HBFT training were included as control variables in the model. Gender was coded as 1= *female* and 2 = *male.* Professional affiliation was dummy coded, with the referent group being psychologists and counselors, who were collapsed into one category due to a smaller number in those groups. One item assessed the average number of HBFT cases on clinicians' caseload (1 = *0 to 5*, 2 = *6 to 8*, 3 = *9 to 11*, and 4 = *12 or more*). Formal HBFT training was also controlled for (0 = *no*, 1 = *yes*).

Analytic Plan

The proposed model was tested with structural equation modeling, using Mplus 6.0 (Muthén & Muthén, 1998-2011) and maximum likelihood estimation. Full information maximum likelihood estimation (FIML) was used to estimate missing values. Three variables were included as auxiliary variables in the model to explain the missing data: the therapists' stress related to HBFT work, comfort with HBFT work, and satisfaction with HBFT work. To

determine if supervision and self-care mediated the impact of workload and HBFT experience on professional quality of life, a bootstrap analysis of the indirect paths was conducted.

--Table 1 about here—

RESULTS

Table 1 presents the mean scores, standard deviations, and correlations for variables used in this study. Our primary goal was to analyze direct and indirect relationships between our variables of interest: perceived workload, HBFT experience, frequency of self-care, frequency of supervision, and professional quality of life. To compute the degree to which our variables were interrelated, we used a structural equation model to test each of our hypotheses simultaneously in the same model. Figure 1 shows the results of the structural equation model. The direct effects of (a) perceived workload on professional quality of life, and (b) HBFT experience on professional quality of life were tested. Additionally, two mediator variables (i.e., frequency of supervision and self-care activities) were added to this model to account for the underlying mechanism between (a) perceived workload and professional quality of life, and (b) HBFT experience and quality of life. Therapist gender, professional affiliation (marriage and family therapist, social worker, or psychologist), average HBFT caseload, and whether the clinician had received any formal HBFT training were included as control variables in the model. The residuals for the burnout and compassion fatigue indicators of professional quality of life were correlated. Goodness of model fit indices indicated a good fit between the proposed model and the data (Kline, 2010): χ^2 (27) = 32.17, p = .23; comparative fit index (CFI) = .965; Tucker-Lewis index (TLI) = .942; root mean square error of approximation (RMSEA) = .029 (90% CI = <.001, .062); and standardized root mean square residual (SRMR) = .047. In addition, the standardized factor

loadings for the indicators of professional quality of life loaded significantly on the latent construct (range from .53 to .92).

--Figure 1 about here--

Figure 1 contains standardized path coefficients in the model. Higher perceived workload was significantly related to decreased frequency of self-care (β = -.18, p < .05), greater frequency of supervision (β = .07, p < .001), and lower levels of professional quality of life (β = -.45, p < .001). Less HBFT experience was related to more frequent supervision (β = .10, p < .001), and lower levels of professional quality of life (β = -.27, p < .001), but exhibited no association with self-care behaviors. Less HBFT experience and perceived workload also significantly covaried in the model, in that less experience as a home-based family therapist was related to perceiving the workload to be heavier (r = .13, p < .001). Finally, more frequent self-care (β = .30, p < .001) and supervision (β = .22, p < .001) were significantly related to higher levels of professional quality of life. This model accounted for 51% of the variance in professional quality of life.

In order to test whether frequency of self-care and frequency of supervision mediated the influence of perceived workload and less HBFT experience on professional quality of life, bootstrapping analyses were conducted (Preacher & Hayes, 2008). The bootstrapping approach is a relatively novel method for assessing specific indirect or mediating effects, and is capable of testing multiple mediators simultaneously. The basic idea behind bootstrapping procedures, as it would be used to test mediation, is to use resampling techniques (with replacement) to compute numerous subsamples from the original data that can be used to obtain more reliable values for the standard errors of the corresponding mediating pathways (for further details see Preacher & Hayes, 2008).

Each hypothesized mediating effect was tested with a 95% confidence interval, and 2,000 bootstraps. Three significant indirect pathways were found predicting professional quality of life. *First*, a higher perceived workload was related to a higher frequency of supervision, and more supervision was related to a better professional quality of life for the therapist (β = .02, p < .05, CI = .001, .03). Thus, frequency of supervision mediated the relationship between a higher perceived workload and professional quality of life. These results for this indirect pathway can be interpreted as follows: for one standard deviation unit increase in perceived workload, professional quality of life will decrease .05 standard deviation units, via its prior effect on frequency of self-care, while keeping control variables constant. The *second* indirect effect found was that a higher perceived workload was also related to lower self-care, whereas higher self-care was associated with a higher professional quality of life (β = -.05, p < .001, CI = -.06, -.05). In other words, self-care was found to mediate the relationship between perceived workload and professional quality of life. The *third* indirect effect found was that therapists with less HBFT experience was related to having increased frequency of supervision, and that increased supervision was also associated with having a higher professional quality of life (β = .02, p < .001, CI = .01, .03). Thus, supervision frequency mediated the relationship between HBFT experience and professional quality of life.

Finally, two alternative models were tested in addition to our primary model of interest reported above. It is better science to not only test our theoretically driven model, but also test plausible alternative models (Kline, 2011). The first alternative model was constructed so that frequency of self-care and frequency of supervision both predicted perceived workload and HBFT experience and these then both predicted professional quality of life. The second alternative model was constructed so that perceived workload and less HBFT experience both

predicted professional quality of life, and all of these predicted frequency of self-care and frequency of supervision. However, in addition to the models not making as much theoretical sense in these alternative directions, statistical tests comparing these non-nested models also pointed towards our original model being the preferred model. The Akaike Information Criterion (AIC) fit index can be useful for comparing non-nested models to determine whether the original model or either of the two alternative models is most likely to be replicated with another sample (Kline, 2011). The AIC value for the original model was smaller than either of the alternative models, indicating it is preferable to both the alternative models.

DISCUSSION

The purpose of the current study was to explore the direct effects of home-based family therapists' perceived workload and HBFT experience on their professional quality of life and the potential mediating effects of self-care and supervision. The results indicated that a higher perceived workload and having less HBFT experience was directly related to lower levels of professional quality of life. Our study revealed that a higher perceived workload was also related to engaging in less self-care activities and receiving more supervision. Therapists with less HBFT experience were also found to receive more frequent supervision. HBFT experience was not related to frequency of self-care. Receiving more supervision and a higher frequency of self-care activities were both related to a higher professional quality of life. Finally, bootstrapped tests of the indirect pathways revealed that the frequency of supervision mediated the relationship that HBFT experience and perceived workload had on professional quality of life, whereas frequency of self-care only mediated the relationship between perceived workload and professional quality of life.

Effects of HBFT Workload on Professional Quality of Life

A previous study discovered that increased client load potentially exposes a therapist to additional client trauma that can lead to decreased compassion satisfaction, increased compassion fatigue, and eventual burnout (Sprang et al., 2007). Our data also revealed this significant inverse relationship between workload and professional quality of life. There are several implications specifically related to these findings for home-based family therapists. The more hours providing HBFT may correspond with increased work stress. Home-based family therapists experience a number of additional responsibilities that may be linked with increased stress in their job performance, including: complex cases often requiring additional case management, travel time, feelings of isolation due to time away from colleagues and resources available at the office, limited access to the support of a clinical supervisor, as well as stressors encountered within the home environment (i.e. cleanliness; interruptions from unexpected visitors, TV sounds, and phone calls; and safety-related issues in the client family's home and/or community; Lawson & Myers, 2011). Adjusting home-based family therapist's workload may entail some of the following: limiting case loads, providing additional time to complete documentation, and increasing accessibility to resources and support. Future research could examine if these adjustments could increase therapists' competency and reduce the stressors associated with that workload.

Effects of In-Home Clinical Experience on Professional Quality of Life

Deighton and colleagues (2007) found that, despite accumulated exposure to clients with trauma, years of experience comprise a protective factor against clinical burnout. Indeed, results from the current study provide empirical support to that statement. Thus, more experienced home-based family therapists have an advantage over less experienced home-based family

therapists in obtaining higher levels of professional quality of life in HBFT. One possible explanation for this is that with increased HBFT experience, opportunities arise for refining clinical skills and improving therapeutic effectiveness while also learning to better manage the concomitant stressors associated with this unique clinical work. In turn, this increased competence may result in higher levels of professional quality of life. However, to be clear, the current study does not specifically test acquisition of therapeutic skill and mastery as the link between experience and professional quality of life. Certainly, this finding could also be understood as a selection effect, such that therapists who experience decreased professional quality of life may choose to leave home-based work, and those who enjoy it have longer work histories. Conversely, those with limited HBFT experience may have a limited repertoire of experiences from which to draw on for conceptualizing and addressing client issues.

Mediating Effects of Therapist Self-Care on Professional Quality of Life

Our data revealed the link between self-care and professional quality of life corroborates Eastwood and Ecklund's (2008) previous finding suggesting that clinicians with increased frequency of self-care practices reported less stress and lower rates of burnout. The results of our study further suggest that increased use of self-care practices helps ameliorate the negative effects of a heavy workload on professional quality of life. This is good news for home-based family therapists who may not have direct control over the size of their caseload because they do have control over a salient mechanism responsible for maintaining higher levels of professional quality of life: self-care.

HBFT clinical experience, on the other hand, was not related to self-care. This may be because home-based family therapists' self-care practices have more to do with the demands and stresses of their work occurring at any level of experience. Based upon the conceptual work of

Carroll, Gilroy, & Murra (1999), therapist self-care should optimally be an ongoing, multifaceted program rather than limited to specific, periodic activities that are reactive to increases in stress. Our data appears to suggest that both novice and experienced therapists may benefit from developing and maintaining patterns of self-care based upon its significant direct and indirect effects on professional quality of life.

Mediating Effects of Clinical Supervision on Professional Quality of Life

Clinical supervision has the capacity to provide support, resources, and assistance to home-based family therapists struggling with issues of job stress and associated isolation. This study confirmed what Lawson and Meyers (2011) have previously suggested, that clinical supervision has the potential to improve a therapists' professional quality of life. Questions arise that compel one to look beyond the mere frequency of clinical supervision toward the quality and effectiveness of supervision that may be established over time.

Supervision is often thought of as an important stepping stone for ensuring quality clinical services are being rendered to clients (Cortes, 2004; Zarski, Greenbank, Sand-Pringle, & Cibik, 1991). As supervision appears to provide positive benefits to the home-based family therapists' professional quality of life, therapists' engagement in clinical supervision has the potential to enhance improvements in clinical effectiveness and may also improve staff retention (Eastwood & Ecklund, 2008).

Limitations

This study bears several limitations that should be noted. This study was cross-sectional; thus, longitudinal inferences cannot be made from these results. Next, although these findings suggest that more therapist self-care and clinical supervision have a positive effect on home-based therapists' professional quality of life, it remains unclear what specific self-care behaviors and supervisory approaches are most beneficial. It is likely that there are specific approaches and activities that are more impactful than others. Uncovering these specific factors would provide both clinicians and supervisors with important information about how best to increase their professional quality of life and what activities are most likely to help reenergize their professional identity. A therapist using self-care in response to stress may experience a different benefit than one who engages in self-care activities through an ongoing, intentional program to prevent the occurrence of stress. The current and previous studies have not examined the circumstances that may prompt a therapist to engage in self-care activities or request clinical supervision. Data revealing an average frequency for supervision and self-care masks potential fluctuations that may occur over time and under varying circumstances.

Related to these concerns about limited quantitative research on the benefits of therapists' self-care and supervision, our analyses relied heavily on single-items in the measurement. There are a number of weaknesses with using single-items as it relates to reliability and validity. For example, internal reliability cannot be established with only one-item. Further, validity may be compromised, especially if the underlying construct of interest is multi-faceted. Measurement with a well-established measure that has already been demonstrated to be valid and reliable would have been preferred, but we were not aware of any such measure. Future research should work towards this purpose of improving measures of self-care and supervision. It is perhaps

surprising that more quantitative research has not been done in this area that therapists so commonly discuss as important to therapists' professional quality of life, and ultimately in respect to the quality of service provided to our clients. Also, our measure of therapist workload limited our ability to determine if that construct simply reflects perception of workload or the effect of the actual number of hours of providing home-based services.

Implications for Future Studies

Future research should evaluate differing theoretical approaches to supervision and common factors that underlie positive processes throughout supervision that can impact professional quality of life. Additionally, future research should test if varying types of self-care may yield differing results for perceived professional quality of life. Furthermore, it will be important to identify ways that clinical training and supervision can foster the establishment of an ongoing self-care regimen for trainees.

Additional studies are needed to explore situations and circumstances that may influence therapists' decisions and engagement in the use of self-care and clinical supervision. Furthermore, exploring therapists' use of self-care and clinical supervision may improve our understanding of specific ways they impact professional quality of life. Overall, we call upon researchers to begin gathering quantitative data to test many of our long-held assumptions, such as the importance of self-care and clinical supervision, to test if each actually has a positive impact on clinicians.

Conclusions

This study found that workload and clinical experience had a direct impact on home-based family therapists' professional quality of life that was partially mediated by the frequency of self-care activities and clinical supervision. The discovery of these significant mediating roles

of therapist self-care and clinical supervision suggest activities home-based family therapists can do to improve their professional quality of life. Expanding our understanding of these practices has the potential to guide therapists' development and to inform the use of ongoing self-care and supervisory support. Improving support for therapists attempting to meet the demands of an already-burdened mental health system has the added potential of guiding agencies and clinical supervisors to meet those demands. A refined focus on therapists' developmental and clinical support has the potential to improve therapists' professional quality of life, work experiences, and effective provision of client services.

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Table 1

Means, Standard Deviations, and Correlations among Study Variables (N = 225)

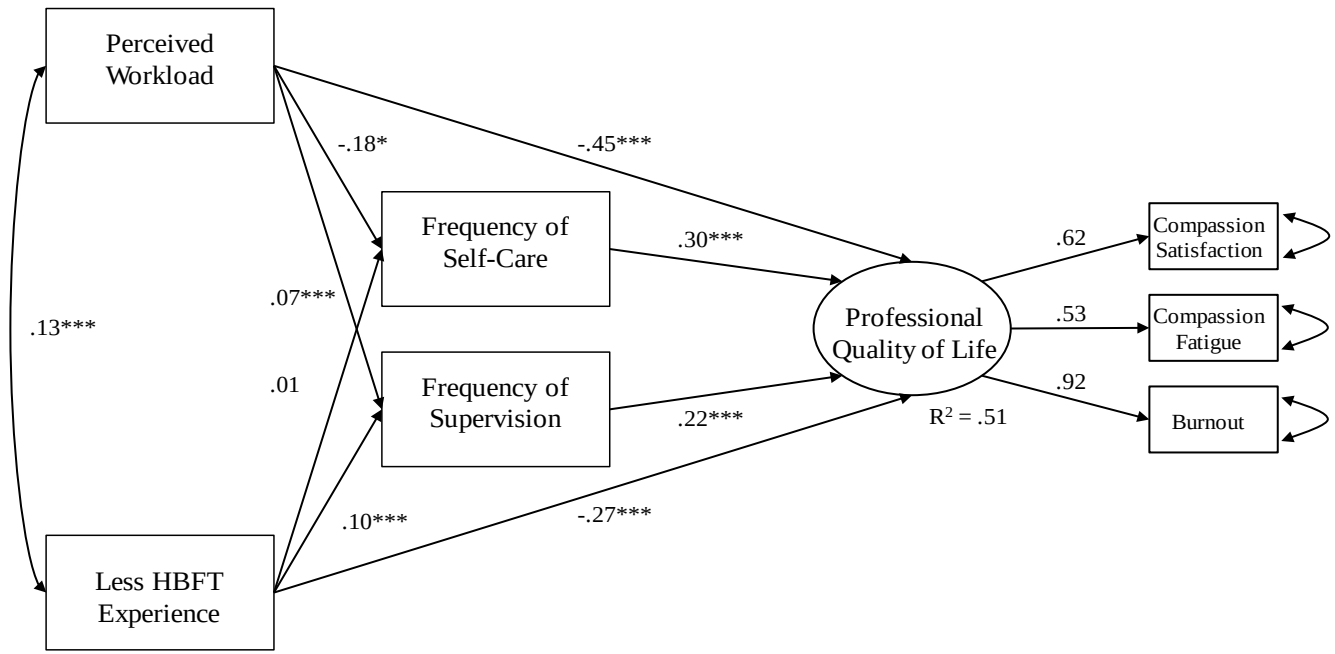
Variable	1	2	3	4	5	6	7
1. Perceived Workload	___						
2. Less HBFT Experience	.12†	___					
3. Frequency of Self-Care	-.19*	-.01	___				
4. Frequency of Supervision	.09	.11	.09	___			
5. Compassion Satisfaction	-.27**	-.20*	.41***	.12	___		
6. Compassion Fatigue	-.29**	-.20*	.08	.18†	.35***	___	
7. Burnout	-.53***	-.35***	.30**	.16	.57***	.64***	___
M	2.82	1.71	3.46	1.52	2.83	4.06	3.69
SD	1.21	1.17	.88	1.08	.55	.56	.61

Note: HBFT = Home-Based Family Therapy.

†$p < .10$. *$p < .05$. **$p < .01$. ***$p < .001$ (two-tailed).

Figure 1

Model with Frequency of Self-Care and Frequency of Supervision Partially Mediating the Impact of HBFT Experience and Perceived Workload on Professional Quality of Life among HBFT Therapists (N = 225)



Note: Model Fit Indices: χ^2 (27) = 32.17, *p* =.23; CFI = .965; TLI = .942; RMSEA = .029 (90% CI = <.000, .062); SRMR = .047. HBFT = Home-Based Family Therapy. Gender, professional affiliation, HBFT caseload, and HBFT training were included as control variables in the model. The residuals between frequency of self-care and frequency of supervision were correlated, as were the residuals for compassion fatigue and burnout.

**p* < .05. ****p* < .001 (two-tailed).

HOME-BASED FAMILY THERAPY PARTNERSHIP
FY2013: 4th Quarter Report
July 1, 2013

This report summarizes our work as trainers and supervisors with the Home-Based Family Therapy (HBFT) Partnership at the KSU Family Center during the fourth quarter of the FY2013 contract year. The focus of our work during this contract is ***program adaptation and expansion***! As new legislation has led to the development of KanCare, our team is prepared to support the changes needed to encourage and improve the delivery and effectiveness of the home-based family therapy services in Kansas. We are looking forward to the research and the extension of our reach to engage with partners throughout the state in the months to come.

We have attended the Clinic and CBS Directors' meetings to discuss the tasks of the current contract and the resources available through the HBFT Partnership: newsletters, CD Learning Companions, and Group Training Kits. We have also expanded our communication with our HBFT partners by corresponding directly with therapists about different resources and continuing education credits that are available through our website. As a result of this change, we have had 10 new requests for group training kits, resulting in a total of 30 kits sent. We have also had 2 requests for cd companions and 2 participants complete at least one of our online modules. We are pleased with the increased utilization of these resources.

HBFT Website

Currently there are 1,253 persons registered with the HBFTPartnership.com website. This is an increase of 243 users since the start of this contract on July 1, 2012. Attached is a description of the users from our Google Analytics account that tracks website visits and usage. During this quarter, the website has had 285 unique visitors of which 54.6% were new visitors to the site. Based upon an average of approximately 4:57 minutes on the site, it appears that most visitors are using the site to access information, order group training kits and register for events.

Core Training

Two trainings were scheduled during this quarter on April 3rd and May 15th, 2013 both at the Alumni Center in Manhattan (KDADS sponsored training). The April 3rd training consisted of 18 participants, from Hall and Associates, TFI, Counseling Solutions LLC, St. Francis, Comcare of Sedgwick County, Bert Nash, and Mental Health Center of East Central Kansas. We received such comments as **"Excellent opportunity" and "will continue to use HBFT as a resource"**. The May 15th training included 12 participants from several agencies such as Pawnee Mental Health, Area Mental Health, TFI, Bert Nash, St. Francis, DCCCA, Kids TLC, Family Service and Guidance Center, and KDADS. We received such comments as **"Very good resource in the future", and "I thought the training was useful and helpful. It definitely allowed me to start thinking different about the things to be aware of when providing in home therapy".**

Over the fiscal year, we have had 93 clinicians attend our Core Trainings. Overall, both presenters averaged over a 4.5 on a 5-point scale when considering effectiveness of delivery, knowledge of the subject matter, responsiveness to participants, and organization of material.

Additionally, 89% of clinicians throughout the fiscal year indicated that they either *Agree* or *Strongly Agree* that the Core Training was accessible and helpful to them.

The focus of the core training has been to assist clinicians in understanding the unique opportunities and challenges with providing therapy in the home. Although the core training evaluations have reflected overall satisfaction with the training, there have been requests to involve more practical aspects of home-based work. In response, the core training has been revised to address these requests by adding additional information that is therapist specific (self-of-the therapist) as well as interventions and techniques that, when used as part of a well formed treatment plan, can integrate all members of a family. The training implemented more real world examples of home-based family therapy, and less time was spent on the theories behind different home based family therapy models. Since some of the more experienced participants felt that the training was a little basic, the curriculum now utilizes breakout groups according to experience levels in order to address "stuck" cases that participants identified, prior to the training, as needing help with. This allowed the participants the opportunity to more directly apply the core training principles. Since the implementation of these changes, participants have stated that the training was very informative and beneficial. Participants have also stated that the training was well-run and mentioned they would be willing to attend other HBFT training events in the future. In past trainings, clinicians with extensive experience in providing home-based work stated that the training was too remedial, and such clinicians did not receive much benefit from the training. Several clinicians suggested providing a new training with more advanced topics for those who have had more experience with in-home work. Due to these clinician's concerns, the HBFT partnership team is looking forward to implementing an advanced core training in the new contract year, specifically for clinicians with 5 or more years of experience providing in-home therapy.

Videoconference

On April 19th, we held a DSM videoconference titled, **Using the DSM 5 in Home-Based Family Therapy Part II.** The objectives for this training were as follows: develop a better understanding of diagnosing children and adolescents, examine the DSM-5's expanded and comprehensive approach to disorders organized by categories, and to allow participants to engage in diagnosing according to the new format. In total, 20 people attended at 7 different sites across the state. According to our post-evaluation, 100% of participants said they would attend future videoconferences offered through HBFT. We received comments such as ***"The presenters were well versed in the material - even though the DSM is not fully completed. They did an excellent job at contextualizing the material and helping it to be relevant. Thank you!!" and "Absolutely, it was engaging, kept my attention, and was very informative"***. Some participants felt that the information was far too broad for a three hour training. We will take this into consideration when developing future videoconferences, however, our desire is for the videoconferences to provide an adequate amount of information for clinicians with a broad range of experience levels.

Collaborative Partnership Promotion

The summer newsletter was published and distributed electronically in early July 2013 to the 1,252 persons registered with the website. We use the newsletters to highlight the topics of trainings and promote participation in the upcoming events. The focus of this newsletter was related to the advanced supervision videoconference that will be held November 15, 2013. This quarter's newsletter includes an interview with a supervisor of Home-Based therapists. The newsletter also highlighted a description of the new Advanced Core Training videoconference.

Special Projects

The HBFT team had previously reviewed the literature on the current methods used with adolescents discharging from Psychiatric Residential Treatment Facilities (PRTFs) stays. The team compiled an annotated bibliography detailing the processes used to ensure positive discharges and reduce recidivism rates. Focus groups consisting of PRTF and CMHC providers were held during February and March via phone conferences. Of all 22 participants total, a wide variety of relationships to PRTFs were represented. Of those who participated, there were several case managers, clinic directors, program directors, social workers, counselors, psychologists, and PRTF liaisons. The HBFT team met to analyze the focus group transcripts in April. In the new fiscal year, the HBFT team plans to confer with the University of Kansas in order to move forward with this project.

The HBFT team is also compiling information in regards to supervision for home-based family therapists. The team has been predominantly researching techniques that may be beneficial for videoconference training. At this time, the team has compiled an annotated bibliography detailing techniques and whether supervision may be beneficial. CMHCs have been contacted in order to create a list of HBFT supervisors who could participate in a focus group to gather knowledge about supervision practices in Kansas. Due to low responses, private contractors will also be solicited in order to obtain HBFT supervisors because of the nature of private contractor's work being primarily home-based. A survey was compiled and sent to Clinic Directors, CBS directors, and private contractors to share with their HBFT supervisors. Currently, 20 people have completed this survey.

The beginning phases of the self-care app started in December 2012. This therapist self-care website will allow participants to receive support for stress management and potentially improve professional quality of life. We have begun the initial phases of mapping and compiling information that will appear on the web page. Beta testing of basic website contents will continue through July. We hope to have a more thorough outline of the website by August.

Next Quarter At A Glance

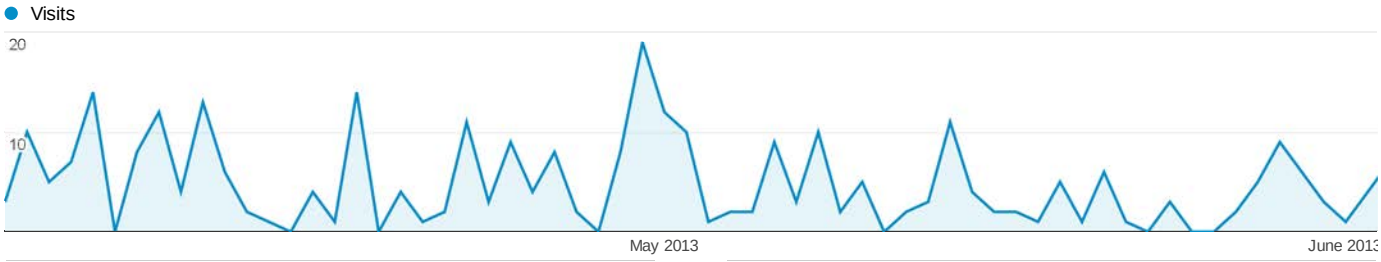
September 6- Core Training, Garden City, KS
October 4- Advanced Core Training Videoconference
October 25- Ethics Videoconference: Ethics of Diagnosis and Assessment
November 15- Advanced Supervision Videoconference

Nancy T. O'Conner, M.S., LCMFT
Contract Co-Administrator

Camille Lafleur, Ph.D., LCMFT
Contract Co-Administrator

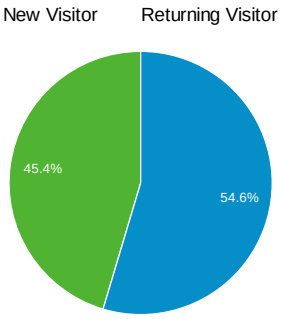
http://www.hbftpartnership.com - http://www.hbftpartnership.c...
www.hbftpartnership.com [DEFAULT]

Reporting | Customization | Admin | Help



285 people visited this site

Visits	445
Unique Visitors	285
Pageviews	1,756
Pages / Visit	3.95
Avg. Visit Duration	00:04:57
Bounce Rate	44.04%
% New Visits	54.61%



Demographics

- Language
- Country / Territory
- City

System

- Browser
- Operating System
- Service Provider

Mobile

- Operating System
- Service Provider
- Screen Resolution

Language	Visits	% Visits
1. en-us	420	94.38%
2. en-gb	5	1.12%
3. es	4	0.90%
4. ar	2	0.45%
5. c	2	0.45%
6. en	2	0.45%
7. pt-br	2	0.45%
8. tr	2	0.45%
9. da	1	0.22%
10. de	1	0.22%

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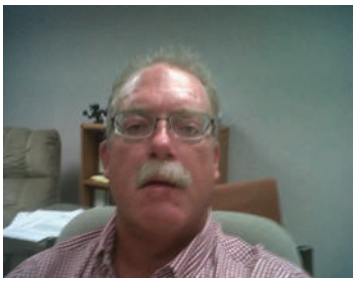
Home-Based Family Therapy Partnership Update

The Connection

www.HBFTPartnership.com June 2013

Supervision Interview with Sean Wagner, MS



Sean Wagner received his B.S. and M.S. degrees from Fort Hays State University in Clinical Psychology in 1992. Around that same time, he also started as a Qualified Mental Health Professional at Horizons Mental Health Center. Wagner billed over 1,000 hours a year as a Qualified Mental Health Professional at Horizons Mental Health Center for 16 years before becoming a department head supervising ten therapists, fifteen rehab staff members, and six support staff members in four separate offices spanning Kingman, Pratt, Harper, and Barber counties.

How do you as a supervisor empower your supervisees in supervision?:

I encourage my staff to be self-sufficient by assigning a wide range of clients. Our area is rural, so every clinician see's every type of client. I encourage each clinician to pursue his/her personal interests, while maintaining an eclectic case load and treatment options.

How often does safety come up as an issue that needs to be addressed in supervision?

Not too frequently. Fortunately, with our affiliation with Hutchinson Regional Medical Center, we have frequent safety trainings, drills, inspections and reminders regarding safety throughout the year. Everyone keeps their daily schedules in our EHR [Electronic Health Record] so everyone knows where each other is at any given time.

What is your role as a supervisor when your supervisees are dealing with client crises?

Clinicians can call anytime with any situation that may arise. Each clinician is Mandt trained, and all clinicians are responsible to take on-call duties on a rotating basis in order to maintain their skills. They also have training in Crisis Intervention.

How do you help or encourage your supervisees to take care of themselves?

Through frequent supervision, monthly therapist meetings, quarterly all staff meetings in our Hutchinson facility. We frequently get together outside of work also, and have an excellent benefit package.

Supervision Suggestions for HBFT Therapists

Supervision should provide the therapist with support in the following areas:

- Managing appropriate boundaries
- Simultaneously maintaining varying points of view
- Connecting therapist self-care and the supervision process
- Accessing available resources
- Receiving guidance and support
- Creating a relationship with your supervisor that involves vulnerability

Supervision and Training: Supervisory Dilemmas

According to authors Nancy Boyd-Franklin and Brenna Hafer Bry (2000), supervisory philosophy is based on the empowerment of family therapists and supervisors, but sometimes supervisory dilemmas can arise. Such dilemmas include:

Cultural and Racial Issues in Supervision:

Because of the increasing diversity in the U.S., supervisors must feel comfortable themselves in raising concerns about ethnic and racial issues with supervisees. If the supervisees are to feel comfortable in exploring these issues with their clients, they must first be able to discuss them in supervision.

Supervision as a Process of Negotiation:

It takes time for a new staff member and supervisor to establish a positive working relationship but it can be complicated by the fact that the supervisor is responsible for evaluating the supervisee's progress. It is helpful to approach supervision as a process of negotiation or to frame supervision as a consultation, which implies a partnership not a hierarchy.

Training as an Antidote to Burnout:

Continuous training not only serves as an antidote to burnout, it also helps therapists to keep their skills current in recent developments in the field.

Professional Growth and Development:

Supervisors should make a commitment to meet with supervisees at least once a year to discuss professional growth and plans for development. It's important that everyone can discuss their plans in a supportive environment.

For a more in-depth look into supervisory dilemmas check out Boyd-Franklin and Bry's book:

Boyd-Franklin, N., & Bry, B. H. (2000). *Reaching out in family therapy: Home-based, school, and community interventions*. New York, NY, US: Guilford Press.

New Training: Advanced Supervision Videoconference

This fall the HBFT Partnership is offering a videoconference training over Advanced Supervision on

November 15th 2013

Registration for this event will open September 16, 2013 and will close 7 days before the event.

Description of Advanced Supervision Videoconference:

The Advanced Supervision training is geared towards clinical supervisors who provide supervision for home-based family therapists. Clinical supervisors who supervise office-based clinicians could also benefit from this training. This training will address ways to adapt office-based supervision to support the needs of home-based family therapists. Supervisors will develop and refine their orientation to supervision in order to ensure meeting the unique needs of home-based family therapists.

Additional Resources

- **American Association for Marriage and Family Therapy—Resources: Supervision**
  www.aamft.org
- **Association for Counselor Education and Supervision—Resources**
  www.acesonline. net

Also be sure check out our Resources section on our website:
www.HBFTPartnership.com

Upcoming Core Training

The HBFT Partnership is offering a Core Training in Western Kansas at

The Clarion Inn
1911 E. Kansas Ave
Garden City, KS 67846

On
Friday, September 6th, 8:30a.m.-3:30p.m.

Kansas State University
HOME-BASED FAMILY THERAPY PARTNERSHIP
FY2014: 4th Quarter Report
July 15, 2014

This past fiscal year, the Home-Based Family Therapy (HBFT) Partnership, based at the Kansas State University (KSU) Family Center, has gone through major changes. This report is to summarize our work during the fourth quarter of the FY2014 contract year. This report should also provide information regarding ongoing projects that will be continued throughout the fiscal year. Each contract year provides an opportunity to re-focus our efforts in order to better serve the community. For this contract year, we plan to focus on monitoring and improving ***Therapists' Self-care*** in order to maintain a healthy professional quality of life. Additionally, we will be working to finalize the ***HBFT model*** and begin working towards ***fidelity***.

Throughout the FY2014, we will continue to attend the Clinic and CBS Directors' meetings to discuss the tasks of the current contract and the trainings and resources available through the HBFT Partnership: newsletters, CD Learning Companions, and Group Training Kits. We hope to recruit the use and increased use of the resources available through HBFT Partnership, particularly our new self-care website. We will continue to communicate directly with our HBFT partners, particularly the therapists, about the different resources and continuing education credits that are available through our website.

Quarterly Projects

Core Training

One Core Training was held this quarter.

The training took place on April 17, 2014 at the Alumni Center in Manhattan, KS. A total of 55 participants attended the training, with several CMHCs and private contractors being represented. CMHCs represented in the training include: Family Service and Guidance Center, Horizons Mental Health, Johnson County Mental Health Center, Pawnee Mental Health, South Central Mental Health Counseling Center, Compass Behavioral Health, and The Guidance Center, Inc. After compiling the post-evaluation from all participants, 92.7% indicated that they either *Agree* or *Strongly Agree* that the Core Training was accessible and helpful to them. 81.2% of participants indicated that they either *Agree* or *Strongly Agree* that the Core Training was valuable in increasing their skills as a home-based family therapist. Likewise, 85.5% indicated that they either *Agree* or *Strongly Agree* that they now have a better understanding of the unique features of HBFT work and the ways a collaborative approach contributes to effective therapy. And finally, 74.7% of all the participants indicated that they either *Agree* or *Strongly Agree* that they are looking forward to trying some of these new approaches with their families.

We received such comments as **"I enjoyed the presenters, their knowledge, and enthusiasm**

on the topic”, **“the resources were helpful, and the environment was friendly and comfortable”**, and **“I think I feel more confident in starting to do in-home family therapy. I have a better understanding of situations in which in-home will be helpful”**.

We also received some helpful feedback such as, **"The information was good but not new. I did not think the Bafa Bafa exercise was very useful as it seemed like something that would have been used in an introductory exercise in a general sociology type of course in an undergraduate program. I was hoping for more depth of critical thinking.”**, and **"Too much feedback allowed. The presenters were so knowledgeable that it would have been beneficial to hear what they had to say."**

Videoconference

One videoconference was held this quarter.

On April 11, 2014, the HBFT Partnership held the second installment of the annual DSM videoconference series. This year’s topic covered Autism Spectrum Disorders (ASDs), with a focus on using DSM 5 criteria. Part 2 of the series discussed best practices for treatment of ASD, including a discussion regarding comorbid diagnoses. Twelve people attended the training at six different locations. Agencies represented included Compass Behavioral Health, Counseling and Mediation Center, High Plains Mental Health Center, Pawnee Mental Health, Mental Health Center of East Central Kansas, Amerigroup Kansas, Advanced Behavioral Healthcare, Four County, Mental Health Center, Center for Counseling and Consultation, Mental Health Association of South Central Kansas, and several school districts.

Collaborative Partnership Promotion

We use the newsletters to highlight the topics of trainings and promote participation in the upcoming events. This quarter’s Summer Connection highlighted the success our partnership has had over the past seven years in providing resources and supporting therapists throughout the state of Kansas. Likewise, the Summer Connection introduced our new self-care website and provided some information about why self-care is important for those in the helping profession.

Ongoing Projects- FY2014

Core Training

Over the fiscal year, we have had 83 clinicians attend our Core Trainings. Overall, both presenters averaged over a 4.6 on a 5-point scale when considering effectiveness of delivery, knowledge of the subject matter, responsiveness to participants, and organization of material. Additionally, 91.6% of clinicians throughout the fiscal year indicated that they either *Agree* or *Strongly Agree* that the Core Training was accessible and helpful to them and 80.7% agree that

the Core Training was valuable in increasing their skills as a home-based family therapist.

An Advanced Core Training for clinicians with at least five years' experience working in home-based family therapy was held as a videoconference. This training also approved therapists to be able to bill at the advanced rate, similar to the Core Training. We had five clinicians attend this training, which provided a more in-depth look into the unique supports HBFT therapists need and the specific theoretical approaches that have been found effective for in-home family therapy.

Videoconferences

Over the fiscal year, we hosted 5 different videoconferences, including the new Advanced Supervision and Advanced Core Training events. In total, we have had 57 clinicians attend our videoconferences this year. Throughout the year, sites located in Olathe, Manhattan, Hays, Dodge City, Pittsburg, Salina, and Hutchinson have been utilized.

HBFT Website and Self-Care Website

During the second quarter, the transition of HBFT event registrations to the Training Teams website was complete. Both trainings held during the third quarter utilized the Training Teams website for registration without any problems. The HBFT Partnership Team is in close contact with the Training Teams staff in order to continue maintaining registrations, as well as making registration as easy as possible for clinicians.

Currently there are 1,323 persons registered with the HBFTPartnership.com website. This is an increase of 7 users since the start of this contract on July 1, 2013 to the end of the quarter, June 30th, 2014. Attached is a description of the users from our Google Analytics accounts that tracks website visits and usage. During this quarter, the website has had 221 unique visitors of which 65.2% were new visitors to the site. Based upon an average of approximately 2:28 minutes on the site, it appears that most visitors are using the site to access information, order group training kits, and complete the online modules. Due to transferring registration to the Training Teams website, we also believe that most new users are creating accounts in order to gain access to additional resources provided on our website and to complete the online learning modules rather than just joining to register for trainings.

During the quarter, 1 clinician completed one online module from the HBFT Partnership website. The module utilized was Utilizing Supervision with HBFT. However, 8 other clinicians have completed pre-tests for several of the modules as well. Also during this quarter, 22 Group Training Kits were purchased. The Group Training Kits sold included Juvenile Bipolar Disorder parts 1 and 2, Diagnosis and Assessment of ASD, Treatment of ASD, Reactive Attachment Disorder parts 1 and 2, Ethics of Assessment and Diagnosis, Addressing ADHD in HBFT Parts 1 and 2, Children with PTSD and Depression parts 1 and 2, Ethics of Treating Child Sexual Abuse, Ethical Issues of Therapists and Social Networking, Ethical Controversies in Domestic Violence, Ethical Implications of Collaboration, and DSM-5 Diagnosis and Treatment.

Throughout the third quarter, the HBFT Partnership team has also been working with Gary Piland from Umbrella in order to revise the HBFT Partnership website. The electronic binder has also been updated on the HBFT website, which provides information regarding all HBFT materials from the previous three quarters. The binder includes available Group Training Kits, Videoconference materials, additional resources for clinicians, newsletters, and quarterly reports. All clinicians with registered accounts on our website have access to this information. Next quarter, we plan to further promote the online modules through e-mail and social networking once the new HBFT Partnership website has been completed.

Next Fiscal Year At A Glance

September 19, 2014- Core Training (Garden City)
November 7, 2014- Core Training (Olathe)
January 23, 2015- Core Training (Topeka)
March 27, 2015- Core Training (El Dorado)
May 1, 2015- Core Training (Independence)

Nancy T. O'Conner, M.S., LCMFT
Contract Co-Administrator

Camille Lafleur, Ph.D., LCMFT
Contract Co-Administrator

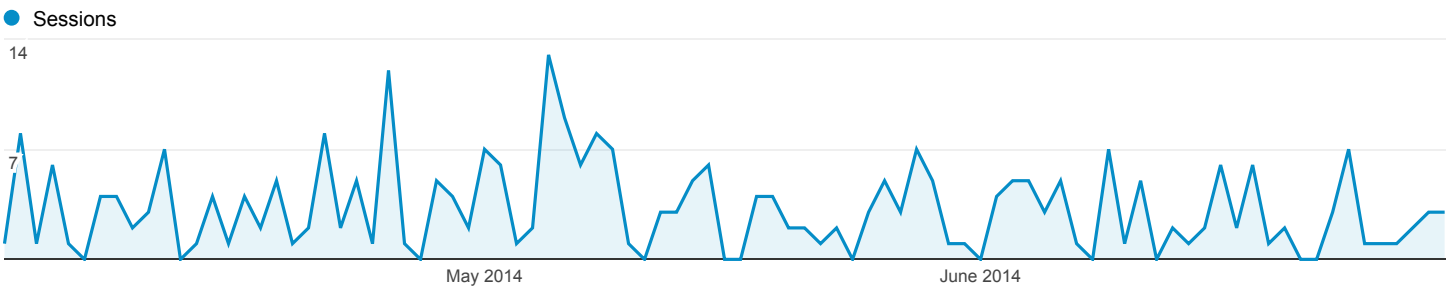
Audience Overview

Apr 1, 2014 - Jun 30, 2014

All Sessions
100.00%

+ Add Segment

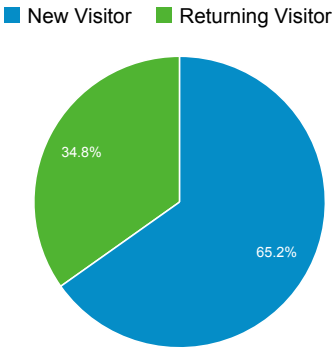
Overview



Sessions	Users	Pageviews
293	221	1,089

Pages / Session	Avg. Session Duration	Bounce Rate
3.72	00:02:28	43.00%

% New Sessions
65.19%



	Language	Sessions	% Sessions
1.	en-us	239	81.57%
2.	pt-br	19	6.48%
3.	de	4	1.37%
4.	de-de	4	1.37%
5.	en-gb	4	1.37%
6.	it-it	4	1.37%
7.	ar	2	0.68%
8.	en-ca	2	0.68%
9.	pt-pt	2	0.68%
10.	ar-ae	1	0.34%

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Home-Based Family Therapy Partnership Update

The Connection

www.HBFTPartnership.com June 2014

The HBFT Partnership Launches a New Website!

Research shows that as therapist's stress increases, so does the likelihood of burnout and compassion fatigue in professionals. Self-care helps to mediate these effects. By integrating self-care into a routine, the likelihood of burnout decreases. Our brand new HBFT self-care website allows you to track weekly self-care activities and even see the connection between your own personal self-care and professional quality of life. The website also provides great resources for self-care research, tips, and tricks. The site is mobile friendly, making it even more accessible. You can track your self-care or access resources right from your smart phone! Give our new website a try for yourself at **www.hbftself-care.com.**

A Little Bit About Self-Care

Research suggests that therapists and supervisors should be aware that higher workloads are linked to a lower professional quality of life, but engaging in different types of self-care are related to therapists feeling more positive about their clinical work. Self-care can come in many different forms such as personal reflection, social engagement, leisure and recreation, and professional development. By integrating self-care into a clinician's routine, the likelihood of burnout decreases. These types of self-care on their own can be very beneficial, but research shows that when combined they have an increased impact on reducing burnout and compassion fatigue.

See below for descriptions of the four types of self-care:

- **Leisure and Recreation:** a category of self-care that involves spending time engaged in hobbies and activities that refresh, rejuvenate and invigorate the mind and body.
- **Personal Reflection:** this form of self-care involves clarifying your view of yourself as an adult and a professional.
- **Professional Development**: this is an important facet of self-care that involves attending continuing education workshops and conferences, as well as receiving support from colleagues and supervisors.
- **Social Engagement**: this type of self-care involves seeking and receiving help and support from others, especially friends and family.

Celebrating Seven years of Success!

The Home-Based Family Therapy Partnership was first established in 2007 through a contract between the Kansas State University Family Center, the Kansas Department of Aging and Disability Services, and the Community Mental Health Centers in order to train and support home-based family therapists and promote best practices for home-based family therapy in Kansas. The following reflects the success the partnership has seen in providing resources and supporting Kansas professionals over the last seven years.

- Over the past seven years we have hosted 32 Core Trainings in several different locations. The Core Training has been updated over the years in order to best reflect our ever growing field. Our Core Trainings have reached over 1,007 professionals across the state of Kansas!

- Over the past seven years we have developed 10 online learning modules, and from these modules created CD learning companions to allow clinicians to experience online material in audio format, perfect for long drives! We have distributed approximately 1,500 CDs across the state!

- Over the past seven years we have developed and hosted DSM and Ethics Videoconferences to provide clinicians the opportunity to earn CEU credits while learning about a variety of topics. Since 2007 we have hosted 16 videoconference trainings and served roughly 400 clinicians.

Over the years the HBFT Partnership has continued to grow and expand to include other components that have helped get resources to home-based clinicians in Kansas and beyond. Group Training Kits were created to get resources and access to CEU credits available to those who couldn't attend videoconference trainings. The HBFT Partnership is dedicated to continual growth in order to best serve the changing needs of home-based family therapists in Kansas.

A New Direction for the HBFT Partnership

Given the success we have experienced over the past seven years, as well as our desire to continue providing resources and support for professionals in the state of Kansas, the HBFT partnership is making some changes! We feel these exciting changes will better meet the needs of those all over Kansas who partner with HBFT. One of the biggest changes we are making is increasing our number of Core Trainings to five a year! We will be hosting a Core Training every other month in all of the major Community Mental Health Center Hubs around Kansas. Keep your eyes and ears open for those dates on our website, www.hbftpartnership.com and our new website www.hbftself-care.com! Likewise, follow us on Facebook and Twitter to keep up-to-date with our newest projects and trainings, to gain new resources, and learn about new self-care tips!

Additional Resources

- Norcross, J., & Guy, J. (2007). *Leaving it at the office: Psychotherapist self-care.* New York: Guilford. Yates, K., & Couteur, A. L. (2012). Diagnosing autism. *Pediatrics and Child Health,* 23(1), pg. 5-10.
- Importance of Practicing Self-Care. Ricardo, C. (2006).

Upcoming Trainings

The HBFT Partnership is traveling to Western Kansas in order to provide a Core Training in Garden City this upcoming September.

Keep your eye on our website at www.hbftpartnership.com and our self-care website at www.hbftself-care.com for dates and locations of all of our upcoming trainings!

Contemp Fam Ther (2010) 32:444–458
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ORIGINAL PAPER

Common Components of Home-Based Family Therapy Models: The HBFT Partnership in Kansas

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Abstract In this article, we provide an analysis of components shared by varying home-based family therapy (HBFT) practices and evidence-based models. Applying a consistent statewide standard for HBFT presents challenges for the training of therapists from varying disciplines, with different levels of experience, and from diverse agencies. We propose focusing on common components across existing evidence-based models and discuss the trainings developed to integrate those components. We address indications and contraindications for using an HBFT approach and illustrate ways to address the particular challenges of HBFT supported by a unique partnership in Kansas. We conclude by offering suggestions for further research and for continued training development.

Keywords Home-based family therapy · Training · Evidence-based practice

Introduction

Clinicians have employed home-based family therapy (HBFT) practices since the 1980s. Whereas previous programs had emphasized *individuals at risk*, with the establishment in 1993 of the Family Preservation and Family Support Services Program communities began to acknowledge the larger systemic nature of a child's mental health and his or her behavior within the context of the family (United States Congress 1993).

The family preservation model is based on a preference for leaving a child in the home while empowering families to be actively engaged in the therapeutic process. The model assumes that a child who is safe from neglect and abuse will fare better in the home than

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will one placed outside of the home. This preference provides the least restrictive environment and an opportunity for therapists and other human service workers to address issues affecting the whole family (Christensen 1995; Cortes 2004). In this article, we address the specific types of training needed to prepare clinicians for effectively delivering HBFT.

A review of the HBFT-related literature to date reveals the use of several theoretical frameworks: a social ecological model, social learning theory, cognitive behavioral therapy (CBT), general family systems, functional family therapy, multisystemic therapy, structural-strategic family therapy, solution-focused family therapy, and family psychoeducation (Berg 1994; Boyd-Franklin and Bry 2000; Henggeler and Lee 2003; Lindblad-Goldberg et al. 1998; Sexton and Alexander 2000). Despite the use of diverse theoretical frameworks, models informing HBFT address five common components relevant to clinical practice in a family's home. These components include the environment and context, the family's roles and expectations, the therapist's roles and expectations, the therapeutic relationship, and the focus of clinical work. Each component influences the other components and the progress of therapy.

A social ecological lens (Bronfenbrenner 1979) provides a focus on the environmental and contextual components impacting the family and the therapy process. This lens broadens the scope beyond individual family members and the family as a whole. Consideration is given to physical and cultural contexts including, but not limited to the following: the family home, neighborhood, local and state agency policies and involvement, ethnicity, socio-economic status, and treatment history. A family's current and intergenerational experiences within those contexts influence the members' expectations of the therapy process and outcomes.

The therapeutic relationship between the therapist and the family members is defined and refined throughout the therapy process. However, joining, assessment, and contracting influence the trajectory of that relationship. The therapeutic relationship within the therapy office begins with the family accommodating to the therapist's familiarity with the clinical context. By contrast, in the family's home, that relationship begins with the therapist as the guest accommodating to the family's familiar environment. Cottrell (1994) describes varying degrees of anxiety a therapist may experience while visiting the home. Issues of safety, perceived lack of control over the environment, and the distances traveled to get to the family's home also produce a degree of anxiety, stress, and even burnout that the therapist must manage effectively to engage in the work while in the home (Adams and Maynard 2000; Christensen 1995).

Several mental health disciplines address the importance of acquiring a set of core competencies or meeting standards necessary for providing effective clinical treatment (American Counseling Association 2005; National Association of Social Workers 2000; Nelson et al. 2007; Rodolfa 2009). However, none of the disciplines describes the competencies uniquely associated with using an HBFT approach. Training programs generally focus on preparing clinicians to provide therapeutic services in office-based settings (Christensen 1995). HBFT therapists attempting to develop those competencies are often challenged with obtaining training after graduate school while they attempt to meet the competing demands of high caseloads and other agency responsibilities. Additional challenges arise as they attempt to apply their knowledge of evidence-based treatments while simultaneously adhering to both the protocols of manualized treatments as well as their agencies' policies, procedures, and expectations. Adaptations of an evidence-based model aimed at meeting competing expectations potentially undermine the principles of the model. Developing a state-wide training program that can be effectively applied across

agencies, geographic locations, and varying client populations requires an overarching framework rooted in the evidence while also adaptable to unique contexts.

The HBFT Partnership

In 2005, the Social and Rehabilitative Services of Kansas requested proposals from several educational institutions to provide training for the HBFTs throughout Kansas. A training contract for the HBFT Partnership was established with Kansas State University to provide HBFT therapists with the training needed to become credentialed and, therefore, eligible for Medicaid reimbursement. The Kansas partners include Kansas State University, the Kansas Department of Social and Rehabilitative Services, 28 community mental health centers, and Kansas Health Solutions, a managed care organization that oversees mental health services provided through Medicaid funding.

Since the initial contract, beginning in 2006, the HBFT Partnership has provided 535 therapists in Kansas with the trainings necessary for credentialing to obtain Medicaid reimbursement. Through annual contracts, the HBFT Partnership provides practitioners with the necessary resources and training for using evidence-based practices to evaluate the process and impact of their home-based work with the families they serve. Currently, 715 clinicians from various agencies are registered with the partnership, including 267 from 29 community mental health centers, 197 from 5 private contractors, and 41 private practitioners. The combined work of these practitioners serves clients in all of the 105 counties of Kansas.

Mission and Objectives

The mission of the HBFT Partnership is to provide an approach to training clinicians that addresses two priorities: explore and apply the best principles of current evidence-based practices while evaluating the impact resulting from participation in the training components on the clinicians' practice. The components are designed to support HBFT clinical practice. The objectives and principles guiding the development of each component include providing focused knowledge and skill development, prioritizing the use of supervision, facilitating therapist self-care strategies, providing multiple opportunities for ongoing therapist support and collegial relationships, and encouraging therapist collaborations and consultations.

Components of the HBFT Partnership

The training components are designed to facilitate the mission and objectives of the HBFT Partnership. The components include core trainings, videoconferences, and a tailored website including online learning modules and CD learning companions. Participants involved in each of the contract components also receive continuing education credits needed for maintaining state clinical licensure with the Kansas Behavioral Sciences Regulatory Board.

Core Training

The Core Training is a one-day, in-person experience annually offered at three different sites throughout the state of Kansas. Therapist participation in the Core Training meets the criteria for reimbursement of HBFT therapy services set by the Kansas Department of

Social and Rehabilitation Services, Division of Disability and Mental Health Services (SRS), and the Centers for Medicare and Medicaid Services (CMS). To-date, 535 therapists have participated in 16 Core Trainings over the past 4 years. Wasik and Roberts (1994) note,

> Ongoing training and supervision may be especially important for home visitors because home visiting is a difficult, stressful, and at times, lonely position…. Project directors should consider group training, where sharing of information among home visitors is possible and opportunities are available to learn not only from trainers and supervisors, but also from other home visitors. (p. 340)

Therefore, the training reviews the principles of evidence-based HBFT practices while providing several experiential opportunities for therapists to share ways to connect the evidence-based principles with specific strategies and techniques for conducting culturally competent HBFT. Integrated throughout the training are specific strategies necessary for prioritizing therapist self-care and use of supervision to reduce the stress and potential burnout that is often associated with providing varying types of therapy (Bakker and Schaufeli 2001; Carroll et al. 1999). Use of the Professional Quality of Life Scale (ProQOL R-IV, (Stamm 2002) provides a measure for therapists to assess personal levels of compassion satisfaction, compassion fatigue, and burnout.

Videoconferences

The videoconferences address diagnoses listed in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychological Association, DSM-IV-TR 2000) as well as ethical issues specifically associated with the practice of HBFT. Offered from the university site, 158 clinicians have participated at each of eight different locations via videoconference during eight trainings. The availability of multiple sites minimizes the distance clinicians must travel to attend, and the videoconferencing capability enables participants an opportunity to interact with and develop collegial relationships with others around the state. Figley (2002) explained,

> The evidence that regional workers are more at risk than workers in major cities is probably linked [with therapists' experience of secondary trauma]…. This has implications for organization and deployment of resources, especially in rural areas. The utilization of technology such as video conferencing to enable rural case managers [and HBFT therapists] to discuss stress-related issues with other professionals could be expected to reduce isolation. (p. 101)

Videoconferences have addressed topics such as *Families of a Child with an Autism Spectrum Disorder*, *HBFT Treatment of Children with PTSD and Depression*, *Ethical Implications of Therapist Self-Care*, and *Ethical Implications of Collaboration in HBFT*.

Website, Online Learning Modules, and CD Learning Companions

The HBFT Partnership website has been designed to provide HBFT therapists with ongoing training and support, opportunities for connecting and sharing with colleagues, and access to the latest HBFT resources in varied, accessible formats. The website includes a *Discussion Board* and a *Resources Section* that are located behind a gated access available to all registered users. HBFT Partners can access each either directly from the website home page or through the online learning modules. The *Discussion Board* provides

a place for clinicians to discuss challenges of providing HBFT and share resources with one another. The *Resources Section* includes articles, websites, and other documents referenced throughout each of the training components. A *Therapists Spotlight* section, located on the homepage, is regularly updated to highlight the work of an HBFT therapist, including personal reflections on his or her development and application of skills that have improved the effectiveness of his or her service delivery. The website components provide HBFT clinicians with multiple opportunities to reduce the isolation experienced while expanding opportunities for obtaining helpful resources and developing clinical skills.

The online learning modules are designed to provide advanced training in four different areas: *Therapeutic Skills*, *Family Issues*, *Therapist Self-Care*, and *Supervision*. Modules address therapeutic skills most relevant to HBFT, including crisis management, cultural competency, and safety training. Those focusing on family issues train clinicians to work with families who have a member with a chronic medical condition and with stepfamilies. Modules on therapist self-care address unique HBFT factors that influence clinicians' ability to manage anxiety, prevent burnout, and balance their personal and professional lives. A supervision module explores ways therapists can effectively use supervision to manage appropriate boundaries between their personal and professional lives, access available resources, receive guidance and support, and simultaneously maintain varying points of view in their work with clients. Through the most recent contract, CDs were developed to enable therapists to listen to the content of three of the modules while they travel to and from families' homes. When clinicians return to the office after listening to the CD, they are able to log onto the module, review content they would like to explore in greater depth, access supporting literature, and participate in discussion threads. Lastly, they complete a post-test to signify their completion of the module and evaluate their understanding of the material.

Providing a statewide training plan requires an increased understanding of the common components shared by the varying models of HBFT. This understanding informs the development and delivery of training to and support of HBFT therapists. Each of the training opportunities is designed to address the common components of the current evidenced-based models of HBFT.

Common Components of HBFT Evidence-Based Practice

There are a few widely known and well-established evidence-based, home-based, family therapy, family preservation, and community-based approaches. These approaches are designed to work with specific client family populations where a child is at risk for out of home placement. Functional family therapy (FFT) has been applied to work with families with a youth who is at risk for delinquency, violent behaviors, and drug use (Sexton and Alexander 2000); multisystemic therapy (MST) has guided work with youth exhibiting antisocial behaviors and substance abuse (Henggeler and Lee 2003; Lindblad-Goldberg et al. 1998; Saldana and Sheidow 2005); homebuilders' intensive family preservation and reunification services (IFPS) has focused on therapy with families who have a child experiencing problems with delinquency and drug use (Fraser and Haapala 1987; Institute for Family Development 2005); and the Oregon multidimensional treatment foster care model (MTFC) has informed work with children and adolescents exhibiting serious behavioral issues and their families (Chamberlain and Smith 2003; National Institute of Mental Health 2007). Adherents of these approaches work with families addressing the issues that lead to their involvement in the child welfare and juvenile justice systems.

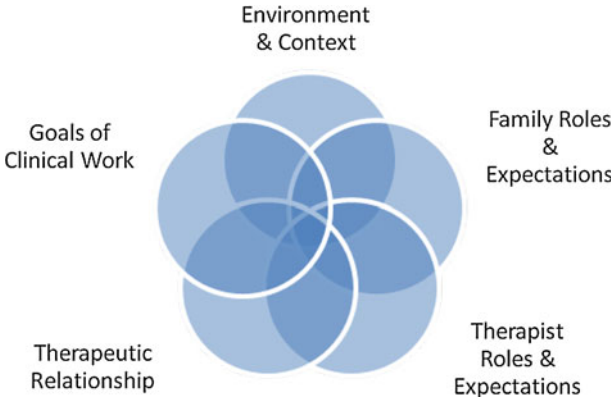

Fig. 1 Integrated components of HBFT partnership training

Each model is based on a common assumption that community-based support provides the family with the most immediate, accessible, and generalizable treatment. Each model describes a therapeutic process that is time-intensive for the family and the therapist; collaborations occur among the therapist, family members, clinical supervisors, and other professionals within the community; and treatments facilitate family change over a relatively brief period. The evidence-based treatments use standardized approaches that are responsive to the distinct features of the family and the issues they are currently facing. Because HBFT is demanding work, evidence-based models suggest that therapists carry limited caseloads, allowing the therapist to make longer and more frequent visits with families. Furthermore, the demands on the therapist necessitate continuous and consistent administrative and supervisory support. Despite subtle differences between the models, each addresses similar components including the environment and context, the family roles and expectations, the therapist roles and expectations, the therapeutic relationship, and the goals of clinical work. Figure 1 illustrates the interlocking properties of each component. While an HBFT component reflects one aspect of the work, each component influences the other components in several ways. In the next sections we examine the components and the varying ways the HBFT Partnership developed an integrated approach to training and support that address each component.

Environment and Context

An HBFT approach utilizes the environment and contexts of the home to assess and treat families. The home provides access to a family's natural setting while the therapist's visit demonstrates a therapist's willingness to enter that environment and access the resources available in the home and surrounding community. The HBFT Partnership assists clinicians in examining ways to adapt treatments to address and incorporate elements of the home environment while offering ways to overcome barriers to service provision.

HBFT creates opportunities for direct translation of therapeutic processes into a family's daily living. The home environment offers the therapist multiple opportunities to experience the family's home life without relying simply on reports of those experiences. However, while the home offers certain advantages, it also brings disadvantages. For instance, while unexpected visitors, phone ringing, or television volume provide data about the family's daily life, they also may disrupt the therapy process. Cherniss and Herzog

(1996) note that distractions can be used to empower the family to manage their own boundaries in the midst of competing demands. The HBFT Partnership trainings attempt to guide clinicians to view "distractions" as important data revealing the family's lived experiences and opportunities for direct intervention.

Some have suggested that the therapist's home visit sends an implied message to the family that the therapist is going the extra mile to meet the family and address their issues (Christensen 1995; Woodford et al. 2006). In addition, the therapist has several opportunities to use the immediacy of in-home experiences to help raise the family's awareness of issues and engage the members in specific, change-making behaviors. The HBFT Partnership reminds clinicians about the powerful effect of their efforts to meet the family in their own space as aspects of developing a level of trust with and demonstrating respect for the family.

On another level, home-based work is community-based work. While there are multiple resources within the home that inform therapy, the context of that home in the broader community serves to further broaden the scope of treatment, utilizing available resources such as relationships with neighbors and friends as well as school, church, and civic organizations. Establishing more direct connections with these resources may reduce the family's need for formal human service system involvement over time. While HBFT therapists often feel isolated from their supervisors and colleagues, the HBFT Partnership explores ways the clinicians can develop potential partners with those in the family's surrounding community.

Family Roles and Expectations

An HBFT approach recognizes a family's unique position of familiarity, comfort, and authority in their own home. HBFT is often chosen because other office-based approaches have not been successful. Experiences of the family's roles and expectations in the office can reflect a position of powerlessness and limited investment in therapy. An HBFT approach aims to foster family ownership and influence throughout the treatment process.

Family members bring varying concerns and points of view to therapy. Aside from diverse perspectives of the presenting problem, a family approaches therapy with specific role expectations for each family member, perceptions about the therapist's role within their home (Lawson 2005), and an assessment about the role and ability of therapy to address the therapeutic issues. While family members attending therapy in an office-based setting may feel a degree of intimidation, the home visit offers a familiarity that can enhance the members' perception of their active and empowered role within therapy (Fuller 2004). The HBFT Partnership instructs clinicians on ways to invite family members to become involved in the process of therapy, beginning with joining and throughout the phases of treatment. Clinicians are instructed on ways to ask the family members to teach and model for them their family experiences in the home.

Families involved in HBFT are often chosen to participate in this form of therapy precisely because they have multiple problems, often caught in cycles of perpetual crises (Adams and Maynard 2000; Cortes 2004; Kagan and Schlosberg 1989; Slesnick and Prestopnik 2004). Brymer and Phillips (2006) and Cortes (2004) suggest that the involvement of social service systems with a family may, over time, create an expectation of the system's ongoing presence. Visiting the family in their home has the potential of inverting roles and expectations and reestablishing the family's place "in the driver seat" of the therapy process and ultimately informing the decisions affecting their lives (Osher and Osher 2002). Training is focused on helping HBFT clinicians to use the family's "host" role to actively participate in treatment.

Therapist Roles and Expectations

The HBFT Partnership trainings equip clinicians with the awareness and skills needed to assist them in transforming the home environment from a living space to a therapeutic space. Identifying resources that can inform the therapist's understanding of the family's daily experiences, the therapist more effectively addresses current issues in the context of ongoing family interactions. Training is focused on ways to embrace the "guest" status and enable clinicians to listen, interact, and interpret their experiences in the home. The trainings give attention to the family's culture and, therefore, enable clinicians to hold assumptions and judgments about their experiences tentatively. Therapists are equipped to make the following adaptations: modifying office-based practices to work in the home, adjusting responsibilities associated with being a visitor rather than a host, adapting therapeutic skills that use the additional data offered by the home context, and monitoring the tension between responsibilities associated with work with the family and responsibilities to the agency.

HBFT enables the therapist to learn information in the first visit that may take several sessions of listening to family descriptions in the office. Doing therapy in the home provides a dramatic representation of the family experiences and environment—information the family may not think to report or have words to describe. Direct observations and experiences while interacting with the family in their home provide the therapist familiarity with the family members' experiences (Slattery and Knapp 2003; Snyder and McCollum 1999). However, while the visit provides an opportunity to collect additional data, home-based therapists often experience decreased control of the therapeutic milieu that accompanies their role as a visitor in the home environment. Woodford et al. (2006) and Snyder and McCollum (1999) note that the therapist's *guest status*, in an unfamiliar environment, challenges the therapist's control and, therefore, perceived level of comfort and safety.

HBFT trainings challenge therapists to appropriately determine their role with the family. Therapists are encouraged to continually compare their own perceptions of their role with the family members' views of and responses to their role. Fouad and Arredondo (2007) suggest that a culturally competent therapist engages in a continual process, both inside and outside of the therapeutic environment, seeking ways to improve "awareness of self, knowledge of others, and skills and interventions" (p. 8). The implication of these active efforts suggests that the therapist is ethically obligated to provide a therapeutic process that is responsive to the family and the family's culture. As Lindblad-Goldberg et al. (1998) note,

> The greatest clinical challenge is to create, in essence, a wide-angle therapeutic lens that allows the therapist to conduct a comprehensive assessment, and at the same time, a focusing mechanism to zoom in on the key elements requiring change within the defined treatment period. (p. 143)

Cultural competency provides the therapist with the ability necessary to work with the family while adhering to a respectful, curious, and collaborative approach.

Therapeutic Relationship

Interdisciplinary collaboration at varying levels is a hallmark of HBFT (Saldana and Sheidow 2005; Slattery and Knapp 2003; Stinchfield 2004). The HBFT Partnership was established through collaborations with state and local agencies. The HBFT trainings

instruct clinicians on ways to establish collaborative relationships with their clients, other community agencies and resources, as well as their own agency.

Fuller (2004) notes that therapy in the home must transition from socializing and guest-oriented activities to developing a shared treatment focus. The therapist is responsible for guiding the treatment process while remaining responsive to and empowering the family members' participation. The therapist's efforts to refine and strengthen the parental role are especially important since parents are very aware of the threat posed by possible out of home placement for their children. A relationship of mutual respect, trust, and collaboration requires repeated reinforcement of the parents' ability to choose from the available therapeutic options, identifying the parents' existing skills, and developing new ones to meet the current challenges. As the therapist demonstrates ways to collaborate with the family, the family learns the value of collaboration and is better prepared, with the therapist's help, to identify and use other resources in the community.

The design and functioning of the HBFT Partnership was established to provide a model for collaboration with the assumption that collaboration at one level has an isomorphic effect of encouraging collaborations to occur at other levels. Trainings focus on ways to establish an effective therapeutic relationship that prioritizes collaboration as an overarching goal of home-based treatment.

Goals of Clinical Work

Finally, the HBFT Partnership addresses the importance of developing treatment goals that intentionally incorporate the information and resources available in the family's natural environment. Trainings assist clinicians to use overarching principles of *contextual goaling* that orient the goals toward parent empowerment and increase access to natural supports.

A child's diagnosis(es) and risk for out of home placement are the issues that precipitate a family's referral for HBFT in Kansas. While a diagnostic focus on the child makes financial and social service resources available to the family, the therapeutic focus remains on the family system of which that child is one part (Sheidow and Woodford 2003). Despite the individual designation, the whole family system is addressed. Attention is paid to the ongoing interaction patterns between the members and the available instrumental, emotional, and relational resources they share (Slattery and Knapp 2003; Woolston et al. 1998). Curtis et al. (2004) explain that the treatment is focused on the family relations that serve as the context for the child's behavior with an equally important awareness of the home and community that serve as contexts for the family. Treatment situates the family within larger contexts of extended family, community, social services, and faith communities (Brymer and Phillips 2006; Crenshaw 2004; Woolston et al. 1998; Zarski and Zygmond 1989). Within the family context, attention is given to the parental and sibling roles and the mutually influencing effects of each. Additionally, a focus on empowering parents reflects ways they become vital resources used to facilitate pragmatic changes within the family.

While HBFT addresses family specific goals, the trainings assist clinicians to achieve meta goals that may lead to ongoing family success. Meta goals focus on equipping families with: increased access to resources, improved generalizability of skills applied to new situations, greater awareness and use of family strengths, and increased awareness and involvement in the community.

Factors Influencing the Decision to Use an HBFT Approach

As with any therapeutic approach, HBFT models have strengths and limitations. In this section, we address the indications and contraindications for using an HBFT approach. We also address ways the HBFT Partnership assists in the decision-making process to determine when an HBFT approach is appropriate.

A decision to use HBFT involves the examination of three different dimensions of clinical work: (1) family presenting issues, (2) historical and current course of treatment, and (3) therapist characteristics and competencies. Determining a "good fit" for using HBFT entails making a determination about the costs and benefits as compared with other treatment modalities. Benefits of utilizing an HBFT approach reflect decreased numbers of foster care placements thus increasing family involvement, preserving the integrity of the family, and limiting the additional psychological and financial costs that are associated with out-of-home placements (Cortes 2004; Fuller 2004; Woodford 1999).

Indications Specific to HBFT

Families considered for involvement in HBFT tend to have multiple problems, increased risk of the child being placed out of the home, and limited treatment accessibility (Lindblad-Goldberg et al. 1998). The HBFT Partnership trains clinicians to offer novel approaches to address specific clinical issues, overcome barriers to treatment, identify problems arising with previous treatments that have had limited success, and organize family involvement with multiple systems.

Several studies have suggested that a home-based approach has demonstrated reasonable degrees of effectiveness in addressing the following clinical issues: children identified as "seriously emotionally disturbed" or as having a "serious emotional disturbance" (Cherniss and Herzog 1996; Curtis et al. 2004; Fuller 2004; Schmidt et al. 2006; Sexton and Alexander 2000; Stinchfield 2004; Woodford 1999; Woolston et al. 1998; Zarski et al. 1992; Zarski and Fluharty 1992); children and adolescents exhibiting antisocial behaviors, juvenile delinquents, and those involved with Juvenile Justice Services (Cherniss and Herzog 1996; Curtis et al. 2004; Sexton and Alexander 2000; Woodford 1999; Woolston et al. 1998; Zarski et al. 1992; Zarski and Fluharty 1992; Zarski and Zygmond 1989); children with autism (Cottrell 1994); children in need of foster care (Fuller 2004); and families more broadly defined as multiproblem, at-risk, or multi-challenged (Adams and Maynard 2000; Cortes 2004; Johnson et al. 2002; Schacht et al.1989; Slattery and Knapp 2003; Snyder and McCollum 1999; Zarski and Zygmond 1989). Each of these articles has revealed that families involved in HBFT have experienced greater benefits than those who engaged in traditional, office-based treatment approaches. Results have included member symptom relief, improved family interactions, and families' increased awareness and access to community resources.

Some also have suggested that HBFT approaches provide a way to overcome various physical, psychological, emotional, and cultural barriers to treatment. Families who experience physical barriers often lack transportation, live a considerable distance from a mental health agency, or include a family member who has physical conditions limiting mobility. Visiting the home increases access to and inclusion of family members who might not otherwise attend therapy in the office (Cortes 2004; Cottrell 1994; Schacht et al. 1989; Woodford 1999; Zarski et al. 1991; Zarski and Zygmond 1989). Psychological and emotional barriers are reflected when a key family member resists attending treatment in the office (Schacht et al. 1989; Zarski and Fluharty 1992; Zarski and Zygmond 1989), or

when family members fear and distrust social services and assume that attending therapy in an office may jeopardize the family's perceived security (e.g., immigration status). Cultural barriers often relate to a family's conceptualization about family boundaries. An example occurs when family boundaries are closed, suggesting that a member should turn toward the family for help rather than away from the family to seek help outside of the family system. Families with rigid boundaries may overcome the cultural barrier to treatment if they perceive a therapist's visit to the family home as relieving them of having seek help outside but may simultaneously feel challenged while allowing the therapist into the family milieu.

An HBFT approach is often warranted when a family has experienced limited or no change resulting from past treatment efforts employing other treatment modalities (Schmidt et al. 2006). Furthermore, HBFT has been indicated when a member has not improved after a series of hospitalizations (Schacht et al. 1989; Zarski et al. 1992; Zarski and Zygmond 1989), his or her condition is directly associated with family interactional patterns, or changes have not resulted in a sustainable resolution of the presenting problems (Fuller 2004). HBFT treatment also has been indicated when family members have difficulty generalizing learning and experiences from treatment interventions to daily living outside of the treatment setting (Woods 1988).

Families involved with multiple systems may experience additional support when an HBFT approach facilitates ongoing consultations and collaborations between those systems. Families involved in multiple systems often experience stresses associated simply with the time and involvement of interacting with the differing agencies, including coordinating multiple appointment schedules, problem-solving transportation issues, and taking time off from work. These stressors are further exacerbated when the family is faced with responding to and resolving competing expectations. The cross-system coordination of services establishes compatible resourcing and scheduling to meet the family needs.

The HBFT Partnership trains clinicians to foster a therapeutic relationship that utilizes the home environment, identify family roles and expectations, and assess barriers to treatment using a culturally informed approach. The one-day training leads clinicians through an hour and a half experiential exercise exploring cultural differences; reviewing implications for referrals, assessment, and treatment; and examining the relationship of cultural issues and self-of-the-therapist issues.

Contraindications Specific to HBFT

A thorough review of the literature todate revealed very few explicit contraindications for using an HBFT approach. Those that are mentioned tend to apply to therapy in general and family therapy in particular. The issues raised reveal potential concerns for using an HBFT approach when families give evidence of the following: active abuse, violence, or neglect; acute psychiatric or medical crises or untreated substance abuse; negative perceptions of treatment; and repeated unsuccessful HBFT treatments. An additional factor that potentially contraindicates using an HBFT approach occurs when a therapist lacks an appropriate skill level for managing the additional challenges of providing therapy in the home environment.

Family therapy offered in the office or the home has been contraindicated when family members are at risk of exposure to emotional or physical abuse, violence, or neglect within the context of those relationships. Chaffin (2006), Epstein (1997), and Littell (1997) examined the results of family preservation services and suggested that there is limited evidence of long-term effectiveness of addressing those issues. They each suggest the need

for additional rigorous studies that evaluate the process of treatment to determine the mechanisms that lead to sustainable outcomes. Treatments involving families presenting with abuse or neglect potentially jeopardize the safety of the least powerful members. HBFT under those circumstances also may present safety risks to the therapist who lacks immediate access to supervision and other supports (Cortes 2004; Fuller 2004). Therapist safety in the home is often compromised by other specific hazards such as aggressive dogs, no cell phone coverage, and the potential threat of angry clients (Christensen 1995).

Family therapy that is provided without first addressing a family member's acute medical or psychiatric crises or untreated substance abuse could lead to further instability, thus rendering therapeutic efforts ineffective. Family therapy has repeatedly been acknowledged as an effective modality to work with families with a member who is abusing a substance (Becker and Curry 2008; Henggler et al. 1996; Rowe and Liddle 2003). However, HBFT would be contraindicated if it simply focuses on the substance-abusing member (Steinglass 2009), or if that member is actively using substances and resists addressing the impact of his or her substance abuse or dependence on the family. Working with the family system while at least one member remains substance-impaired may result in unduly burdening the other members with an implied message that suggests they take complete responsibility for the change process. This work also raises potential safety risks for the other family members and the therapist visiting the home.

A review of a family's past or present course of treatment may reveal reasons that preclude using an HBFT approach. Such reasons include demonstrations of unresolved issues, involvement in perpetual cycles of crises, exhibiting repeated resistance to or absence from treatment, or continued displays of a distractive and chaotic home environment. The first three family issues often precede an HBFT referral. These issues reflect unaltered family patterns that have rigidified over time and can appear resistant to clinical efforts. When family members have integrated these patterns despite repeated involvement with in-office treatment, it is reasonable to suggest that the prior treatment approaches actually may have reinforced the family members' responses. These three enduring conditions signal the difficulties inherent in much of the work referred for HBFT. Furthermore, if the family referred for HBFT also perceives the additional efforts as simply more in a long series of ineffective and imposing experiences, then an HBFT approach may also be ineffective.

Families often enter into a series of HBFT treatments involving many different therapists. A family demonstrating little or no evidence of success despite previous intensive home-based treatments suggests either (1) the treatment approach has not been appropriately matched and responsive to the family, or (2) the family has not reached a level of readiness to change needed to engage in additional home-based work (Prochaska and Norcross 1999). Families with these experiences may demonstrate their dissatisfaction with or a *lack of buy-in*to the treatment process through repeated absences when a therapist arrives at the home for a session or active resistance to treatment interventions. These responses suggest that the current contract for treatment requires review, adjustment, and perhaps, reconsideration of the provision of HBFT at the current time.

The remaining issue that may contraindicate using an HBFT approach reflects potential gaps in the skill level and training of clinicians attempting to utilize the home environment. A therapist's ability to guide treatment while navigating through the unique challenges of HBFT requires specialized skills that are often missing from graduate training programs (Cortes 2004; Lawson and Foster 2005). Those skills include: deliberate and integrated use of the home environment in developing goals and interventions; adapting treatment to involve children, adults, and the whole family system; managing proper professional

boundaries that honor the distinctions among family member and clinician roles and responsibilities; effectively transforming the "home visit" into therapeutic work; and matching services to the family needs. The increasing difficulty and intensity of working with families in their home requires the clinician to develop specialized skills. Lawson and Foster (2005) suggest that "In situations such as home-based counseling, where the treatment environment is unstructured, the counselor must be functioning at a higher conceptual level for the counseling interactions to be effective" (p.155). When those skills are absent or underdeveloped there is a potential to undermine HBFT treatment effectiveness and reify a family's negative perceptions concerning the value and efficacy of therapy (Cortes 2004; Lawson and Foster 2005).

HBFT trainings assist clinicians in decision-making and equipping processes needed to determine whether HBFT is the appropriate modality for use with particular families. The trainings help clinicians to reflect upon their existing skills and identify additional skills needed to meet the demands of an HBFT approach. The trainings encourage exploration and skill development to enable clinicians to develop plans that insure adequate safety, utilize supervision and collegial support, identify areas needed for additional training, and establish an ongoing program of self-care.

Conclusion

The HBFT Partnership was developed to meet the demand for a statewide dissemination of training and support of HBFT therapists designed to meet the unique challenges of home-based work in varying contexts. Process and outcome evaluations are being developed to examine the effectiveness of individual components of the partnership. These evaluations will assess the effectiveness of the training approaches, the relevance of the topics, and the impact of clinicians' participation in the various partnership components on their work. The relationships among the following variables will also be examined: therapist levels of clinical experience and training, therapist learning, and the impact of varying strategies of self-care and supervision on treatment effectiveness. Outcome evaluations will compare the training data with the data available from state agencies reflecting the frequency of families' use, types, and extent of therapeutic services.

The continued development of the HBFT Partnership faces significant challenges inherent to collaborating with diverse agencies and clinicians from various disciplines. However, focusing on the common components of HBFT has enabled us to develop trainings with a broad appeal and application. The ongoing emphasis on collaboration has enabled us to become aware of that diversity while tailoring our approaches to meet the varied training needs.

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Home-Based Family Therapy Partnership Update

The Connection

www.hbftpartnership.com

September 2007

Mark Your Calendar!

October 4
Core Training
(Private Contractors Priority)
KSU Alumni Center
Manhattan

October 19
Ethics Teleconference
"Ethical Implications of Home-Based Family Therapist Self-Care"

November 6
Core Training
(CMHC Priority)
KSU Alumni Center
Manhattan

Welcome

As a way to make the HBFT website easier to navigate for our users, we are currently in the process of updating it. Please save the new website **www.hbftpartnership.com** to your favorites so you can access all of the new updates. If you have any questions, please contact us at hbft@ksu.edu or call (785) 532-7695 for assistance. Thank you for your cooperation!

Why HBFT is Important

The Home-Based Family Therapy (HBFT) Partnership was launched by the Kansas State University Family Center, SRS, the Community Mental Health Centers in Kansas, and Kansas Health Solutions. This contract has been designed specifically to train and support home-based family therapist.

HBFT is offered through the community mental health centers in Kansas to families who have a child diagnosed with a Serious Emotional Disturbance (SED). Home-based work utilizes the resources of the family's home environment to provide family-driven therapeutic care. Family therapy focuses on the systemic processes that support individual and family issues. The family therapist's work focuses on understanding and intervening in family members' ongoing interactional processes around the SED.

Three main components of the contract provide therapist with training and support: Core Training workshops, Teleconferences, and Online Learning Modules. The one-day Core Training workshop provides an introduction to a systemic approach to home-based family therapy. Televideo Conferences include addressing assessment, diagnosis and treatment of disorders, and addressing ethical issues related to the use of HBFT modality within family contexts. Web-Based Learning Modules offer training and support on therapist self-care, family issues, therapeutic skills, and supervision. For more information visit www.hbftpartnership.com

One group of the Web-Based Learning Modules focuses on specific therapist strategies to manage personal anxiety, health, and wellness.

The HBFT Research Team

We are proud to introduce you the HBFT Research Team. The team is composed of graduate and undergraduate students, and LCMFTs. Team members help develop web-based learning modules and prepare materials for Core Training workshops and Teleconferences.

The HBFT Research Team (left to right)**:**

C.R. Macchi, Kevin Garrett, Kelli Petersen, Yvonne Amanor-Boadu, Nancy O'Conner, Amy Veenendaal, & Yolanda Bernard

Home-Based Family Therapy Partnership Update

The Connection

www.hbftpartnership.com

Winter 2007

Mark Your Calendar!

January 25
Ethics Videoconference
(eight locations across Kansas)

February 14
Core Training
(CMHC's given priority)
KSU Alumni Center, Manhattan

February 22
DSM Videoconference
Part 1
(eight locations across Kansas)

February 28
Regional Core Training
(Private Contractors given priority)
Wichita, KS

Welcome to the Team!

The HBFT Research Team would like to welcome their new team members:

Matt Johnson

Lizzy Walter

Brent Westover

Brent and Matt are both first year MFT students at K-State, and Lizzy is an undergraduate in Family Studies and Human Services at K-State.

HBFT Research Team Developing a New Online Learning Module

The HBFT Research Team is currently in the process of developing a new Web-Based Learning Module that users will soon be able to access. This module addresses the development of cultural competency in relation to therapeutic skills.

In this module, users will learn about the current knowledge in approaches to cultural competency that the fields of counseling, marriage and family therapy, and social work use. The module users will also explore their own ideas about culture and cultural competency as they relate to these approaches and evaluate current approaches to cultural competency in terms of what works best for them in home-based work.

The *Cultural Competence Research Team*: (from left to right, back to front) Yolanda Bernard, Lizzy Walter, Amy Veenendaal, & Yvonne Amanor-Boadu.

Yvonne Amanor-Boadu, the cultural competency module group leader, is a Ph.D. student in the School of Marriage and Family Therapy. She is a licensed MFT and specializes in culture and diversity issues.

This module will be completed by this quarter. It will be available on the HBFT website under the "Therapeutic Skills" module category.

The Kansas Health Solutions, Social and Rehabilitation Services, and Kansas State University "Come Together"

Written by: Lorna Clarke, Michele Johnson, and Krista Morris

KHS and SRS are excited to announce a partnership with KSU to provide Home-Based Family Therapy training for clinicians who are looking for an alternative setting for therapy with the family. This training addresses the more intensive issues often associated with home therapy i.e. boundaries, ethical dilemmas and safety concerns. Participants are exposed to the latest thinking and innovations in the field and provided opportunities to collaborate with other home-based clinicians.

Beyond the one day course, you will have several opportunities for videoconferences and in-person workshops offered to enhance the training experience and provide an opportunity to meet and network with other practitioners of this service.

Stay tuned for the upcoming dates added to the 2007-2008 training calendar!

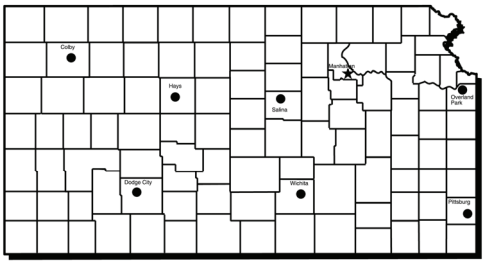
Videoconferences: An Added Advantage for Home-Based Family Therapists

Special Note!: The HBFT team has recently changed the component originally named *Teleconference* to *Videoconference* in an attempt to emphasize how the conference is delivered; via satellite video.

Videoconferences are delivered from the Educational Communications Center at Dole Hall on the KSU campus. Two types of videoconferences are offered each year. One focuses on the diagnostic and assessment of a DSM, while the other addresses an ethical issue related to in-home family therapy. DSM Videoconferences span two 3-hour sessions. The separate Ethics Videoconference addresses the unique ethical challenges involved in providing home-based family therapy.

The videoconferences are available at eight sites across Kansas to minimize clinician travel. The site locations include *Colby, Dodge City, Hays, Manhattan, Overland Park, Pittsburg, Salina, and Wichita*.

TELENET 2 Locations



A Kansas map showing the eight Videoconference site locations.

Videoconferences are designed to encourage sharing between clinicians from all over Kansas. Each conference is limited to 80 total participants, and each is directed by participants' ongoing threaded discussions on the website and the guidance of the HBFT coordinating committee.

The next Ethics Videoconference is January 25, 2008 and the next DSM Videoconference is February 22, 2008. Sign up today by registering on the website!

CEUs and The HBFT Partnership

If you are looking for a way to increase your knowledge and skills as a home-based family therapist and to obtain CEUs, HBFT is a great way to do this. Through the *Web-Based Learning Modules, Core Trainings*, and *Videoconferences* you will be able to obtain both CEUs and knowledge that you can apply in your practice as a home-based family therapist.

A participant can acquire **3 CEUs** for videoconferences, **6 CEUs** for core trainings, and **2 CEUs** for each online module completed. It is important to remember that in order to receive CEUs for the online learning modules, you will need to complete the post-test within 7 days of finishing an online module.

There is a $25 fee associated with registering for core trainings and videoconferences. Community mental health centers are billed directly by HBFT for each person from their agency who registers. For private contractors and agencies associated with KHS, HBFT will bill KHS for these registrations.

> *"As a HBFT user, you will be able to obtain both CEUs and knowledge that you can apply in your practice as a home-based family therapist."*

Quarterly Self-Care Tip

Taking care of yourself physically, cognitively, emotionally, and spiritually is important in your work as a therapist. Self-care is a way to prevent and minimize therapist burnout. By taking care of yourself, you will be able to provide effective clinical services to those with mental health needs.

The self-care tip for this quarter: **Remember to have a sense of humor!** Appropriately using humor with clients and others can reduce blood pressure and anxiety. Laughing supports overall well being and vascular health.

Start laughing and enjoy all the benefits of humor.

Home-Based Family Therapy Partnership Update

The Connection

www.hbftpartnership.com

Spring 2008

Mark Your Calendar!

April 25
DSM Videoconference
"HBFT Treatment of Children with PTSD and Depression" Part II
(eight locations across Kansas)

May 8
Regional Core Training
Clarion Inn
Garden City, KS

May 22
Core Training
KSU Alumni Center
Manhattan, KS

June 12
Core Training
KSU Alumni Center
Manhattan, KS

Notice!

The Web-Based Online Learning Modules are currently unavailable. The HBFT Partnership Team is migrating the HBFT website to a new system.

The HBFT Partnership Team will notify all users when the modules can be accessed again.

Thank you for your cooperation!

HBFT Core Trainings: Coming to a Town Near You

In an attempt to make the Home-Based Family Therapy Partnership Core Trainings more accessible to therapists, the HBFT team has developed *Regional Core Trainings*. Instead of having core trainings exclusively in Manhattan, Kansas we are traveling to three separate locations across Kansas to deliver the training.

On February 28, 2008 a core training was held in Wichita, Kansas at United Methodist Youthville. A total of 16 participants attended the training. The April 1, 2008 Core Training is being held in Olathe, Kansas at the Ball Conference Center. A total of 50 participants are registered for this core training. The last *Regional Core Training* will be **May 8th in Garden City, Kansas** at the Clarion Inn. There are still over 40 seats open for registration for this core training.

If you are interested in registering for the May 8th Core Training, please visit *www.hbftpartnership.com* to sign up!

You can also register to attend a core training in Manhattan by visiting the website. The dates for these two core trainings are **May 22nd** and **June 12th**.

Just a friendly reminder that the HBFT Core Training is the only piece of the partnership that is required for practitioners to complete in order to provide in-home services. You only need to attend the training one time. By attending the training you will receive 6 CEUs.

Quarterly Self-Care Tip

Now that it is officially spring the weather is warmer, flowers are blooming, and everyone is anxious to spend some time outside.

It is important not to forget the importance of taking care of yourself physically. Now that it is getting

warmer, try to participate in physical and recreational activities. Walking, running, or biking outside can reduce anxiety and support better overall well being and health.

Reading or partaking in hobbies can also be activities you can enjoy outside. With summer approaching, try to plan a vacation for you or your family.

Take the time to enjoy yourself and the warm weather!

Upcoming DSM Videoconference: HBFT Treatment of Children with PTSD and Depression

The DSM Videoconference *"HBFT Treatment of Children with PTSD and Depression: Part II"* is being held on **April 25, 2008 from 9:00 a.m. to 12:00 p.m.** The videoconference will be **broadcast to eight locations across Kansas**: Colby, Dodge City, Hays, Manhattan, Overland Park, Pittsburg, Salina, and Wichita.

During the DSM Videoconference the trainers will address home-based family therapy issues within multiproblem families. Children exposed to enduring stressful situations within multi-problem families often result in experiences of varying degrees of trauma and depression. The videoconference workshop will examine ways to use an HBFT approach to diagnose, develop a family system treatment plan, and apply specific therapeutic techniques for working with the family and the child in the home.

Although the videoconference being held on April 25th is "Part II," you can still attend the workshop. You can access information from Part I on the HBFT website. Individuals that attend the April 25th Videoconference will obtain **3 CEUs**.

If you would like to attend this workshop, you can register online at *www.hbftpartnership.com.* There are still seats available, so sign up today! Registration closes April 18, 2008.

Utilizing Available Resources

Are you searching for additional support or help for your work as a home-based family therapist? If so, the HBFT website has a great tool for users to access: the *Resources Tab*.

> *"You can access a variety of journal articles and books that discuss home-based work."*

Under the resources tab, you can find a variety of journal articles and books that discuss specific issues related to home-based work. There are five sections in the resources section to make finding specific articles easier.

One section is the "Core Training Resources." Individuals who have attended the core training, can access the resources referenced during the training. Users can also access articles and books mentioned throughout the Web-Based Learning Modules and the Videoconferences.

Another great resource that users can check out, is the *HBFT Literature Review Report*. This report is an overview of the most current home-based therapy articles and practices.

To obtain these resources visit the HBFT website.

The *HBFT Event Policy*

After registering for an event, be sure to read the *HBFT Event Policy* under the "News" section on the HBFT website. The document details the HBFT Partnership policies regarding training event registration and scheduling.

The event policy discusses:

- The opening and closing dates of each event
- The fees associated with each event
- Event rescheduling and cancelling procedures
- The number of CEUs available for each event.

If you have any questions about the event policy please let the HBFT Team know.

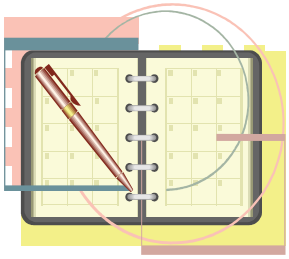
The Connection

HOME-BASED FAMILY THERAPY PARTNERSHIP

www.hbftpartnership.com

Fall 2008

A LOOK AHEAD: 2008-2009 YEAR



Mark your calendars for the upcoming HBFT events!

During the 2008-2009 contract year, the HBFT team will be busy hosting and preparing several core trainings and videoconferences for our users.

The first core training is on **September 18th** in Manhattan. The next and last core training occurring in 2008 is on **November 20th** in Emporia. On **April 14,** 2009 the third core training for the year will be held in Manhattan. The last core training available for therapists will be on **May 5th** in Great Bend.

On **October 17**, 2008 the Ethics Videoconference *"The Ethics of Confidentiality in HBFT"* will be broadcast to eight different locations across Kansas. All videoconferences are televised to multiple locations for your convenience!

A two part videoconference featuring a DSM topic of interest will be held during 2009. Part I of the DSM Videoconference is on **January 30th,** and Part II is on **March 27th.**

If you would like more information on any of these events, please visit the HBFT website:

www.hbftpartnership.com

You can also:

- call 785-532-7695 or
- email hbft@ksu.edu

Helpful Hint

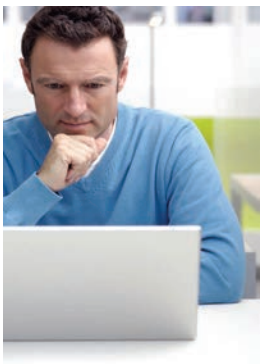
REGISTRATION OPENS 60 DAYS BEFORE ANY EVENT AND CLOSES 7 DAYS BEFORE THE EVENT DATE. YOU CAN REGISTER ONLINE FOR AN EVENT AT THE HBFT WEBSITE.

Ethics Videoconference — Sign Up Now!

You can register online for the upcoming Ethics Videoconference being held on Friday, October 17, 2008. The videoconference will discuss *"The Ethics of Confidentiality in HBFT."*

Providing therapy in the home often raises important and often unavoidable ethical dilemmas associated with insuring client confidentiality. This workshop is designed to identify and address the common ethical issues of HBFT and provide a framework for addressing and minimizing the impact of those issues.

By attending, you can earn 3 CEUs.



Quarterly Self-Care Tip: Focus on YOU!

This quarter take the time to clarify your view as an adult and as a clinician. Increasing your self-awareness is a great self-care tool. To increase your self-awareness, you can seek personal therapy.

There is no shame in utilizing personal therapy. As a clinician it is important to be aware of the demanding nature of home-based work. Seeking therapeutic services when you feel overwhelmed or out of balance is a healthy way to take care of yourself and your clients.

STAYING CONNECTED

On the HBFT website home-page, there is a "Discussion" tab. The "Discussion" tab allows users to participate in ongoing discussion boards with other clinicians.

You can post questions and answers on various home-based topics that are seen by all HBFT users.

Post your thoughts if you have questions or great advice!

Need CEUs?

Online learning modules are accessible on the HBFT website. The modules cover four topic areas:

- Therapeutic Skills
- Family Issues
- Therapist Self-Care
- Supervision

Each Module = 2 CEUs

You can complete the module at your convenience, because the website remembers the page you last visited!

Home Based Family Therapy Partnership

The Connection

www.hbftpartnership.com hbft@ksu.edu Winter 2009

New modules and videoconference

The HBFT Partnership is pleased to announce the launching of two new modules and a new videoconference.

The *Utilizing Supervision* module has been designed to assist HBFT clinicians in intentionally using supervision to guide and support their clinical work. This module reviews the literature describing the varying dimensions of supervision. The module provides a guide for therapists to examine their current supervision and discover specific ways to request the types of supervision processes that will best support their work.

The *Families and Domestic Violence* module is theoretically based with a strong application area. Specific attention was focused on clinician safety in working in the home where violence is a presenting a problem or jeopardizing family safety. There is a guide for the therapist to assess for violence and handouts that can be printed out to help the family members achieve safety. These handouts can be modified for particular practice in geographic areas.

On January 30, 2009 the first part of a DSM videoconference titled *Managing ADHD Through Family Therapy* was held. This videoconference is designed to explore the various child and family experiences, clinical presentations and treatments of Attention-Deficit/ Hyperactivity Disorder (ADHD).

We hope to have a transcript of this videoconference available on our website soon. However, please take note that this will solely be for informational purposes; you will only be able to obtain CEUs by attending the event.

You may participate in the second part of the DSM videoconference on March 27, 2009 by visiting one of eight different videoconference sites across the state. Visit our website for more information or to sign up.

Notice something different?

The Spanish version of this newsletter appears courtesy of undergraduate intern Shannon Sulanke and the assistance of her faculty advisor in the Department of Modern Languages at Kansas State University.

Modules in Development

The final two modules for the contract year are in development. The Therapeutic Skills module is *Using Play Therapy in the Home.* This module features information on a "play therapy toolbox" which will contain transportable toys that involve the entire family in the play therapy process. The Self-Care module will focus on *Maintaining Personal and Professional Boundaries*.

Look for these modules on our website in June.

Reminder:
Registration for HBFT events opens 60 days before the event and closes 7 days before the event. See our updated event policy on the next page.

New Staff Members

The HBFT Research Team has recently welcomed four new staff members.

Gladys Barkey Asiedu joined the team in September 2008 as a Team Leader. Gladys is responsible for compiling literature from peer reviewed journals and scholarly books for use in the Online Modules. She also designs, implements, and analyzes data from pre and post tests used in the Online Modules.

Shannon Sulanke joined the team as a volunteer in September 2008 and then as an intern in January 2009. She will be working on the Therapist Self-Care module. She is also responsible for the publication of the newsletter in both English and Spanish and will be translating Therapist Safety Tips into Spanish.

Rachel Meether joined the team as an intern in January 2009. She will be working on the Play Therapy module and will be developing a play therapy toolbox that will be transportable to the home. In addition, she is going to develop a comparison grid identifying cultural interpretations of the various toys in the toolbox.

Breanna Burns became a part of the team as a volunteer in February 2009. She will assist in researching for and composing the Therapist Self-Care module.

Clockwise: Dr. C.R. Macchi, Nancy O'Conner, Breanna Burns, Rachel Meether, Lizzy Walter, Shannon Sulanke, Gladys Asiedu, and Kelli Stubenhofer

Upcoming Events

Friday, March 27th
DSM Videoconference (Part II)
Eight locations across KS

Tuesday, April 14th
Core Training
Manhattan, Kansas
K-State Alumni Center

Tuesday, May 5th
Core Training
Great Bend, Kansas
Location TBA

Visit our website for more information or to sign up for any of these events.

Quarterly Self-Care Tip

Self-care involves varying dimensions, including physical, emotional, and spiritual aspects. While each is important, this quarter's tip will focus on physical self-care due to the fact that it is the prime time of the year to catch a cold, the flu, or another type of bug. Avoid infecting yourself and/or others by taking a few precautions when you make your home visits. Wash your hands often (carry hand sanitizer if necessary) and keep them away from your nose, mouth, and eyes. Avoid touching common surfaces such as doorknobs with your bare hands, especially if you are around clients who are coughing or sneezing.

It would also be a good idea to carry sanitary wipes (such as those made by Clorox or Lysol) to wipe off your shoes, handbag, toys brought for children, and any other materials you bring into the home.

When not with clients, be sure to take care of your body by eating a healthy diet, exercising regularly, drinking plenty of fluids, and getting sufficient rest.

Notice of new event policy

The HBFT Partnership has adopted a new policy concerning events due to repeated problems of not receiving payments. Invoices will be sent two weeks preceding an event and we encourage you to send your payment before the event or bring it with you. If you have not submitted payment for an event you have attended, your certificate will be withheld until we receive it. Remember that you are not certified to perform home-based services until you receive a certificate! Additionally, you will not be permitted to register for future events if you have an outstanding bill. Thank you for your cooperation.

La Asociación de Terapia Familiar Domiciliaria

La Conexión

www.hbftpartnership.com hbft@ksu.edu Invierno 2009

Módulos nuevos y videoconferencia

La Asociación HBFT tiene el placer de anunciar el lanzamiento de dos módulos nuevos y una videoconferencia nueva.

El módulo *Como Utilizar la Supervisión* se ha diseñado para ayudar a los terapeutas de HBFT a usar la supervisión intencionalmente para dirigir y apoyar su trabajo clínico. Este módulo resume literatura que describe las varias dimensiones de la supervisión. El módulo provee una guía para los terapeutas a examinar su supervisión actual y descubrir maneras específicas a pedir los tipos de procesos de supervisión que mejor apoyen su trabajo.

El módulo de *Las Familias y Violencia Domestica* se basa en la teoría pero incluye un fuerte elemento de aplicación práctica. Se enfocó espeúticamente en la seguridad del terapeuta de trabajar en una casa donde existe la violencia o donde pone en peligro la seguridad de la familia. Hay una guía disponible para el terapeuta que facilita la evaluación de violencia en el hogar al igual que hojas informativas que pueden ser impresos para ayudar que haya seguridad entre los miembros de la familia. Estas hojas informativas pueden modificarse para ser utilizados en diferentes lugares geográficos.

El 30 de enero 2009 presentamos el primer parte de una videoconferencia DSM titulada *Cómo Manejar ADHD Mediante la Terapia Familiar.* Esta videoconferencia fue diseñada para explorar las diferentes experiencias de los niños y la familia, presentaciones clínicas, y los tratamientos de Trastorno por Déficit de Atención con Hiperactividad (ADHD).

Esperamos tener una transcripción de esta videoconferencia disponible en nuestro portal electrónico muy pronto. Sin embargo, por favor anote que el trasunto tiene propósito informativo solamente, sólo puede obtener CEUs por asistir al evento.

Usted puede participar al visitar uno de ocho sitios diferentes para videoconferencias a través del estado. Visite nuestro sitio Web para obtener más información o para inscribirse.

¿Nota alguna diferencia?

La versión en español de este boletín informativo aparece por cortesía de la interna subgraduada Shannon Sulanke y la ayuda de su mentor de facultad del Departamento de las Lenguas Modernas en Kansas State University.

Módulos en desarrollo

Los módulos finales para el vigente año de contrato están en desarrollo. El módulo de “Destrezas Terapéuticas” es *Utilizar la Terapia de Juego en el Hogar.* Este módulo incluye información sobre una “caja de herramientas para la terapia de juego” que contiene los juguetes portátiles que incluyen a toda la familia en el proceso de la terapia de juego. El módulo de Asistencia Personal se enfocará en *Mantener Límites Personales y Profesionales.*

En junio, busque estos nuevos módulos en nuestro sitio web.

¡Ojo!

La matricula para los eventos de HBFT empieza 60 días antes del evento y termina 7 días antes del evento. Mire a la pagina siguiente para nuestra política actualizada con respecto a los eventos.

Asociadas Nuevas

El equipo de investigación de HBFT da la bienvenida a cuatro personas que se unieron recientemente. Gladys Barkey Asiedu se incorporó al equipo en septiembre de 2008 y está haciendo su doctorado en Estudios de la Familia. Gladys es responsable por la compilación de la bibliografía de revistas y libros eruditos para usarlos en los Módulos En Línea. También diseña, pone en práctica, y analiza los datos de las pre y post-pruebas utilizadas en los Módulos En Línea.

Shannon Sulanke pasó a formar parte del equipo como voluntaria en septiembre de 2008 y sigue como interna en enero de 2009. Ella trabajará en el módulo Asistencia Personal. También es responsable por la publicación del boletín informativo en inglés y español y traducirá los Consejos de Seguridad para los Terapeutas del inglés al español.

Rachel Meether se incorporó al equipo como interna en enero de 2009. Trabajará en el modulo del Terapia del Juego y desarrollará una caja de herramientas de terapia de juego que pueda llevarse a la casa. Además, va a desarrollar una cuadrícula para comparar las interpretaciones culturales de los varios juegos en la caja de herramientas.

Breanna Burns se integró al equipo como voluntaria en febrero de 2009. Ayudará con la investigación y composición del módulo Asistencia Personal.

De izquierda a derecha: Dr. C.R. Macchi, Nancy O'Conner, Breanna Burns, Rachel Meether, Lizzy Walter, Shannon Sulanke, Gladys Asiedu, y Kelli Stubenhofer

Eventos Próximos

viernes, 27 marzo
DSM Videoconferencia (parte II)
Ocho localizaciones por el estado

martes, 14 abril
Capitación Profesional
Manhattan, Kansas
K-State Alumni Center

martes, 5 mayo
Capitación Profesional
Great Bend, Kansas
Localización por confirmar

Visita a nuestro sitio Web para obtener más información o inscribirse.

Consejo de Asistencia Personal Trimestral

La asistencia personal implica varias dimensiones, incluyendo aspectos físicos, emocionales, y espirituales. Mientras cada aspecto es importante, el consejo de este trimestre se enfocará en la asistencia personal física porque ésta es la temporada del año en donde mas comúnmente se cogen resfriados, la influenza, y otro tipo de virus o bacteria. Evite contagiarse y/o contagiar a otros al tomar ciertas precauciones cuando haga sus visitas al domicilio. Lávese las manos frecuentemente (lleve desinfectante para las manos si es necesario) y no toque la nariz, la boca, y los ojos. Evite tocar las superficies comunes como las perillas con las manos descubiertas, especialmente si está cerca de clientes que tosen o estornudan.

También es una buena idea llevar toallitas sanitarias (como las de Clorox o Lysol) para limpiar los zapatos, su bolso, los juegos para los niños, y los demás materiales que lleve a la casa.

Cuando no está trabajando con clientes, ponga atención a su cuerpo y coma una dieta saludable, haga ejercicio regularmente, tome muchos líquidos, y duerma suficientemente.

Nueva póliza con respecto a los eventos

La Asociación HBFT ha adaptado una póliza nueva con respecto a los eventos por continuos problemas con clientes que no pagan las cuentas. Las facturas serán enviadas dos semanas antes de un evento y nosotros le recomendamos enviar el dinero antes del evento o llevarlo consigo. Si no nos pago por un evento al que ha asistido, su certificado será retenido hasta que lo recibamos. ¡Recuerde que no está certificado para hacer los servicios basados en el hogar hasta que reciba un certificado! Además, no podrá inscribirse para futuros eventos si tiene alguna cuenta pendiente. Gracias por su cooperación.

Home Based Family Therapy Partnership

The Connection

www.HBFTPartnership.com hbft@ksu.edu Spring 2009

In Focus: Domestic Violence

Domestic violence has garnered much attention in the media in recent weeks due to an alleged violent encounter between hip-hop artists Chris Brown and Rihanna. It serves as a critical reminder, or newfound awareness for some, that domestic violence can happen to anyone, anywhere, anytime.

Although definitions for domestic violence vary, Miller & Knutsen (2007) assert that it consists of episodes that are "usually repeated but always purposeful social behaviors or omissions that tend to be motivated by inappropriate intentions to control or dominate family members or situations that affect family relationships".

Domestic violence can occur in many forms, including physical attacks, emotional manipulation, verbal insults, sexual assault, and stalking. Victims can be of any age, sex, race, culture, religion, education, employment or marital status. Domestic violence occurs within all types of families (biological, adoptive, stepfamilies, etc) and within intimate partner relationships where the partners may be married or not married; heterosexual, gay, or lesbian; living together, separated, or dating.

As a home-based family therapist, you will undoubtedly encounter a situation of domestic violence in your client homes if you have not already. We encourage you to be informed about domestic violence and how to ensure the safety of yourself and your clients.

In this edition of the newsletter, we will focus on a theme pertinent to home-based family therapists.

You may still learn about current events and activities of our organization by visiting our website.

Prevalence

- 1 in 4 (25%) women has experienced domestic violence in her lifetime.
- Women account for 85% of the victims of domestic violence, men account for 15%.
- Women ages 20-24 are at the greatest risk for nonfatal domestic partner violence.
- Studies suggest that between 3.3-10 million children witness domestic violence annually.
- One in 12 women and one in 45 men will be stalked in their lifetime, for an average duration of almost two years.
- On average, more than three women and one man are murdered by their intimate partners in this country every day.
- On average, only 70% of nonfatal partner violence is reported to law enforcement.

Frog in the Kettle: A Metaphor for Domestic Violence

"They say that if you put a frog into a pot of boiling water, it will leap out right away to escape the danger. But, if you put a frog in a kettle that is filled with water that is cool and pleasant, and then you gradually heat the kettle until it starts boiling, the frog will not become aware of the threat until it is too late. The frog's survival instincts are geared towards detecting sudden changes."

Although this famous fable has been debunked in recent years, it has been around long enough to still convey its original meaning in a variety of contexts.

We can connect this fable to the context of tolerance of domestic violence by the victim. Domestic violence begins slowly and gradually escalates to more serious acts. The victim is unaware of the threat of escalating violence until it becomes dangerous because he/she slowly adjusted their tolerance, much like the frog adapting to the slowly increasing temperature of the water. Because domestic violence does not start suddenly, its victims are unable to perceive its true danger, sometimes until it is too late.

Want to know more about domestic violence?

We have recently published an online learning module entitled Families and Domestic Violence. You may access it by visiting the On-Line Learning section of our website, www.HBFTPartnership.com.

In Focus: Domestic Violence

Therapist Safety

When working with couples and families experiencing domestic violence, you may encounter a situation that puts you in danger while doing your home-based work. It is critical for you to stay safe in these situations. In our online module, we have included information about taking necessary precautions before making a home visit and physical warning signs of a potential assault. Additionally, if an intervention is needed, we have described the eight stages of escalation:

1. Informative seeking
2. Non-compliance
3. Challenging
4. Threatening
5. Emotional outburst
6. Acting out toward self
7. Acting out toward others
8. De-escalation

Client Safety

As a home based family therapist, you have a responsibility to work with the victim and help them develop a safety plan. To better assist your work, you may find a Personalized Safety Plan and Domestic Violence Safety Tips in our online module. These discuss how the victim can accomplish the following:

- Protect oneself at home
- Make one's children safer
- Make oneself safer at work
- Using the law to help
- Be safe at the court house
- Be informed about criminal proceedings

Separating Fact from Fiction

Myth: If a woman is abused, she must have deserved it.
Truth: No one deserves to be abused. The only one responsible for the abuse is the perpetrator.

Myth: Domestic violence is caused by alcohol/drug abuse, stress, and mental illness.
Truth: Although any of these may be involved in a domestic violence incident, they are not the cause of domestic violence but rather the excuse used by the abuser.

Myth: If someone is being abused so badly, they would just leave the relationship.
Truth: The most dangerous time for a victim of abuse is when he/she tries to leave. There may be many reasons why the victim does not leave, but that does not mean the victim is okay with the situation or wants to be abused.

Myth: The abuser has poor anger management control.
Truth: Many abusers admit to calmly planning violent incidents and most batterers are able to control their emotions when on the job, with friends, in court or when dealing with the police.

Domestic Violence Resources

National Sexual Assault Hotline
800-656-HOPE (800-656-4673)
www.rainn.org , info@rainn.org

National Domestic Violence Hotline
800-799-SAFE (800-799-7233)
www.ndvh.org , ndvh@ndvh.org
TTY: 800-787-3224, deafhelp@ndvh.org

Child Abuse Hotline
800-4-A-CHILD (800-422-4453)
www.childhelpusa.org

National STD/HIV Hotline
800-227-8922

National Hopeline Network
800-SUICIDE (800-784-2433)
www.hopeline.com

Want to know more about domestic violence?

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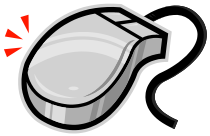


La Asociación de Terapia Familiar Domiciliaría

La Conexión

www.HBFTPartnership.com hbft@ksu.edu Spring 2009

Enfocado: La Violencia Doméstica

La violencia doméstica ha ganado mucha cobertura informativa en las semanas recientes como resultado de un alegado encuentro violento entre los artistas de hip-hop Chris Brown y Rihanna. Esto sirvió como una advertencia crucial, que la violencia doméstica le puede ocurrir a cualquier persona, en cualquier lugar, y en cualquier momento. Esto también implica la oportunidad de acceder lo que para algunos podría ser nueva información sobre violencia doméstica.

Mientras las definiciones para la violencia doméstica son variadas, Miller & Knutsen (2007) afirman que ésta consiste de episodios que "usualmente son repetidos pero siempre y tienden a ser motivados por las intenciones inapropiadas para controlar o dominar a los miembros de la familia o las situaciones que afectan cómo la familia se relaciona".

La violencia doméstica puede ocurrir de diferentes formas incluyendo los ataques físicos, la manipulación emocional, los insultos verbales, el asalto sexual y acecho. Las victimas pueden ser de cualquiera edad, raza, cultura, o religión, de ambos sexos, de cualquier estado civil o tener cualquier empleo. La violencia doméstica ocurre dentro todos los tipos de la familia (biológicos, adoptivos, ensamblados, etcétera) y dentro de las relaciones íntimas donde las parejas pueden estar casadas o no casadas; heterosexuales, homosexuales, o lesbianas; viviendo juntos, separados, o cortejándose.

Como terapeuta domiciliaria, usted sin duda encontrará situaciones de violencia doméstica en los hogares de sus clientes, si ya no ha ocurrido. Le animamos a que se informe sobre la violencia doméstica y cómo asegurar la seguridad de sí mismo y de sus clientes.

En esta edición del boletín informativo, nos enfocaremos en un tema pertinente a los terapeutas domiciliarios.

Todavía puede aprender sobre los eventos actuales y las actividades de nuestra organización al visitar nuestro sitio en el internet.

Frecuencia

- 1 en 4 (25%) mujeres ha experimentado la violencia doméstica en su vida.
- 85% de las mujeres son víctimas de violencia doméstica, al igual que el 15% de los hombres.
- Las mujeres entre las edades de 20 a 24 años corren el mayor riesgo de violencia doméstica no-fatal.
- Los estudios sugieren que entre 3.3 a 10 millones de niños dan testimonio de violencia doméstica anualmente.
- Una en 12 de las mujeres y uno en 45 de los hombres serán acechados en su vida con duración promedio de casi dos años.
- Un promedio de más de tres mujeres y un hombre son asesinados por sus parejas íntimas en nuestro país cada día.
- Solamente un promedio de 70% de la violencia de pareja no-fatal es reportado a la policía.

La rana en la tetera: una metáfora para la violencia doméstica

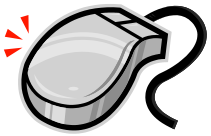
"Se dice que si se pone una rana en una cacerola de agua hirviendo, saltará inmediatamente para escapar el peligro. Pero, si se pone una rana en una tetera que está llena de agua fresca y agradable, si se calienta el agua en la tetera gradualmente hasta que empieza a hervir, la rana no se da cuenta del peligro hasta que es demasiado tarde. Los instintos de supervivencia de la rana están acostumbrados a detectar los cambios repentinos."

Aunque esta fábula famosa ha perdido prestigio en los últimos años, ha existido por bastante tiempo y transmite su significado original en una variedad de contextos.

Podemos conectar esta fábula al contexto de la tolerancia de la violencia doméstica por parte de la víctima. La violencia doméstica empieza lentamente y gradualmente aumenta a actos más serios. La víctima no se da cuenta de la amenaza del aumento de la violencia hasta que se pone en peligroso porque él/ella ajusta su tolerancia lentamente, tanto como la rana se adapta a la temperatura del agua que aumenta lentamente. Porque la violencia doméstica no empieza de repente, sus víctimas no pueden percibir su peligro actual, algunas veces hasta que es demasiado tarde.

¿Quiere saber más sobre la violencia doméstica?

Hemos publicado recientemente un módulo en línea titulado: Las Familias y la Violencia Doméstica. Puede accederlo al visitar la sección de Aprendizaje en Línea en nuestro página de internet, www.HBFTPartnership.com.



Enfocado: La Violencia Doméstica

Seguridad del Terapeuta

Cuando trabaja con parejas y familias que están experimentando la violencia doméstica, es posible que encuentre una situación que lo ponga en peligro mientras hace su trabajo domiciliario. Es imperativo para usted asegurar su seguridad en estas situaciones. En nuestro módulo en línea, incluimos información sobre las precauciones necesarias antes de hacer una visita a la casa y señales físicas de peligro de un asalto potencial. Si una intervención es necesaria, también describimos las ocho etapas de la intensificación:

1. Buscando informativo
2. Incumplimiento
3. Desafiar
4. Amenazar
5. Arrebato emocional
6. Agresión hacia si mismo
7. Agresión hacia otros
8. Desaceleración

Seguridad de los Clientes

Como terapeuta domiciliario, tiene la responsabilidad de trabajar con la víctima y ayudarle a desarrollar un plan de seguridad. Para su ayuda en el trabajo, puede encontrar un Plan de Seguridad Personalizado y Consejos de Seguridad en Situaciones de Violencia Doméstica en nuestro módulo en línea. Estos discuten como la víctima puede realizar los siguientes:

- Cómo protegerse a usted mismo
- Cómo asegurar la protección de los hijos
- Cómo asegurar su protección en el trabajo
- Cómo buscar ayuda usando la ley
- Cómo protegerse en la corte
- Cómo informarse sobre los procedimientos criminales

Separar la realidad de la ficción

Mito: Si una mujer es abusada, lo merecería.
Verdad: Nadie merece ser abusado. La única persona que es responsable del abuso es el perpetrador.

Mito: La violencia doméstica es causada por el abuso del alcohol/ drogas, el estrés, y la enfermedad mental
Verdad: Aunque es posible que cualquiera de estas pueda estar envuelta en un incidente de violencia doméstica, no son la causa de la violencia doméstica pero la excusa utilizada por el abusador.

Mito: Si una persona está siendo muy abusada , debería de salir de la relación.
Verdad: El tiempo más peligroso para una víctima del abuso es cuando él/ella trata de escaparla. Haya muchas razones por las qué la víctima no sale, pero eso no significa que la víctima consiente a la situación o quiere ser abusada.

Mito: El abusador tiene poco control sobre su ira.
Verdad: Muchos abusadores admiten planificar los incidentes violentos con calma y la mayoría de los perpetradores tienen la capacidad de controlar sus emociones cuando están en el trabajo, con amigos, en la corte, o cuando tienen que testificar con la policía.

Recursos para la Violencia Doméstica

Línea Telefónica Nacional de Agresión Sexual
800-656-HOPE (800-656-4673)
www.rainn.org , info@rainn.org

Línea Telefónica Nacional de Violencia Doméstica
800-799-SAFE (800-799-7233)
www.ndvh.org , ndvh@ndvh.org
TTY: 800-787-3224, deafhelp@ndvh.org

Línea Telefónica para el Maltrato de Menores
800-4-A-CHILD (800-422-4453)
www.childhelpusa.org

Línea Telefónica Nacional para ETS/HIV
800-227-8922

Red Nacional Hopeline
800-SUICIDE (800-784-2433)
www.hopeline.com

¿Quiere saber más sobre la violencia doméstica?

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Home-Based Family Therapy Partnership

The Connection

www.HBFTPartnership.com hbft@ksu.edu Fall 2009

In Focus: Problem Gambling

Since the Kansas Expanded Lottery Act passed by one vote in the Kansas Legislature in 2007, legislatures, therapists, gambling counselors, and casinos have been preparing for the expansion of gaming in Kansas. However, since 2001 preparations have been in the making with the development of helpline and referral services, prevention, public awareness and marketing.

For most people, gambling is a fun and relaxing pastime. For about 4% of the population, gambling is a huge problem. In Kansas alone, there are 73,000 people who are problem gamblers. Problem gambling describes activity when gambling negatively affects/disrupts life for the gambler and their loved ones. Studies have shown that 6% of problem gamblers will seek help.

The Kansas Coalition on Problem Gambling is trying to minimize problem gambling through prevention and education, while recommending treatment and services to those already addicted.

The Problem Gambling and Addictions Grant Fund, established in 2000, is furnished by 2% of all casino profits. The Problem Gambling Fund goes towards prevention, treatment, crisis intervention, and research of problem gambling.

Criteria for Pathological Gambling

(Published in the Diagnostic and Statistical Manual)

1. Preoccupation with gambling
2. Need to gamble with increasing amounts
3. Repeated unsuccessful efforts to control
4. Restless/irritable when cutting back
5. Gamble as escape from negative feelings
6. Chasing losses
7. Lies to significant others to conceal gambling
8. Committed illegal acts
9. Has jeopardized/lost job, relationships, etc. because of gambling
10. Relies on others to get money for gambling

Kansas Problem Gambling Helpline

Started in 2001, the Gambling Helpline is staffed by trained professionals 24/7 in order to provide help to gamblers or their friends and family. The objectives of the helpline include: de-escalating situations, preventing harm to self or others, and referral and placement into the appropriate level of care.

Gambling Helpline Number:
(888) 662-3800

Self-Exclusion Program

Problem Gamblers may choose self-exclusion as an option for recovery. Their request to be excluded from the casino is taken very seriously. They may also ask to be taken off all casino mailing lists. In order to join the self-exclusion program, gamblers must contact the casinos directly.

Problem Gambling and Co-Occurring Disorders

Problem and pathological gamblers are usually impulsive, thrill seeking, anxious, and have difficulty learning from experiences. These characteristics are not unlike those of other addictions. In fact, many of these disorders go hand in hand. Two diseases occurring together, or co-morbidity, dramatically increases the problems the gambler faces and increases the treatment and recovery time.

Problem gamblers have a clinically significant increased rate of substance, nicotine, and alcohol use compared with non-gamblers. They also have increased rates of major depression, schizophrenia, OCD, and anxiety disorder.

Studies have shown that there is increased suicidal rates among people with co-morbid substance abuse disorder and problem gambling than with either population separately. 70.1% of this population has had active suicidal thoughts, and 41.3% have attempted suicide.

Treatment for problem gamblers with other diseases and disorders need special treatment to insure full recovery. These services include individual counseling, couples/ family counseling, group counseling, financial management counseling, and medication management.

With an understanding of the prevalence of co-morbidity among problem gamblers, counselors can help their clients address the entire issue.

THE STATS

- 73.2% of pathological gamblers have an alcohol use disorder.
- 38.1% have a drug use disorder
- 41.3% have an anxiety disorder
- 60.8% have a personality disorder
- 49.6% have a mood disorder
- 60.4% have nicotine dependence

Kansas Certified Gambling Counselors

On October 1, 2009, the eligibility requirements to become a Kansas Certified Gambling Counselor came into effect. Those wishing to acquire the Kansas Certified Gambling Counselor Level 1 must have current certification as a National Certified Gambling Counselor or meet these conditions. Individuals must hold a Master's or Doctorate Degree in a related field and complete a designated gambling specific training program approved by SRS Addiction and Prevention Services. Once the program is completed, individuals must pass the National/International Certification Examination for Gambling Counselors and complete 24 hours of supervised problem gambling counseling. Training begins April 13th.

For More Info on Problem Gambling

Kansas Coalition on Problem Gambling
http://www.ksproblemgambling.org/

For Information on Kansas Certified Gambling Counselor Training contact:

Kansas Department of Social and Rehabilitation Services

Addiction and Prevention Services

Or contact:

David Dickinson
David.Dickinson@srs.ks.gov
(785) 368-6392

Jean Holthaus
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Home-Based Family Therapy Partnership Update

The Connection

www.hbftpartnership.com

Winter 2010

In Focus: Fetal Alcohol Spectrum Disorder

Fetal Alcohol Spectrum Disorder (FASD) describes a continuum of permanent birth defects caused by the consumption of alcohol during pregnancy. FASD includes, but is not limited to Fetal Alcohol Syndrome (FAS).

Although FASD is not included in the Diagnostic and Statistical Manual, it is still widely recognized as a serious problem with multiple consequences.

The Surgeon General recommends women not drink alcohol at all while pregnant. However, 10% of pregnant women report any alcohol use and 2-4% report binge drinking. It is estimated that the lifetime medical and social costs of each child with FASD is $800,000.

Alcohol use during pregnancy is one of the leading preventable birth defects and childhood disabilities in the U.S. It is also the number one cause of mental retardation in the Western world.

Along with mental retardation, there are a wide range of other physical, behavioral, and cognitive effects that can result from prenatal alcohol exposure.

Because FASD is preventable, screening from physicians, social workers, therapists and other professionals is essential. Screening is recommended by the U.S. Preventative Services Task Force and the CDC.

Along with screening, therapists play an important part in diagnosing FASD and teaching adaptive techniques to overcome the disability.

Therapists can maximize the potential a person with FASD has with early and persistent intervention.

The Best Practices in the Care of a Child with FASD are….

Early Recognition
and
Early Intervention!

Upcoming Events

February 19

FASD Videoconference Part 1

March 26

FASD Videoconference Part 2

April 14

Core Training Manhattan

May 12

Core Training Pittsburg

Risk Factors: Which Women are most likely to drink while Pregnant?

The birth defects caused by maternal consumption of alcohol during pregnancy are permanent, therefore it is very important for therapists to be aware of the women who are at risk for having babies with FASD.

Women who are alcohol dependent, have previously abused alcohol while pregnant, or have a previous biological child with FASD at the most at-risk for having a baby with FASD.

Women also increase their risk if they have depression, use other drugs or tobacco, or live with someone who is a heavy drinker.

Other Risk Factors

- Low Socioeconomic Status
- Unmarried
- African-American and American-Indian/Alaska -Native ethnicity
- Younger maternal age

Past and Current Models of Alcohol Use

Moral Model

- Personal choice whether to drink or abstain.
- Individual doesn't have the moral strength to resist alcohol's temptation.
- Blame is placed on the alcohol-dependent individual.

Sociocultural

- Abuse is facilitated by society
- Problem due to lack of economic opportunity and positive role models.
- Treatment involves education, economic opportunity and reintegration into society.

Psychological

- Heavy drinking is promoted by observing others and it used to numb pain or achieve pleasure.
- Problem due to lack of other coping skills to deal with stress.
- Treatment involves learning positive coping skills, reducing stressors and resolving emotional problems.

Addictive

- Promotes idea that addiction is a disease that is progressive and curable.
- Loss of control of drinking and denial of problem are indicators of disease.
- Abstinence is the first step to treatment.

Biomedical

- Most widely supported in scientific literature.
- Alcohol dependence is a brain disorder.
- Abstinence advisable but not seen as necessary for all people.
- Favors harm-reduction approach, drug substitution, craving reduction medication, and brief psychotherapy.

Effects of Alcohol on the Fetus

Prenatal exposure to alcohol can have serious negative effects for all aspects of development, including physical, behavior and cognitive defects. The severity of FASD depends on the dosage, timing of exposure, and duration of exposure.

Physical

The physical effects of FASD include low birth weight, craniofacial defects, growth retardation, renal defects, skeletal defects, and negative impacts to the cardiovascular and central nervous system.

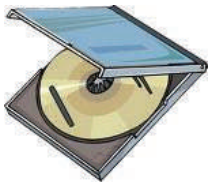
Cognitive

People with FASD may experience memory and learning impairments, including difficulties with verbal learning, visual-spatial learning, attention, and reaction time.

Behavioral

Behavioral deficits may include hyperactivity, disrupted school experiences, trouble with the law, incarceration, inappropriate sexual behavior, and alcohol or other drug problems.

Now Available!



CD Companion on Domestic Violence

Ask your Director or contact HBFT at hbft@ksu.edu

Recommended Alcohol Screening Instruments Specifically for Women who are or may become Pregnant

TWEAK

1. A How many drinks does it take to feel effects of alcohol? ***[Tolerance]*** (3 or more drinks = 2 points)
2. Have friends/relatives *Worried* about your drinking in the past year? ***[Worried]*** (yes = 2 points)
3. Ever drank first thing in the morning? ***[Eye-opener]*** (yes = 1 point)
4. Ever drank but can't remember what you said or did in am? ***[Amnesia]*** (yes = 1 point)
5. Ever feel the need to cut down on your drinking? ***[K(C)ut down]*** (yes = 1 point)

T-ACE

1. Does it take more than it used to for you to get high? ***[Tolerance]*** (yes = 2 points)
2. Have you become ***Angry*** *or* ***Annoyed*** when others express concern about your use? (yes = 1 point)
3. Have you tried to ***Cut down*** or quit? (yes = 1 point)
4. Have you ever had a drink first thing in the am? ***[Eye opener]*** (yes = 1 point)

For more information, visit the National Institute on Alcohol Abuse and Alcoholism at http://www.niaaa.nih.gov/

Home-Based Family Therapy Partnership Update

The Connection
Let's Talk Play Therapy

www.HBFTPartnership.coM

November 2010

Spotlight Therapist: Interview with Denise Filley

What is the KC certificate program?

It is a 10 month program that allows practitioners or grad students to be thoroughly trained in play therapy. Our program meets the national standards for becoming a Registered Play Therapist with the Association for Play Therapy. It includes both instructional training and play therapy supervision. Students can attend either Monday night classes or a once-a-month weekend class. We currently offer our program in KC, Omaha, St. Louis and, starting next year, in Wichita and online.

What advice would you give to beginning play therapists?

Be creative and flexible. Start by finding your theory approach and the play therapy will fall into place easily.

What advice would you give to advanced play therapists?

Never stop learning. Attend national conferences and local ones, too, to keep your skills up-to-date and to keep up with current evidence based treatments.

Full Interview can be found online at HBFTPartnership.com

Upcoming Events

February 11th
DSM Videoconference on Juvenile Bipolar Disorder: Assessment and Diagnosis (Part I)

March 11th
DSM Videoconference on Juvenile Bipolar Disorder: Treatment Planning and Interventions (Part II)

What is Play Therapy?

Play therapy is a type of psychotherapy generally used with children ages three to eleven. Its goal is to help children communicate their experiences and feelings through play under the guidance or observation of a therapist.

14 Major Types of Play Therapy:

* Psychoanalytic
* Cognitive Behavioral
* Jungian
* Family
* Adlerian
* Group
* Child-centered
* Ecosystemic
* Filial
* Phenomenological
* Gestalt
* Object Relations
* Attachment-oriented
* Prescriptive

A Little Bit about Theraplay

Theraplay is modeled after healthy parent-child relationships. It falls into four dimensions of a healthy parent-child relationship:

Structured

Therapist is in charge and directs the activities. This helps the child to acquire self-control and maintains order in a chaotic atmosphere. It is very beneficial to children who tend to be overactive or directionless.

Engaged

Engaging activities shows the child surprises and new experiences can be fun and enjoyable. Good for any child but particularly helpful to children who are very withdrawn, avoidant, too rigidly structured, or autistic.

Nurture

Caretaking activities that soothe and calm the child. These activities help the child feel safe and secure. Beneficial for overactive, aggressive children.

Challenge

Challenging, enjoyable, group activities that allow a child to take minor, age-appropriate risks. Accomplishing these activities gives the child confidence in their abilities. This is helpful to children who are withdrawn, timid, or rigid.

*Theraplay typically lasts 20-25 sessions with four follow up sessions.

For more information visit: www.theraplay.org

Helpful Links

- annastoydepot.com
- apa.org
- a4pt.org
- childtherapytoys.com
- kcplay.com
- lianalowenstein.com
- parisandme.com
- theraplay.org
- toysofthetrade.com

Play Therapy On-the-Go: A Tool Kit for HBFT play therapists

What you will need:

- Rolling suitcase (medium-sized)

- Homemade sandtray made of small clear plastic storage bin + sand
- You'll also want to bring a Ziploc bag of miniature toys for sandplay

Other ideas for things to include:

- Puppets
- Finger Puppets
- Dolls
- Age-appropriate books
- Games
- Paper and Crayons/ Markers

*Be Creative! The possibilities are endless!

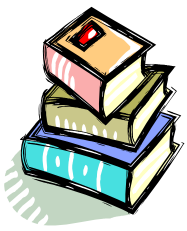
Audio Companion Available

Mp3 and CD available for:

- **Understanding & Working with Stepfamilies**
- **Families and Domestic Violence**
- **Therapist Self-Care (*Coming soon!*)**
- **Play Therapy CD (*Coming soon!*)**

Recommended Books from the Reading Corner

- Liana Lowenstein Books—
- Childs First Book about Play Therapy (Nemiroff, Annunziata, Scott, 1990)
- Dibs In Search of Self (Axline, 1986)
- Parenting from the Inside Out: How a deeper self-understanding can help you raise children who thrive (Siegel & Hartzell, 2003)
- Play Therapy: The art of the relationship (2nd edition) (Landreth, 2002)
- Playful approaches to serious problems: Narrative therapy with children and their families (Freeman et al., 1997)
- Reaching Children through Play Therapy (Norton, C., Norton, B. 2002)
- Theraplay: A new treatment using structured play for problem children and their families



Home-Based Family Therapy Partnership Update

The Connection: Juvenile Bipolar Disorder

www.HBFTPartnership.com

April 2011

What is Juvenile Bipolar Disorder?

Although, Bipolar Disorder used to be considered solely an adult disorder, currently there are almost one million children and adolescents in the U.S. diagnosed with Bipolar disorder at any time. Some of the common symptoms these children and/or adolescents may exhibit include:

- Abrupt mood swings &
- Energy changes that occur rapidly several times a day
- Intense outbursts of temper
- Low frustration levels
- Oppositional defiant behaviors

In addition, children and adolescents with Juvenile Bipolar Disorder may quickly change their moods between being: irritable, easily annoyed, and angry to feeling silly, goofy, and giddy elation. Afterwards, having periods of low energy and intense boredom, depression, and social withdrawal, fraught with self-recriminations and suicidal thoughts.

Although, it's very important to remember that not every child exhibits the same symptoms.

Because of this, children and adolescents with juvenile bipolar disorder can often be misdiagnosed as having either childhood depression, ADHD or oppositional defiant disorder.

Also, some studies have shown that diagnosis can take an average of 10 years after the moment symptoms first appear.

For more information visit: http://www.bpchildresearch.org/juv_bipolar

Don't forget to register for our Upcoming Core Training!

May 10th

At the Kansas State University Alumni Center in Manhattan, KS

Controversial Issues: What's all the fuss about?

There is some disagreement among clinicians surrounding the diagnosis of Bipolar disorder in children and adolescents. The main argument is that although some children present with the same symptoms as the current DSM criteria for adults, others only present with a few of the symptoms. Often, children may show impulsivity and irritability which could be a result of other mood disturbances. In addition, children with Bipolar Disorder may have several comorbid disorders such as ADHD.

As a result, it can be very difficult to distinguish the cause of their presenting symptoms. Still, other clinicians believe that the current DSM criteria should be used for children as well, but that their age and the normal behavior associated with it should also be taken into account.

For more information visit: http://www.nimh.nih.gov/about/updates/2007/nimh-perspective-on-diagnosing-and-treating-bipolar-disorder-in-children.shtml

Available Treatments

Family Focused Therapy has been shown to be very useful in helping children with Juvenile Bipolar Disorder. This is especially true when the child is going through depressive episodes. This form of therapy involves both the child and their parents in treatment sessions. Both participate in psychosocial treatment in which they learn what the symptoms of bipolar disorder are, the course of the disorder, and how to recognize when an episode may occur. They also learn good communication and problem solving skills, as well as how to cope with the illness.

Other treatments may include:

- **Cognitive Behavioral Therapy**
- **Interpersonal Therapy**
- **Psycho-education**
- **Medications such as**: mood stabilizers, antipsychotics, antidepressants. Although the use of these medications on children and their effects are still being researched.

***Early detection is key!**

For more information visit:
www.nimh.nih.gov & www.nami.org

Helpful Links

- http://www.bpchildresearch.org/juv_bipolar
- http://www.mental-health-today.com/bp/bi1.htm
- http://www.nami.org/Template.cfm?Section=By_Illness&Template=/TaggedPage/TaggedPageDisplay.cfm&TPLID=54&ContentID=23037
- http://www.nimh.nih.gov/science-news/2008/family-focused-therapy-effective-in-treating-depressive-episodes-of-bipolar-youth.shtml
- http://www.nimh.nih.gov/science-news/2007/rates-of-bipolar-diagnosis-in-youth-rapidly-climbing-treatment-

Family Support

Family support can be very beneficial for children with Juvenile Bipolar Disorder. Some ways parents can help their children deal with the symptoms of Juvenile Bipolar disorder include:

- encouraging the child to participate in activities that build on existing skills
- learning skills for good family communication
- providing regular routines
- removing objects that may injure the child during rages
- Helping the child learn how to anticipate and manage stress

In addition, parents should inform the school and teachers of their child's illness and special needs.

For more information visit:
http: //www. psychiatric disorders.com/articles/bipolar-disorder/bp-children.php

Audio Companion Available

Mp3 and CD available for:

- **Understanding & Working with Stepfamilies**
- **Families and Domestic Violence**
- **Therapist Self-Care**
- **NEW: Play Therapy**
- **Coming Soon! Supervision**

Recommended Books from the Reading Corner

- An Unquiet Mind
  — Kay Redfield Jamison
- Breaking the Bipolar Cycle
  — Elizabeth Brondolo & Xavier Amador
- The Bipolar Disorder Survival Guide: What You & Your Family Needs to Know
  —D.J. Miklowitz
- The Bipolar Child: The Definitive and Reassuring Guide to Childhood's Most Misunderstood Disorder
  — Demetri Papolos and Janice Papolos

Home-Based Family Therapy Partnership Update

The Connection: Supervision

www.HBFTPartnership.com

April 2011

A Day in the Life of a Supervisee

Michelle Gorzek
Smart Start

What is the purpose of supervision?

To help facilitate my growth as a therapist and help integrate theory and content I'm learning in class. Also it's to integrate content, ethical, and cultural competency and to connect back to the MFT community.

What do you mean by that?

Supervision is a place to know whether your work matches the ethical codes.

What were your expectations about supervision when you first began as an HBFT?

I don't feel like I had that many. I just expected to get support from supervision and help with issues that are unique to Home-Based work.

Did your experience meet your expectations? Why or why not?

Yeah, it has met my expectations. One thing I'd be more interested in is having more contact with other home-based family therapists but that's a supplement, just as another supportive group.

What would you say is unique about supervision of your HBFT work versus other your work in the Family Center?

Variables like the home-setting distractions, like if they have pets or friends coming over or if it's neat or messy and it can be more difficult to minimize those distractions. How to work with those distractions and focus on the therapy process is harder. But a good thing is that it allows you to see the natural process. As far as safety, we've made some reports with child abuse but not really different. I feel safer having a partner or a team with me. I like that.

How does your supervisor address the added safety issues you face as an HBFT?

At one point we had to make a report about child abuse. In supervision we talked about it in the context that we're not the investigator we just make the report. My supervisor helped us by framing how to talk about it with families and supported us more by coming with us.

What has been most helpful to you in supervision?

I think talking about cultural issues, especially the military and issues relevant for military families and also talking about how to create structure in home-based work. Also how to work with distractions that are there and just being able to get support overall cause it kind of feels like you're out on your own so getting connected to other clinicians as a resource.

What has been least helpful to you in supervision?

Sometimes there are too many ideas or not tying things to the treatment plan

Why is that?

I think that I still need help making treatment cohesive. So sometimes I think supervision is good for brainstorming but I still need help fitting it together like how it relates to therapy goals.

What does your supervisor do to help you with your self-care?

Just bringing it up in conversation asking me how I'm doing with it. Also, modeling low anxiety and modeling how to separate work from home life and having compassion for the feelings I do have as well as finding the balance between work and self-care. My supervisor is good at being compassionate about how much we care for clients and work and how difficult it can be to separate the two.

Is there anything else you feel would be important for other HBFTs to know about supervision?

There is more intensity in the home and it is easier to have more intense relationships with those in the home. So just talking about unique things about supervision is important.

For more interviews visit our website at HBFTPartnership.com

Special Considerations Addressed in HBFT Supervision

Providing in home therapy presents the therapists with several additional challenges that may include:

- Safety concerns
- Utilizing the home environment
- Structuring sessions in the home

Supervisors have a vital role in helping HBFT therapists navigate these unique challenges arising in the home setting.

Safety Concerns

- See Safety First! section below

Utilizing the Home Environment

- Therapists need guidance and support to recognize the usefulness of observing the family's home environment and behavior as a resources for assessment and intervention
- Therapist's effectiveness can improve with a greater understanding about the many opportunities for change that are gained form viewing the family in vivo

Structuring Sessions in the Home

- Therapists should plan sessions to be both accommodating to the family's schedule and facilitate a therapeutic process in their own environment
- Therapists can use spontaneous encounters toward therapeutic ends by providing gentle limit-setting, rules, and reminders
- Deliberate pacing while simultaneously identifying therapy fatigue in the family is crucial to the success of HBFT

For more information read: *Developmental characteristics of home-based counselors* by Lawson & Foster (2005)

Helpful Articles on Supervision

Visit the *Resources Section* of our website

Safety First!
A Supervisor's Role

- The supervisor encourages the therapist to conduct ongoing safety assessments (physical and emotional) for every family
- The supervisor invites the therapist to inform the supervisor of concerns and to request help as issues arise
- The supervisor helps the therapist to trust their emotions and observations as well as identify the level of risk for violence in the home to be able to ensure their personal safety as well as the family's safety during the counseling process
- With lower risk families, supervisors encourage therapists to utilize pre-session alerts regarding level of risk and call-in at a specific time during the session.
- With higher risk families, the supervisor encourages the therapist to work with a co-therapist or team for added security.
- With extremely risky cases, therapeutic services may need to be temporarily relocated to a clinical setting.
- The supervisor regularly reviews important safety measures with the therapist including:
  - Leave contact information and time of return with the office
  - Check the weather before leaving the office
  - Fully charged cell phone

For more information read: *Special Consideration for the Supervision of Home-Based Counselors* by Lawson (2005)

Recommended Books from the Reading Corner

Clinical Supervision: A Competency Based Approach by Carol Falender & Edward Shafranske

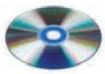
Essentials of Clinical Supervision by Jane Campbell

Letters to a Young Therapist by Mary Pipher

The Complete Systemic Supervisor by Thomas Todd & Cheryl Storm

The Gift of Therapy: An Open Letter to a New Generation of Therapists and Their Patients by Irvin Yalom

Audio Companions Available



- *Understanding & Working with Stepfamilies*
- *Families and Domestic Violence*
- *Therapist Self-Care*
- *Play Therapy with HBFT*

- *Utilizing Supervision*

Home-Based Family Therapy Partnership Update

The Connection

www.HBFTPartnership.com October 2012

In Focus: Child Sexual Abuse

Child sexual abuse is a global problem lacking a coherent definition that makes it difficult to report. Essentially, child sexual abuse can be any interaction between a child and an adult or a peer, where the child is used for sexual stimulation. This includes touching such as genital stimulation and non-touching behaviors such as exposure, voyeurism, and child pornography.

It is also important to realize that although child sexual abuse occurs by non-family members most children are abused by someone they know and trust. This can be a family member, a peer, or a close family friend.

Research estimates that approximately 300,000 children are abused every year in the U.S.A. Unfortunately, the rate of these occurrences are thought to be quite low due to problems with underreporting. Research suggests that child sexual abuse is a problem that affects children of all ages, races, ethnicities, cultures, and economic backgrounds. Geographically, child sexual abuse remains a problem in rural, urban or suburban communities.

For more information:
http://www.apa.org/pubs/info/brochures/sex-abuse.aspx

What to Look For: Symptoms and Risk Factors

Children who are sexually abused may exhibit behavioral changes. These behaviors may be sexual or nonsexual in nature. Sexual behaviors are stronger indicators of sexual abuse than nonsexual behaviors that can also be indicators of other types of trauma such as physical and emotional maltreatment or the death of a loved one. It is important to be attentive to these presenting symptoms which are generally characterized by the child's age:

Children up to age 3:

- Fears or excessive crying
- Vomiting
- Sleep disturbances
- Feeding and bowel problems
- Failure to thrive

Children ages 2-9:

- Regression to earlier behaviors such as bedwetting
- Victimization of other children
- Feelings of shame or guilt
- Withdrawal from friends or family

Older children and adolescents:

- Depression
- Poor school performance
- Promiscuity or early pregnancy
- Eating disturbances
- Anger about being forced into situations outside their control

Children living in households characterized by instability, conflict, and other notable forms of abuse are at greater risk for child sexual abuse. Likewise, children with physical, emotional, or cognitive disabilities are over three times more at risk for child sexual abuse. Being aware of the risk factors is crucial especially for children with disabilities who have difficulties disclosing to a trusted adult due to communication impairments.

For more information on symptoms and risk factors:
http://www.americanhumane.org/children/stop-child-abuse/fact-sheets/child-sexual-abuse.html
http://www.advocatesforyouth.org/publications/410?task=view

Ethical Issues

The following are some ethical issues professionals may face when treating families and victims of child sexual abuse:

Informed consent. A major dilemma may occur when a therapist discloses mandatory reporting obligations. As a result, family members may subsequently monitor what they disclose. Though this respects the client's autonomy, it can also result in withholding information about the occurrence of current harm to the children. The therapist must decide how to best handle the tension between the client's right to disclose and the mandate to prevent harm.

Therapists competence. It is essential for therapists working with families and victims of abuse to be aware of their own personal and emotional limitations. The AAMFT code of ethics instructs therapists not to practice outside their area of competence but therapists may feel ethically conflicted in making a referral to another professional after a strong therapeutic relationship has been established. The best way to resolve this conflict is to get specialized training and to help the family understand that referral affirms the therapeutic promise of promoting their welfare.

Balancing. A tension arises between therapist self-care and beneficent client care. Many clinicians have described the emotional turmoil and physical exhaustion that often accompanies work with such difficult cases. The increased stress associated with working with abused clients can decrease the effectiveness of therapy. It is highly recommended that therapists balance their ethical obligations to client care with efforts focused on protecting themselves from burnout.

For more information:
http://www.jstor.org/stable/585445

How to Cope as a Therapist

Below are some therapist self-care tips to help you cope with the vicarious traumatization (VT) or secondary traumatization (ST) that is associated with caring for clients of abuse.

- Place limits on the provisions of services you offer
- Exercise control over your scheduling by spreading out your heavy case load and intersperse some lighter cases
- Maintain a health-promoting life-style through good nutrition and regular workouts
- Use team approaches to provide protection for both therapist and clients
- Maintain self-awareness by recognizing and charting signs of stress
- Engage in relaxing and soothing activities
- Do not take on responsibility to "heal" your client
- Focus on resilience in therapy
- Seek personal counseling if necessary
- When necessary, take time off

For more information on coping strategies:

http://www.melissainstitute.org/documents/Meichenbaum_SelfCare_11thconf.pdf

Additional Resources

- American Professional Society on the Abuse of Children
  http://www.childhelpusa.org/
- Child Welfare Information Gateway
  http://www.childwelfare.gov/
- Stop the Silence
  http://www.stopcsa.org/

Also be sure check out the child sexual abuse articles located under the Resources section on our website:
www.HBFTPartnership.com

Upcoming Videoconference

The HBFT Partnership is offering a videoconference

The Ethics of Treating Child Sexual Abuse in Families

on Friday, November 16, 2012, 9:00am-Noon
Register today on the
HBFT Partnership website.

Home-Based Family Therapy Partnership Update

The Connection

www.HBFTPartnership.com

March 2013

Spotlight: Visiting Researchers from Germany

Dr. Barbara Bräutigam and Dr. Matthias Müller are both professors of SG Social Work and SG Early Education at the University of Applied Sciences Neubrandenburg in Germany. Together with their two research assistants, Katrin Hankel and Sarah Lüngen, they began a research project that aimed at improving home-based treatment in Germany. For this project they contacted the HBFT Partnership and sought to meet with us to discuss the process of creating trainings for professionals while gaining ideas on how to improve home-based treatment. For the HBFT Partnership, the opportunity to meet and discuss aspects of home-based treatment with professionals from Germany was a wonderful experience. We will continue to communicate with our new friends and we look forward to remaining in a collaborative partnership with them around home-based treatment.

The Full Spotlight can be found online at HBFTPartnership.com

Front (Left to Right): Jenny Brown, Jordon Weideman, Dr. Camille Lafleur
Middle (Left to Right): Katrin Hankel, Nancy O'Conner
Back (Left to Right): Una Henry, Dr. Barbara Bräutigam, Sarah Luengen, Dr. Matthias Müller

In Focus: DSM-5

Changes to the Definition of Mental Illness.

One of the major changes in the DSM 5 is the definition of mental illness itself.

The current definition of mental illness is,

- "a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual [which] is associated with present distress, disability… or with a significant impairment in important areas of functioning."

In the new DSM 5 the proposed definition of mental illness is,

- "a condition characterized by dysfunction in thought, mood or behaviors which cause distress. The condition should not be a result of social deviance or conflicts with society."

Additions to the Definition.

In addition to this new definition there are three things to keep in mind when diagnosing someone with a mental illness.

- The illness must draw concern from others in a relational, social, occupational, or vocational setting that requires a referral for treatment to be considered a mental illness.
- You must incorporate respect for age, gender, and culture-specific factors and sensitivity to these factors when making a diagnosis.
- The third thing to keep in mind when diagnosing a mental illness is that diagnostics are guidelines for understanding human behaviors. Diagnostics are not to be considered legal definitions to be used by law enforcement and courts.

Important Features of Mental Illnesses

Also, there are three things it is important for practitioners to understand when diagnosing someone with a mental illness.

- It is important for clinicians to understand that in order to diagnose a mental illness the behaviors must not be an expected or culturally sanctioned response to a particular event.
- Likewise, another thing to be aware of is that these behaviors may or may not be medical or biological illnesses.
- And finally when diagnosing a person's behaviors it is important to realize that these behaviors are conditions that the person has and that the behaviors do not define that person.

History of the DSM

DSM-I (1952)
The DSM-I had descriptions of 106 disorders that were referred to as "reactions." It was very clinically oriented and subjective in nature. The goal of the DSM-1 was to create a common nomenclature.

DSM-II (1968)
The DSM-II was a dramatic response to the subjectivity of the DSM-I. It introduced the multi-axial system and eliminated the biographical review of clients. The sole focus of the DSM-II was on behaviors and diagnostic accuracy. It also increased the number of disorders from 106 to 182.

DSM-III (1980)
The DSM-III was heavily based on scientific findings so its reliability was greatly improved. However, it also focused more on treating conditions and not people. It was so popular that it's revenues led to the formation of the American Psychiatric Press and became a guideline for insurance.

DSM-III-R (1987)
This revision to the DSM-III had categories renamed, reorganized and had some significant changes in criteria. At this point the DSM now contained 297 diagnoses, but it saw a return to the spirit of DSM-I.

DSM-IV (1994)
The DSM-IV offered detailed information about each disorder and now included 365 diagnoses. Likewise, it now suggested treatment "outcomes" and welcomed psychiatrists back to the clinical arena. However, it also had overlapping diagnostic criteria and NOS categories that could be confusing.

DSM-IV-TR (2000)
The DSM-IV text revision did not change any disorders but it did correct factual errors and perpetuated the medical model and the social stigma attached to mental disorders.

DSM-5 (May 2013)
The process of creating the DSM-5 started in 1999 and many who participated in the creation of the DSM-IV were not invited back. Some major goals of the DSM-5 are to improve diagnostic accuracy, reduce the use of NOS diagnosis, and reduce the stigma of some mental disorders.

DSM-5: Organization

TWENTY CLASSIFICATIONS

1) Neurodevelopmental disorders
2) Schizophrenia Spectrum Disorders
3) Bipolar & Related Disorders
4) Depressive Disorders
5) Anxiety Disorders
6) Obsessive-Compulsive & Related Disorders
7) Trauma & Stressor Related Disorders
8) Dissociative Disorders
9) Somatic Symptom Disorders
10) Feeding & Eating Disorders
11) Elimination Disorders
12) Sleeping Disorders
13) Sexual Dysfunctions
14) Gender Dysphoria
    *May or may not be included in DSM-V
15) Disruptive, Impulse Control & Conduct Disorders
16) Substance Use & Addiction Disorders
17) Neurocognitive Disorders
18) Personality Traits that Affect Treatment
19) Paraphilic Disorders
20) Other Disorders

Additional Resources

- www.dsm5.org
- http://www.forbes.com/sites/emilywillingham/2012/10/11/new-dsm-5-criteria-for-autism-who-will-be-left-behind/

Also be sure check out the DSM-5Changes located under the Resources section on our website:
www.HBFTPartnership.com

Upcoming Videoconference

The HBFT Partnership is offering a Videoconference series

Using the DSM-5 in Home-Based Family Therapy

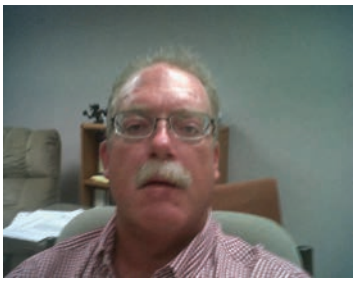
Part II on Friday, April 19th
Register for Part II today on the HBFT Partnership website.

Home-Based Family Therapy Partnership Update

The Connection

www.HBFTPartnership.com June 2013

Supervision Interview with Sean Wagner, MS



Sean Wagner received his B.S. and M.S. degrees from Fort Hays State University in Clinical Psychology in 1992. Around that same time, he also started as a Qualified Mental Health Professional at Horizons Mental Health Center. Wagner billed over 1,000 hours a year as a Qualified Mental Health Professional at Horizons Mental Health Center for 16 years before becoming a department head supervising ten therapists, fifteen rehab staff members, and six support staff members in four separate offices spanning Kingman, Pratt, Harper, and Barber counties.

How do you as a supervisor empower your supervisees in supervision?:

I encourage my staff to be self-sufficient by assigning a wide range of clients. Our area is rural, so every clinician see's every type of client. I encourage each clinician to pursue his/her personal interests, while maintaining an eclectic case load and treatment options.

How often does safety come up as an issue that needs to be addressed in supervision?

Not too frequently. Fortunately, with our affiliation with Hutchinson Regional Medical Center, we have frequent safety trainings, drills, inspections and reminders regarding safety throughout the year. Everyone keeps their daily schedules in our EHR [Electronic Health Record] so everyone knows where each other is at any given time.

What is your role as a supervisor when your supervisees are dealing with client crises?

Clinicians can call anytime with any situation that may arise. Each clinician is Mandt trained, and all clinicians are responsible to take on-call duties on a rotating basis in order to maintain their skills. They also have training in Crisis Intervention.

How do you help or encourage your supervisees to take care of themselves?

Through frequent supervision, monthly therapist meetings, quarterly all staff meetings in our Hutchinson facility. We frequently get together outside of work also, and have an excellent benefit package.

Supervision Suggestions for HBFT Therapists

Supervision should provide the therapist with support in the following areas:

- Managing appropriate boundaries
- Simultaneously maintaining varying points of view
- Connecting therapist self-care and the supervision process
- Accessing available resources
- Receiving guidance and support
- Creating a relationship with your supervisor that involves vulnerability

Supervision and Training: Supervisory Dilemmas

According to authors Nancy Boyd-Franklin and Brenna Hafer Bry (2000), supervisory philosophy is based on the empowerment of family therapists and supervisors, but sometimes supervisory dilemmas can arise. Such dilemmas include:

Cultural and Racial Issues in Supervision:

Because of the increasing diversity in the U.S., supervisors must feel comfortable themselves in raising concerns about ethnic and racial issues with supervisees. If the supervisees are to feel comfortable in exploring these issues with their clients, they must first be able to discuss them in supervision.

Supervision as a Process of Negotiation:

It takes time for a new staff member and supervisor to establish a positive working relationship but it can be complicated by the fact that the supervisor is responsible for evaluating the supervisee's progress. It is helpful to approach supervision as a process of negotiation or to frame supervision as a consultation, which implies a partnership not a hierarchy.

Training as an Antidote to Burnout:

Continuous training not only serves as an antidote to burnout, it also helps therapists to keep their skills current in recent developments in the field.

Professional Growth and Development:

Supervisors should make a commitment to meet with supervisees at least once a year to discuss professional growth and plans for development. It's important that everyone can discuss their plans in a supportive environment.

For a more in-depth look into supervisory dilemmas check out Boyd-Franklin and Bry's book:

Boyd-Franklin, N., & Bry, B. H. (2000). *Reaching out in family therapy: Home-based, school, and community interventions*. New York, NY, US: Guilford Press.

New Training: Advanced Supervision Videoconference

This fall the HBFT Partnership is offering a videoconference training over Advanced Supervision on

November 15th 2013

Registration for this event will open September 16, 2013 and will close 7 days before the event.

Description of Advanced Supervision Videoconference:

The Advanced Supervision training is geared towards clinical supervisors who provide supervision for home-based family therapists. Clinical supervisors who supervise office-based clinicians could also benefit from this training. This training will address ways to adapt office-based supervision to support the needs of home-based family therapists. Supervisors will develop and refine their orientation to supervision in order to ensure meeting the unique needs of home-based family therapists.

Additional Resources

- **American Association for Marriage and Family Therapy—Resources: Supervision**
  www.aamft.org
- **Association for Counselor Education and Supervision—Resources**
  www.acesonline. net

Also be sure check out our Resources section on our website:
www.HBFTPartnership.com

Upcoming Core Training

The HBFT Partnership is offering a Core Training in Western Kansas at

The Clarion Inn
1911 E. Kansas Ave
Garden City, KS 67846

On
Friday, September 6th, 8:30a.m.-3:30p.m.

Home-Based Family Therapy Partnership Update

The Connection

www.HBFTPartnership.com October 2013

In Focus: Diagnosis and Assessment

Assessing and diagnosing clients is a major counseling procedure that requires practitioners to be aware of not only the risks and benefits but also the ethical implications of such a procedure. Practitioners should obtain the clients' consent as well as make sure clients are aware of the risks and benefits associated with practitioners' ascription of a DSM diagnosis.

Information about the Risks of Diagnosing

If not careful, a diagnosis can provide an excuse for irresponsibility on the part of the client as well as rob the client of their uniqueness by reducing their individual totality to a single word. This could lead clients to feel resigned about who they are with accompanying despair or self-fulfilling prophecies.

Likewise, if the diagnosed person is the scapegoat in the family, a diagnosis may reinforce the family's perceptions that the identified patient is "the problem" thus reducing the likelihood of the family's effort to change.

Giving a client a diagnosis may also make it easier to see the client as different from the practitioner, thereby encouraging treatment that clinicians would not consider giving to those who are more like themselves.

It is also important to realize that clients may not have full control over what others know about their therapy so clinicians should be present when people are reviewing such records so as to explain the material in a manner that is understandable to those requesting the information. Clients might be seriously harmed by family members who use another's diagnosis for an agenda that is inconsistent with the therapeutic agenda.

Information about the Risks of Not Diagnosing

As a result of a diagnosis, clients may develop a social construction, or a meaning system related to their experiences that allows them to stop "beating themselves up" for being the cause of their own distress. In turn, a diagnosis can also allow them to pursue more helpful methods of managing their "disorder."

Once family members know that a person has a diagnosable disorder, they may stop blaming that person or making them the scapegoat. Likewise, when family members know that they will not be blamed, they may be more willing to participate with their family in treatment.

Without engaging in the diagnostic process, it may be difficult to tell if the client meets the criteria for a disorder for which medication would help to alleviate distress. Similarly, the client's health insurance may not reimburse for counseling services without the client receiving a DSM diagnosis, and clients may then have to pay large sums of money out-of-pocket in order to receive such services.

The benefits that incur to those with DSM diagnoses are, as these situations illustrate, clearly too important to justify dismissing the diagnostic process out of hand or to justify failing to inform clients of the risks of not diagnosing.

Accuracy Versus Misrepresentation in Diagnosing

If mental health professionals choose to participate in a system that only reimburses medically necessary treatment as defined by a DSM diagnosis – and often in order to continue practicing they must so choose – then they need to accurately indicate such a diagnosis.

According to survey research by Danzinger and Welefel (2001), 44% of clinician respondents had changed or indicated they would change a client's diagnosis in order to qualify for additional managed care reimbursement. Professionals may report the diagnosis that they know will be reimbursed, rather than one that will not, despite the greater accuracy of the un-reimbursable diagnosis.

It is critically important that practitioners recognize that their choices to misrepresent a client's diagnosis does not protect clients from the potential harms of diagnosis.

A Dozen General Tips for Accurate and Safe Diagnosis

1. Hippocrates said that knowing the patient is just as important as knowing the disease. Know Context: Time, Place, and Person.
2. Take the time and make the effort. Adequate time. Multiple interviews.
3. When in doubt go with the odds. Stick with the more common diagnoses.
4. Get all the information you can. No one source is ever complete. Triangulation of data.
5. Consider previous diagnoses, but don't blindly believe them. Incorrect diagnoses tend to have a long half-life and unfortunately staying power.
6. Constantly revisit the diagnosis. Don't be blind. Be open to contradictory data.
7. Children and teenagers are especially hard to diagnose. They have a short track record, mature at varying rates, may be using drugs or alcohol, and are reactive to family and environmental stresses. The initial diagnosis is likely to change.
8. The elderly are hard to diagnose. Their psychiatric symptoms may be caused by neurological or other medical illness, and they are prone to drug side effects, interactions, and overdoses.
9. The less severe the presentation, the more difficult it is to diagnose. There is no bright line demarcating the very heavily populated boundary between mental disorder and normality. Milder problems often resolve spontaneously with time and without need for diagnosis and treatment.
10. When you are in doubt, it is safer and more accurate to underdiagnose. It is easier to step up to a more severe diagnosis than to step down from it.
11. Accurate diagnosis can bring great benefits; inaccurate diagnosis can bring disaster.
12. Always remember the other enduring dictum from Hippocrates: "First, do not harm."

Additional Resources

- Eriksen, K., & Kress, V. (2005). *Beyond the DSM story: Ethical quandaries, challenges, and best practices.* Thousand Oaks, CA: Sage Publications.
- Francis, A. (2013). *Essential of Psychiatric Diagnosis: Responding to the Challenges of the DSM-5.*

Also be sure check out our Resources section on our website:
www.HBFTPartnership.com

Upcoming Videoconferences

The HBFT Partnership is offering
two Videoconferences this Fall

The Ethics of Diagnosis and Assessment
On Friday, October 25th, 9am – Noon
Register: www.hbftpartnership.com

Advanced Supervision
On Friday, November 15th, 9am – Noon
Register: www.trainingteams.org

Home-Based Family Therapy Partnership Update

The Connection

www.HBFTPartnership.com January 2014

HBFT Goes to Portland, OR!

This past October the HBFT Partnership presented the Home-Based Family Therapy Core Training as a workshop presentation at the 2013 Annual American Association for Marriage and Family Therapy (AAMFT) National Conference in Portland, OR. We were also able to present our research on therapists self-care at a poster session. The HBFT Partnership has always been interested in interacting with and supporting clinicians across Kansas through research and trainings, and because of this conference we were able to share our research findings make new connections with home-based clinicians from around the country!

HBFT Research Presentations

Core Training Workshop

The HBFT team was excited to present a modified version of the Advanced Core Training as a workshop at the AAMFT National Conference! Through this opportunity we were able to share our model for home-based family therapy with clinicians from around the country. Research has shown that in-home family therapy has been the most effective when working to reduce out of home placements for children, therefore, learning how to effectively implement home-based family therapy work is important. The workshop had about thirty participants who had varying levels of in-home therapy experience but no formal in-home training. There was good discussion centered around the common components of our HBFT model as well as the need for support at multiple levels. The HBFT team received positive feedback with many of the participants stating that they appreciated and found the information presented to be helpful.

Research Poster Presentation

The HBFT team was also fortunate enough to present our research about self-care and its effects on clinician professional quality of life at the poster session. The poster was created by data the HBFT team gathered from an original internet survey completed by Kansas home-based family therapists with differing levels of experience. Our results indicated that professional development and self-care centered around leisure activities had a beneficial impact on clinician's professional quality of life. Several who attended the poster session were interested in how they could use this information personally and to help support the clinicians in their agencies. The HBFT Team received positive feedback on the research poster and had the opportunity to share research findings with different Universities from around the country.

In Focus: HBFT Fidelity Model

The Home-Based Family Therapy (HBFT) model is a research informed model addressing specific therapist characteristics that impact the quality of services provided. This model combines HBFT training with the therapist's advanced clinical degree training to support home-based therapists' theory and practice needs, enabling them to successfully terminate treatment in shorter timeframes, allowing them to work with more families over time. The model consists of the five components that research has found necessary to be effective working with clients in a home-based setting. These five components are:

- **Environment and Context**: natural environment of the home and community which is an important resource for therapy. The environment in home-based therapy makes additional assessment information available through the observations of the natural family processes enacted in the natural environment of the home.
- **Therapeutic Relationship**: considers the fluid relationship that transforms the home environment from visiting to therapy and back to visiting with each visit. There is a strong potential to increase mutual respect and trust with each home-based encounter.
- **Focus of Clinical Work**: contextual view of the child's behavior allowing the therapist with unique opportunities for spontaneity and creativity.
- **Family Roles and Expectations**: the family maintains a familiarity of the therapeutic environment (home) and acts as the host in the process. This natural environment can provide involvement of additional family members in the therapeutic process. It also encourages the generalizability of skills for the family.
- **Therapist Roles and Expectations**: therapist is a guest of the family and facilitates a collaborative process by working with the family to establish a therapeutic structure that is safe in the natural environment. Teachable moments are based on actual vs. reported events.

What connects the therapist's advanced clinical degree training to the 5 common HBFT components are the additional components of self-care, self-of-the therapist, and supervision.

- **Self-of-the-therapist**: Every therapist, every person has a worldview; that worldview influences how that person (therapist) constructs, experiences, and behaves within his or her world. This in turn influences the therapeutic alliance between therapist and family.
- **Self-care**: Each therapist experiences varying degrees of personal and professional stresses that are impacted by working in the family's natural environment. Therapists are encouraged to attend to the impact of the home environment on self, setting appropriate and manageable boundaries in the family's home, and develop plans that ensure adequate safety, utilize supervision and collegial support, and develop an ongoing program of self-care.
- **Supervision**: Home-based family therapists need quality supervision in the form of support when working with the SED population to maintain healthy boundaries, adequate self-care, and clinical guidance.

These three additional components serve as a bridge linking the therapist clinical training to the common components identified in the research. These bridging components are essential to allow the therapist to be effective in a wide variety of home-based settings from frontier to urban environments. It is the combination of these components that address specific therapist characteristics toward preventing burnout thus improving professional quality of life.

HBFT Model

Upcoming Videoconferences

The HBFT Partnership is offering a Videoconference series

DSM-5 Autism Spectrum Disorders

Part I on Friday, March 14th and Part II on Friday, April 11th. You can register for both of these videoconferences through the Training Teams website at *www.trainingteams.org*

Home-Based Family Therapy Partnership Update

The Connection

www.HBFTPartnership.com March 2014

DSM 5 Changes: Autism

Within the new DSM-5 manual, Autistic Disorder, Asperger's Syndrome, Childhood Disintegrative Disorder, and Pervasive Developmental Disorder (PDD) have all been combined to create the new category of Autism Spectrum Disorder (ASD). The consolidation of these disorders was done because these symptoms represent a single continuum of mild to severe impairments in the two domains of social communication and restrictive repetitive behaviors and interests rather than being distinct disorders. This change is designed to improve sensitivity of the criteria for the diagnosis of autism spectrum disorder and to identify more focused treatment targets for the specific impairments identified.

There has been some concern that these changes will affect the way Autism Spectrum Disorders are diagnosed. However, given the similarities in the diagnostic criteria, diagnoses between DSM-5 criteria and DSM-IV-TR criteria remain accurate. According to a study by Huerta et al. in 2012, the majority of children with clinical diagnoses of pervasive developmental disorders met the DSM-5 autism spectrum disorder criteria as well.

For more information check out:

Huerta, M., Bishop, S., Duncan, A., Hus, V., & Lord, C. (2012). Application of DSM-5 criteria for autism spectrum disorder to three samples of children with DSM-IV diagnoses of pervasive developmental disorders. *American Journal of Psychiatry*, 169, p. 1056-1064.

Autism Spectrum Disorders: Assessment and Diagnosis

Diagnosis of any autism spectrum disorder usually starts with an informal assessment done by those who are engaged in the child's life such as the child's parents, caregivers, or teachers. Since these people are around the child more often than practitioners, they are often the ones who are more qualified to make first assessments of ASD. An interview with the caregiver is done first, followed by observation of the individual in a real life setting and in an evaluation center, where a psychological evaluation of the individual's cognitive level is assessed for.

Areas of Assessment include:

- Social interaction skills and communication
- Emotional understanding
- Self-regulation
- Motivation
- Practical skills and motor functioning
- Sexual interests and desires
- Impulse control
- Interests
- Insight

ASD: Comorbidity and Accompanying Problems

According to Yates and Couteur (2012), about 70% of individuals with ASD meet the criteria for at least one other disorder. One reported co-morbid disorder that frequently is underdiagnosed in children with ASD is Down Syndrome. Likewise, a well-recognized co-morbid issue for children with ASD is disordered sleep and food selectivity. Many children with ASD experience difficulties in other areas and may have other diagnosable disorders, which should be a focus of assessment and diagnosis for the clinician. Other problems that may accompany a diagnosis of ASD are:

Fragile X Syndrome

- 2-5% of children with ASD are affected by this, which is most commonly inherited from mental retardation.
- 10-15% of those with Fragile X show autistic traits

Seizures

- 1 in 4 children with ASD develops seizures, often starting either in early childhood or adolescence

Tuberous Sclerosis

- 1-4% of people with ASD also have Tuberous Sclerosis.
- Tuberous Sclerosis is a rare genetic disorder that causes benign tumors to grow in the brain as well as in other vital organs

Communicating an ASD Diagnosis

Communicating an ASD diagnosis can be difficult. Having written information helps parents to understand the diagnosis, although many parents report feeling confused by the information. Therefore, it is helpful to have a structured and focused session to convey the diagnosis and information so that the parents can ask questions and feel supported.

Parents often express anger that the assessment period took so long and the diagnosis might be different than previous explanations for their child's behavior. So having a structured and focused session to discuss the information is very important. A study by Casey & Elswick (2011), found that parents really value clinicians who are holistic and hopeful in their approach to discussing an ASD diagnosis, since receiving an ASD diagnosis can be a very frightening.

Many parents of children diagnosed with developmental disabilities experience a grief process where they mourn the loss of the typical child they thought they had. Each family will need different forms of support so the clinician should be prepared to educate parents on assessment, effective interventions, local supports, continuous services, and educational resources in the community.

For more information check out:

Casey, L. B., & Elswick, S. E. (2011). The social worker's role in the assessment of autism spectrum. *Children & Schools*, 33(3), p. 176.

Additional Resources

- Abbott, M., Bernard, P., & Forge, J. (2013). Communicating a diagnosis of autism spectrum disorder – A qualitative study of parents' experiences. *Clinical Child Psychology and Psychiatry*, 18, pg. 370. DOI: 10.1177/135914512455813.
- Yates, K., & Couteur, A. L. (2012). Diagnosing autism. *Pediatrics and Child Health*, 23(1), pg. 5-10.

Upcoming Trainings

The HBFT Partnership is offering a Core Training in Manhattan Kansas at

KSU Alumni Center

1720 Alumni Circle

Manhattan, KS 66502

On Thursday, April 17th, 8:30a.m.-3:30p.m.

Home-Based Family Therapy Partnership Update

The Connection

www.HBFTPartnership.com June 2014

The HBFT Partnership Launches a New Website!

Research shows that as therapist's stress increases, so does the likelihood of burnout and compassion fatigue in professionals. Self-care helps to mediate these effects. By integrating self-care into a routine, the likelihood of burnout decreases. Our brand new HBFT self-care website allows you to track weekly self-care activities and even see the connection between your own personal self-care and professional quality of life. The website also provides great resources for self-care research, tips, and tricks. The site is mobile friendly, making it even more accessible. You can track your self-care or access resources right from your smart phone! Give our new website a try for yourself at **www.hbftself-care.com.**

A Little Bit About Self-Care

Research suggests that therapists and supervisors should be aware that higher workloads are linked to a lower professional quality of life, but engaging in different types of self-care are related to therapists feeling more positive about their clinical work. Self-care can come in many different forms such as personal reflection, social engagement, leisure and recreation, and professional development. By integrating self-care into a clinician's routine, the likelihood of burnout decreases. These types of self-care on their own can be very beneficial, but research shows that when combined they have an increased impact on reducing burnout and compassion fatigue.

See below for descriptions of the four types of self-care:

- **Leisure and Recreation:** a category of self-care that involves spending time engaged in hobbies and activities that refresh, rejuvenate and invigorate the mind and body.
- **Personal Reflection:** this form of self-care involves clarifying your view of yourself as an adult and a professional.
- **Professional Development**: this is an important facet of self-care that involves attending continuing education workshops and conferences, as well as receiving support from colleagues and supervisors.
- **Social Engagement**: this type of self-care involves seeking and receiving help and support from others, especially friends and family.

Celebrating Seven years of Success!

The Home-Based Family Therapy Partnership was first established in 2007 through a contract between the Kansas State University Family Center, the Kansas Department of Aging and Disability Services, and the Community Mental Health Centers in order to train and support home-based family therapists and promote best practices for home-based family therapy in Kansas. The following reflects the success the partnership has seen in providing resources and supporting Kansas professionals over the last seven years.

- Over the past seven years we have hosted 32 Core Trainings in several different locations. The Core Training has been updated over the years in order to best reflect our ever growing field. Our Core Trainings have reached over 1,007 professionals across the state of Kansas!

- Over the past seven years we have developed 10 online learning modules, and from these modules created CD learning companions to allow clinicians to experience online material in audio format, perfect for long drives! We have distributed approximately 1,500 CDs across the state!

- Over the past seven years we have developed and hosted DSM and Ethics Videoconferences to provide clinicians the opportunity to earn CEU credits while learning about a variety of topics. Since 2007 we have hosted 16 videoconference trainings and served roughly 400 clinicians.

Over the years the HBFT Partnership has continued to grow and expand to include other components that have helped get resources to home-based clinicians in Kansas and beyond. Group Training Kits were created to get resources and access to CEU credits available to those who couldn't attend videoconference trainings. The HBFT Partnership is dedicated to continual growth in order to best serve the changing needs of home-based family therapists in Kansas.

A New Direction for the HBFT Partnership

Given the success we have experienced over the past seven years, as well as our desire to continue providing resources and support for professionals in the state of Kansas, the HBFT partnership is making some changes! We feel these exciting changes will better meet the needs of those all over Kansas who partner with HBFT. One of the biggest changes we are making is increasing our number of Core Trainings to five a year! We will be hosting a Core Training every other month in all of the major Community Mental Health Center Hubs around Kansas. Keep your eyes and ears open for those dates on our website, www.hbftpartnership.com and our new website www.hbftself-care.com! Likewise, follow us on Facebook and Twitter to keep up-to-date with our newest projects and trainings, to gain new resources, and learn about new self-care tips!

Additional Resources

- Norcross, J., & Guy, J. (2007). *Leaving it at the office: Psychotherapist self-care.* New York: Guilford. Yates, K., & Couteur, A. L. (2012). Diagnosing autism. *Pediatrics and Child Health,* 23(1), pg. 5-10.
- Importance of Practicing Self-Care. Ricardo, C. (2006).

Upcoming Trainings

The HBFT Partnership is traveling to Western Kansas in order to provide a Core Training in Garden City this upcoming September.

Keep your eye on our website at www.hbftpartnership.com and our self-care website at www.hbftself-care.com for dates and locations of all of our upcoming trainings!

MARKETING & PRODUCTS

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MARKETING STRATEGIES

- Sample Event Flyer
- Resource Guide
- Social Networking

Home-Based Family Therapy Partnership

Registration is now open for the...

Home-Based Family Therapy Core Training

Tuesday May 10, 2011

8:30 a.m.— 3:30 p.m.

With registration starting at 8:00am

in

Manhattan, Kansas

Kansas State University
Alumni Center
1720 Alumni Center
Manhattan, KS 66506

Register for the core training through our website
www.HBFTPartnership.com
Capacity is limited to 40 so sign up today!

Contact the HBFT Partnership Team with questions at the e-mail listed below.

Registration now open!

www.hbftpartnership.com **hbft@ksu.edu**

Home-Based Family Therapy Partnership

March 11, 2010

To whom it may concern:

First, I would like to thank you for your agency's collaboration with the Home-Based Family Therapy Partnership (HBFT) at Kansas State University in our efforts to train clinicians in providing effective in-home family therapy services across the state of Kansas.

As you may already know, we partner with Social and Rehabilitative Services (SRS) and Kansas Health Solutions (KHS) to provide various opportunities for earning continuing education units (CEUs). Training opportunities include: videoconferences, in-person core trainings, and online learning modules.

We are writing to your agency to announce our newest resource: *CD Learning Companions* (CDs) to our online learning modules. The HBFT team has developed an audio version of the information provided on our website that allows clinicians the opportunity to listen to the learning modules and earn CEUs while they drive to and from clients' homes. We only require that a user take a pre- and post-test online prior to and after listening to the CD. All of the information on the CD is the same as the online version, only now it is in a more convenient format. The first available CD is titled *Families and Domestic Violence*.

Just as with our online modules, these CDs are FREE! We would like to start off by offering to send your agency its own supply. If you would like to request CDs please send an email to hbft@ksu.edu providing the following information: agency name, contact name, mailing address and the number of CDs you would like for your staff. If you are based in Manhattan and are able to pick up the CDs, simply let us know and we can have them available for you at the front desk of the Family Center on the K-State campus.

If you have any questions, comments, or concerns don't hesitate to contact me, Jurdene Ingram, at **785-532-7695** or at hbft@ksu.edu.

Sincerely,

Jurdene Ingram
Graduate Research Assistant
HBFT Event Coordinator

HBFT Partnership
c/o The Family Center
Kansas State University
242 Campus Creek Complex
Manhattan, KS 66506

(785) 532-7695
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Jurdene Ingram, Event Coordinator

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Partnership is Key

The Home-Based Family Therapy (HBFT) Partnership was launched by Social and Rehabilitative Services (SRS) of Kansas and the Family Center at Kansas State University (KSU) in 2005 to promote best practices for home-based family therapy.

HBFT also partners with Association of Community Mental Health Centers of Kansas, Inc. (ACMHCK) and Kansas Health Solutions (KHS).

Partnering is key to HBFT.

Home-Based Family Therapy Partnership

Kansas State University

2010-2011 Resource Guide

HBFTPartnership.com
hbft@ksu.edu
(785) 532-7695

2010-2011 HBFT Resource Guide

www.HBFTPartnership.com

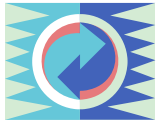
Core Training (6 CEUs)

The beginning of our journey to bridge the gap between office and home-based work.

Core Training is a key event in the HBFT partnership, identifying aspects of home-based family therapy that are distinct from traditional, in-office therapy.

Large and small group experiential exercises provide participants with the opportunity to interact with one another through sharing experiences, resources and ideas.

The result is a network of providers from across the state in various agency settings and from various theoretical perspectives engaged in a rich learning environment **Attendance is only required at one core training.**



Visit the **Discussion Board** and contribute to clinician challenges, or comment on other clinician's discussions through the website.

Online Learning (2 CEUs)

Interactive modules will offer wisdom on topics that include:

Evaluating Models of Cultural Competence

Integrating Play Therapy in the Home
CD available

Understanding and Working with Stepfamilies
CD available

Families and Domestic Violence
CD available

Challenges to Therapist Self-Care
CD available

Balancing Professional and Personal Lives

Utilizing Supervision

Coming Soon
CD companion on Utilizing Supervision

The CD Learning Companion is complementary to online learning. HBFT clinicians can listen to a CD in their car and apply those skills when they arrive at client families' homes. Pre and post tests allow clinicians to earn CEUs (2).

Ask your agency Director or contact HBFT for more information on obtaining your CD.

Videoconference (3 CEUs)

Encourage sharing between clinicians from all over Kansas.

Videoconferences are offered at 8 sites throughout Kansas: Colby, Dodge City, Hays, Manhattan, Overland Park, Pittsburg, Salina & Wichita.

DSM videoconferences include two 3-hour sessions. Part 1 is on diagnostic criteria of a DSM disorder; Part 2 focuses on home-based therapeutic adaptations.

Ethics videoconferences address the unique ethical challenges involved in home-based family therapy.

Now Available!

Group Training Kits simple five step program that allows Clinic Directors to host our trainings from the comfort of their own agencies.

Find downloadable articles, book references, supervision forms, and links in the **Resources Area** on the website.

AVAILABLE PRODUCTS

- HBFT Handbook
- Play Therapy Kit Guide
- Group Training Kit

HBFT Partnership
(785) 532-7695
hbft@ksu.edu

Please visit HBFTPartnership.com to access a link to a survey about this handbook.

Your feedback is very important and greatly appreciated!

This handbook was created by Emily Hatch, a Family Studies and Human Services major at K-State, as an internship project. Emily is currently a graduate student at Friends University studying Marriage and Family Therapy.

Kansas State University

Your Guide to Home-Based Family Therapy

What to Expect from Your Experience with Home-Based Family Therapy

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This handbook was created through the support of a contract with the Kansas Department of Social Rehabilitation Services, Division of Disability and Mental Health Services.

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PLEASE USE THE FOLLOWING PAGES TO WRITE DOWN ANY THOUGHTS, QUESTIONS, OBSERVATIONS, OR TOPICS OF DISCUSSION FOR YOUR NEXT THERAPY SESSION.

The Home-Based Family Therapy Handbook

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"Healing may not be so much about getting better as about letting go of everything that isn't you - all of the expectations, all of the beliefs - and becoming who you are."
- Rachel Naomi Remen

What to Expect from HBFT

Home-Based Family Therapy (HBFT) is a process used in homes to help families function at their best. Family therapists are caring professionals who enjoy working with families. Here are the steps used in HBFT:

Referral– Therapists may receive referrals for therapy from family members, doctors, judges, psychiatrists, etc. Once a referral is made, the therapist will contact the family to set up an initial session. It is important to schedule a time that all family members can attend and will fit into the family schedule for the long-term.

Initial Session– This is the first time the therapist and family meet. This session will be used to fill out intake paperwork and get a better idea of what the family feels the problem is. The therapist will suggest what forms of therapy they think will benefit the family, for example, couples therapy for the parents or play therapy with the children.

> "You don't choose your family. They are God's gift to you, as you are to them."
>
> -Desmond Tutu

REFLECTIONS

- How would I describe my relationship with my family therapist?
- How have I helped my family reach our treatment goals?

6. Don't Fix the Blame, Fix the Problem

Trying to figure out whose fault it was rarely solves the problem.

7. Always Go for Win-Win

No one wants to be a "loser". Work towards a solution where everyone wins.

8. Never Threaten– Physically or Emotionally

Once a threat is made, it cannot be taken back. Threatening "I'm leaving" is emotional blackmail.

9. Don't Bring Up Issues Before Bed

Do not try to resolve large, difficult issues right before bedtime. Issues seem worse when people are tired.

10. Don't Involve Others

Involving others causes the fight to grow. They are usually not told when the issue is resolved so they still have a negative impression of the situation.

Rules for Fighting Fair

1. Choose Your Battles
Before beginning an argument, decide what you are *really* fighting about and if it is worth fighting for.

2. Speak Quietly And Respectfully
Most people react negatively and defensively when they feel attacked.

3. Choose Your Words Carefully
Think before you speak, especially if you are angry or upset. Words can hurt deeply and are usually remembered forever.

4. Don't Bring Up the Past
EVERYONE has an imperfect past and NO ONE can change their past. Dwelling on the past prevents you and your family from moving forward.

5. Allow for Time-Outs
It is important to take a break and calm down if frustrations are high. Remember to come back together to finish the discussion. Do not leave it unresolved.

> "The only rock I know that stays steady, the only institution I know that works is the family."
>
> -Lee Iacocca

REFLECTIONS

- How do I feel about Family Therapy?
- What worries or fears do I have about Family Therapy?
- What do I want my therapist to know about me?

Beginning Sessions– The purpose of these first few sessions is to become comfortable with the therapist in the family home. Therapists are guests in the home and respect the family's private space. They are there to observe and help, not to judge the appearance of the family's home.

Treatment Phase– Once the family and therapist are comfortable with each other, they work together to establish goals for the family and discuss the treatment plan. These sessions are also known as the working phase because it is when the therapy and family work take place.

Termination– Once the therapist and parents feel that progress has been made and treatment goals have been met, they can discuss ending therapy, or termination. Therapists will discuss how to continue the work the family is doing once therapy has ended. The time it takes to reach termination varies for each family.

Provided by Amanda Mazouch,
M.S. in Marriage and Family Therapy

How to Get the Most Out of Your HBFT Experience

Build a therapeutic relationship with your family therapist

Help make goals for the family

Have all members of the family present

Turn off TVs and phones!

Be Honest–
your therapist is there to help you, not judge you.

Ask Questions

Practice the skills you have learned

Have everyone fed before the session begins

Keep a journal and complete the homework assignments your therapist gives you!

- Create a safe environment by not using threats, weapons, or violence
- Be open-minded and open to change
- Plan ahead with my family before each session

I have read these guidelines and agree to follow them to the best of my ability.

_____

_____

_____

_____

_____

_____

_____

"Other things may change us, but we start and end with the family."
-Anthony Brandt

"Change is inevitable, growth is optional"
-Anonymous

LETTER OF COMMITMENT

I promise to:

- Be honest with my therapist and myself
- Participate fully in the therapy process
- Understand that this process will not work unless I am fully committed
- Ask questions when I do not understand
- Remove anything that will distract me during sessions
- Be positive even when I feel frustrated
- Help set family goals
- Attend all of the family therapy sessions
- Complete the homework assignments given to me by my therapist
- Respect others even when I do not agree with them

"In every conceivable manner, the family is link to our past, bridge to our future."
-Alex Haley

Do not allow guests or visitors during your family session

Plan Ahead with your family before your next therapy session–
Do you have questions for next time?
What things do you want to discuss?

Make your "Therapy Room" in your house comfortable.

Everyone needs to participate

Be open to change!

REFLECTIONS

- What have I learned so far in family therapy?
- What changes have I noticed in myself?
- What do I need to remember to talk to my therapist about in our next session?

Frequently Asked Questions

How long is this going to take?

This depends on how long it takes to reach the goals the family has established with the therapist and how much effort is put into the process. The more participation there is, the faster it goes!

Will my therapist talk to other people about what I say?

Your session with your therapist is confidential. However, they are required to report if someone intends to hurt themselves or another person. They must also report any abuse that has not been previously revealed. Your therapist will go over the confidentiality guidelines with you.

Can the therapist fix my child/family?

Families are not broken and therefore do not need to be "fixed". The therapist is there to provide information and tools to help the family function more effectively.

Why does the whole family need to be here?

A family works together as a team, and what happens to one person affects the rest of the family. It is important that the entire family is there for all of the therapy sessions so that everyone is on the same page and moving in the right direction.

REFLECTIONS

- What progress have I seen in myself?
- What things do I still need to work on?
- How would I describe my home-based family therapy experience?

Why is the therapist coming to my house?

The best way for the therapist to help a family is to work in the environment where the issues are happening. In-home family therapy gives you privacy and convenience during treatment!

How is my therapist related to the child welfare system?

Your home-based family therapist is not related to the child welfare system and their purpose is not to take children away from their homes. This is an opportunity to learn more about your family, parenting practices, and what would help your family move past the struggles you are currently having.

Does my house have to be clean?

Your therapist is there for *you*, not to judge your home. However, it will make the therapy process go smoother if the designated "therapy room" is safe, comfortable and quiet. Do not have any weapons in the room and turn off any distractions such as cell phones and TVs.

Group Training Kits

The Group Training Kit was developed to provide a cost effective way for agencies to give their clinicians access to DSM and Ethics CEUs. Clinic Directors order a Kit, which includes videoconference DVDs and PowerPoint's, pre and post tests, and step by step instructions on how to host their very own training. Once the agency has completed the training a one time fee of just $25 is sent along with the requested return materials in exchange for certificates for those who participated. This training program allows clinic directors to reuse a single Kit as many times as they want. Currently we have distributed 60 training kits (30 for each topic of Domestic Violence and Juvenile Bipolar) at the monthly Clinical Directors Meeting. We have not had agencies complete the training but we are in contact with they bi-monthly, checking on their progress toward hosting their own HBFT Group Training. We received positive feedback when the Training was introduced and so we expect a large completion rate.

**A sample Group Training Kit is provided in the attached purple folder*

Home-Based Family Therapy Partnership

HBFT is now bringing trainings to your agency!

One time fee of $25 for 3 CEUs!

Wide variety of Ethics and DSM topics!

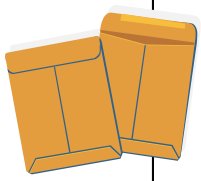
Use as many times as you like—here's how:

Step 1:

Email us at hbft@ksu.edu requesting the required materials to host your own Group Training.

Step 2:

Once we receive your order we will mail clinic directors a packet including:



- Instruction Sheet
- DVD
- Power-point
- Pre-test
- Post-test
- Sign in Sheet
- Evaluations for both the clinic director and Group Training participants
- Self-addressed, pre-paid envelope

Step 3:

Host a Group Training at your agency. The group must consist of five or more people. We want this to be an interactive experience in which participants gather together and discussion is encouraged.

Step 4:

Return the following items in the self-addressed, stamped envelope we have provided for you.

- Pre-test
- Post-test
- Sign-in sheet
- Evaluations
- **Payment — $25**

Step 5:

Clinic director receives certificates for each participant electronically. Then prints and distributes them accordingly.

ORDER TODAY at hbft@ksu.edu

www.hbftpartnership.com

HBFT PARTNERSHIP

(785)532-7695
hbft@ksu.edu

CORE TRAINING

CORE TRAINING

"Core Training is a key event in the HBFT partnership identifying aspects of home-based family therapy that are distinct from traditional, in-office therapy. To bridge the gap between office-based work and home-based practice, we address several unique challenges associated with working with families in their homes. HBFT provides greater access to family data and a direct view of family functioning, and that can be overwhelming. We introduce a lens to help clinicians dissect this new data and focus treatment. The result is a family-driven approach with unique phases of therapy and crucial adaptations that must be met at each phase. By studying a common family issue, participants have the opportunity to interact with one another and work through each of the phases. You'll learn from peers as every professional is encouraged to share his/her own theoretical perspective. Finally, the partnership places a priority on the use of supervision and therapist self-care to support and enhance home-based work. To date, HBFT Partnership has trained 687 clinicians across the state of Kansas."

-HBFTPartnership.com

Billing and Payment Policy

Previous Policy:

There is a $25 fee associated with registering for core trainings and videoconferences. Individual agencies are billed directly by HBFT. You may cancel your registration up to two weeks before an event. Participants who cancel their registrations will not be charged the $25 registration fee ***if*** we are able to fill the slot.

Updated Policy:

There is a $25 fee associated with registering for core trainings and videoconferences. Individual practitioners are billed directly by HBFT. You may cancel your registration up to two weeks before an event. Participants who cancel their registrations will not be charged the $25 registration fee ***if*** we are able to fill the slot.

Rationale:

To increase prompt receipt of payment, the HBFT Partnership has decided to bill individual practitioners for all trainings. Previously this was done solely for videoconferences. The previous billing process prevented some participants from receiving certificates after the training, because their agency had not yet mailed a payment. Now individual practitioners will be able to pay for the trainings and get reimbursed by their agencies at their own pace. This will allow practitioners to become "certified" the day they attend the training and have not lapse between the date they attended the training and their ability to bill at the higher rate.

HBFT PARTNERSHIP

Event Policies

This document details the HBFT Partnership policies regarding training event registration and scheduling. There is a minimum of 10 participants required for each event with a maximum of 40 participants. The HBFT team is aware and seeks to accommodate the multiple demands of our colleagues. We are committed to offering events at multiple times and locations that address those demands. *Therefore we ask that participants register for events in a timely fashion and take responsibility for confirming their attendance.*

Core Training Registration

1. Registration for each event will **open 60 days prior to the event and close one week prior to the event.**
    a. An online pre-event survey will be sent to each registrant upon completion of the registration process and will serve as a confirmation of registration
2. If an event is full, inquiring participants will be added to a waitlist. If a cancelation is received, parties will be contacted in waitlist order.
3. A fee of $25 is charged for anyone **registering** for an event
    a. The registrant or sponsoring agency **will be charged for any cancellation or no show made less than 2 weeks prior to an event** unless the slot can be filled by the wait list

Videoconference Registration

1. Registration for each event will open 60 days prior to the event
2. A fee of $25 is charged for anyone **registering** for an event
    a. The registrant will be charged for any cancellation made less than 2 weeks prior to an event unless the slot can be filled by the wait list
3. There are 8 videoconference sites. One registrant will open a site

Certificates of Attendance

1. Participants must attend the full event to receive credit for the event
2. Core training participants will receive certificates at the conclusion of the training following the completion of an evaluation
3. Videoconference participants will receive certificates via email following confirmation of completion of an online evaluation

Event Rescheduling

1. An event will be rescheduled due to <u>low registration</u> consisting of less than 10 participants registered at the time registration closes **(1 week prior to the event)**
    a. Participants will be notified via telephone and email
2. An event may be rescheduled due to <u>inclement weather</u>
    a. The trainers will hold an event as long as the trainers can attend the hosting site and at least 10 participants are involved
    b. The decision to reschedule an event will be decided at **midnight** the evening before the day of the event
    c. Participants will be notified via the website
    d. If an individual cancels their registration due to inclement weather, the HBFT Event Scheduler will determine on an individual basis whether the $25 is charged.
3. An alternate event date will be determined within one week and (depending upon scheduling availability within a contract year) participants will be notified of the new date
    a. Registrants will be given priority for alternate dates

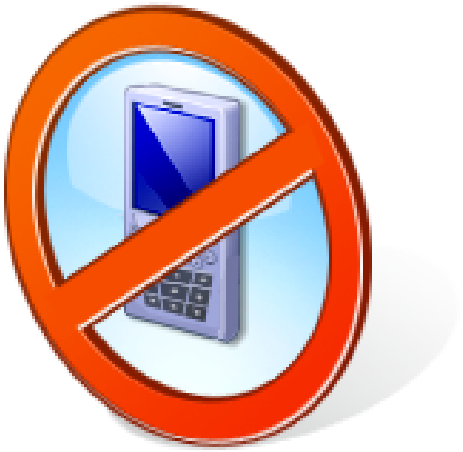
HBFT PARTNERSHIP
Core Training Agenda

Introductions and review of training objectives	8:30am
Introduction of the *partnership* and the HBFTParternship.com website	
A partnership of multiple partners	
Components of the partnership	
Morning Session	9:00am
Common components of HBFT practice	
Constructing a *bridge* between office and home-based work	
Factors influencing the decision to use HBFT	
Break	10:30-10:45am
Bafa Bafa Experience	
Catered Lunch	Noon
Afternoon Session	12:30pm
Techniques and interventions for working with *case examples*	
Additional *case examples* and *stuck cases*	
Break	2:15-2:30pm
Ethical and professional practice: Supervision and self-care	
Adjourn	3:30pm

Home-Based Family Therapy Core Training

Camille Lafleur, PhD, LCMFT
Nancy O'Conner, MS, LCMFT
Una Henry, MA
The Family Center
Kansas State University
HBFTPartnership.com

Housekeeping



Training Objectives

Participants will…

- …be introduced to the web-based, clinical, collaborative *partnership*
- …review effective approaches addressing *factors uniquely related* to home-based family therapy
- …learn to construct and apply a conceptual *bridge* from in-office to in-home family work
- …identify the challenges associated with *focusing* the work of therapy in the family's home
- …explore ways to utilize *supervision* to support the unique challenges related to home-based work
- …discover ways to prioritize *therapist self-care* to support effective work

The HBFT Partnership

The Core Training signals the beginning of an ongoing partnership

Home-Based Family Therapy Partnership Update

The Connection

www.HBFTPartnership.com

The Year-at-a-Glance (2013/2014)

- ***Core Trainings***

  September 6 (Garden City)

  May 2 (Manhattan)

- **Advanced Core Trainings**

  (Videoconference)

  October 4

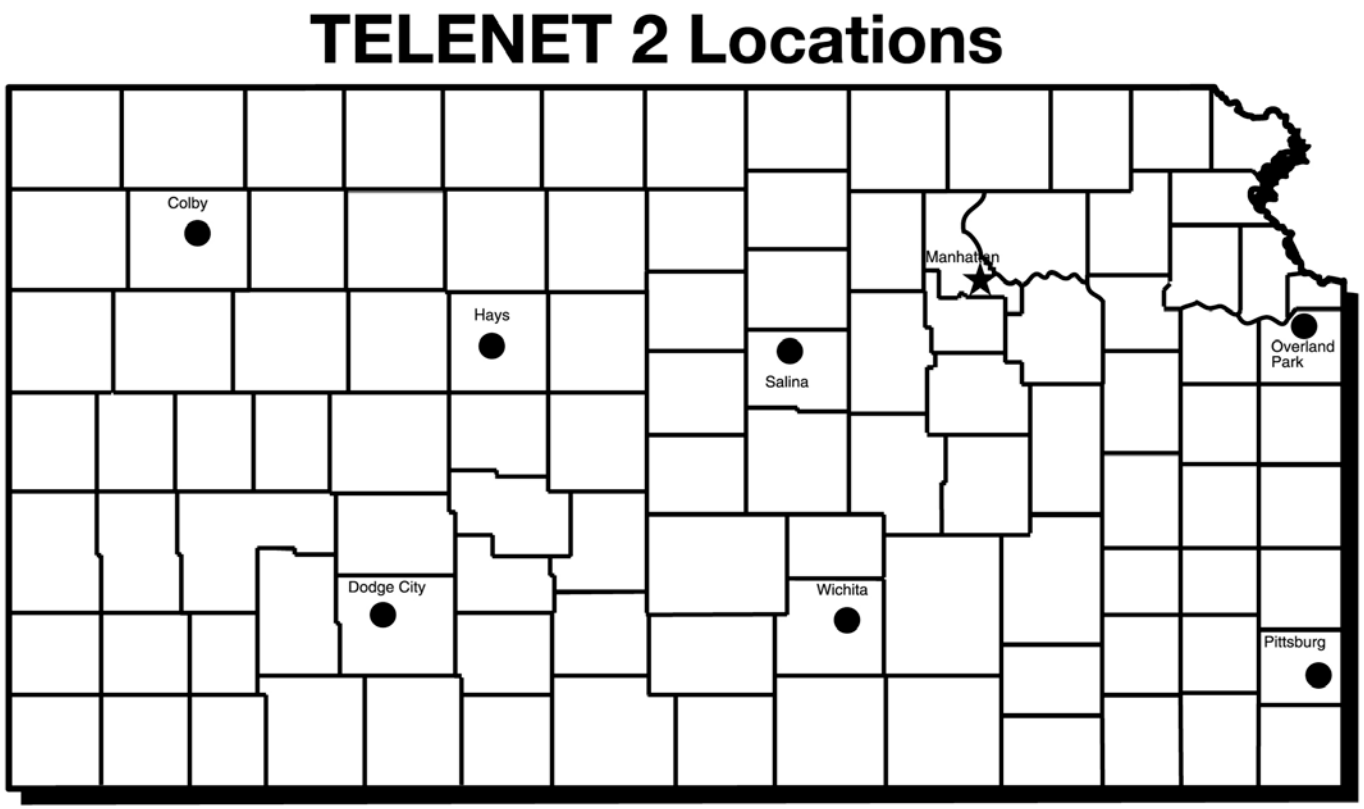
  February 7

- ***Videoconferences***
  - *Advanced Supervision Training for Supervisors* (3 CEUs)

    November 15
  - *Ethics: The Ethics of Diagnosing* (3 CEUs)

    October 25
  - *Diagnosis: Diagnosing Autism Spectrum Disorder using DSM 5* (6 CEUs)
    - **Part I – March 7**
    - **Part II – April 11**

Videoconference Sites



Group Training Kits

Agencies can host a staff training event for groups of 5 or more using a comprehensive training kit available through HBFT

Kits Available:

- Ethics Series
  - Ethical Implications of Collaboration In HBFT
  - Ethical Controversies in Domestic Violence
  - Ethical Issues of Therapists' Involvement in Social Networking
- DSM Series
  - Assessment of Juvenile Bipolar Disorder
  - Treatment of Juvenile Bipolar Disorder
  - Addressing ADHD in HBFT Part I and II

Agencies with copies of the Group Training Kits:

- Horizons Mental Health Center
- Southwest Guidance Center
- Pawnee Mental Health Services
- Crawford County Mental Health

Online Learning Modules & Learning Companions (2 CEUs)

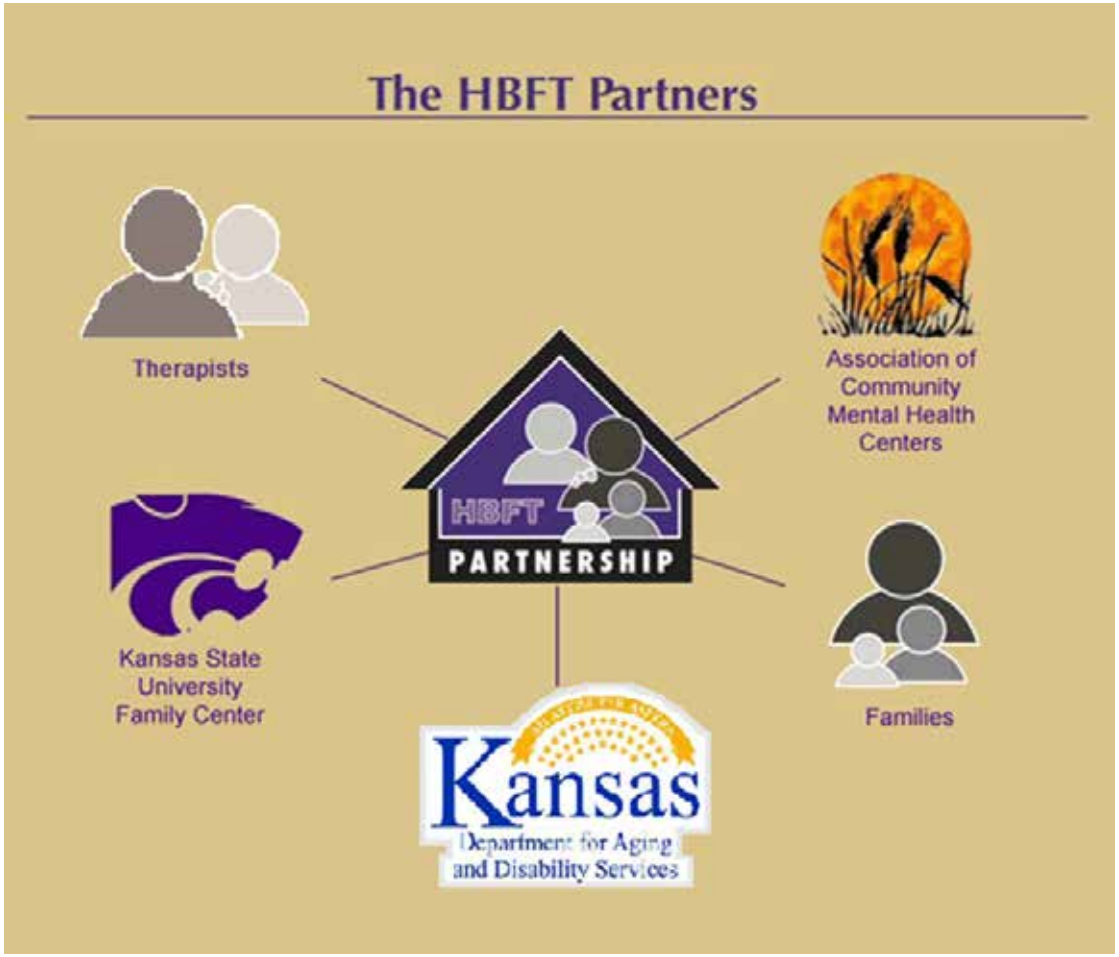
- Therapeutic Skills
  - *Crisis Intervention and Management*
  - *Evaluating Models of Cultural Competence*
  - ***Integrating Play Therapy in the Home-Based Setting***

- Family Issues
  - ***Understanding and Working with Stepfamilies***
  - ***Families and Domestic Violence***
  - *Families and Chronic Illness*

- Therapist Self-Care
  - ***Challenges of Therapist Self-Care with In-Home Work***
  - *Balancing Professional and Personal Lives Through Self-Care*

- Supervision
  - ***Utilizing Supervision***

Multilevel Collaborative Partnership



Collaborative Partnerships Supporting HBFT

Informed by a family-driven approach that is focused on support at multiple levels

- *Family and members* identify personal strengths, determine pacing, and experience ownership of the therapy process
- *Therapist* engages in professional development, improved clinical work, and supportive collegial relationships
- *Supervisor* oversees and supports the therapist and the profession
- *Agencies* provide administrative, policy, and fiscal guidance and oversight

What is HBFT and what do HBFT Therapists do?

- HBFT is
  - Theoretical approach of counseling
  - Family systemic focus of treatment
  - Services delivered in the home of the client
  - Requires planning, persistence, flexibility, patience and the ability to build trusting relationships
- HBFT Therapists are
  - Qualified mental health professionals
  - Capable of formulating interventions
  - Competent to work with both children and adults together and separately

Overview of HBFT Training

The questions that guide our training include:

- *How can your current training be adapted to work in the home?*
  - Most training programs focus on office-based therapy
- *Under which conditions is HBFT indicated or contraindicated?*
  - Family issues
  - Family's past and present course of treatment
  - Therapist characteristics and competencies
- *What are the unique skills and support HBFT therapists need to provide effective HBFT treatment?*

Common Experiences of HBFT Evidence-Based Practice

Common Experiences in HBFT

Foundation	Examples
Environment & context	• Natural environment of the home & community • Resources for therapy
Family roles & expectations	• Family members as hosts • Member familiarity with the environment • Ownership of the therapeutic process
Therapist roles & expectations	• Therapist as guest • Facilitate a collaborative leadership and structure to establish a safe, therapeutic space for all involved • Direct observations of family in natural environment • Link family work with larger social service system
Focus of clinical work	• Contextualized view of child's behavior • Broader approach to child's therapeutic issues
Therapeutic relationship	• Fluid relationship that transforms the home environment from visiting to therapy and back to visiting with each visit • Potential to increase mutual respect and trust with each encounter

Macchi, C. & O'Conner, N. (2010). Common components of home-based family therapy models: The HBFT Partnership in Kansas. *Contemporary Family Therapy*.

Self of the home-based therapist

Self of the Therapist

- Assumption: every therapist, every person has a worldview; that worldview influences how that person (therapist) constructs, experiences, and behaves within his or her world – whether that person is aware of it or not
- Relationship in therapy seems to be influenced by:
  - The degree to which therapists and clients know themselves
  - The openness of the therapists to know their clients as they are, rather than as social or personal prejudice depicts them
  - Therapists' investment in learning about their clients' social norms and social systems
  - Therapists' and clients' acquaintance with the larger systems to which each party is connected

Baker, K. A. (1999). The importance of cultural sensitivity and therapist self-awareness when working with mandatory clients. *Family Process*.

Self of the Home Based Family Therapist

- The effective use of self is the most powerful technique that a family therapist can learn.
  - Based on a therapist's good understanding of herself or himself
- Work with low-income families calls for an active approach to understanding of self because therapists put more of themselves into the work to repair the effects of social deprivation and damage to the psyche and family.
- "Poor families whose boundaries can be diffuse and confusing need therapists who are going to be actively involved with them *and* anchored in their own personal lives." (Aponte, 1994)

Aponte, H.J. (1994). Bread & spirit: Therapy with the new poor; diversity of race, culture, and values.

Bridging Therapeutic Training with In-Home Approach

HOME-BASED FAMILY THERAPY PARTNERSHIP
(HBFT Partnership)

In-Office Work

You bring…

In-Home Work

This training addresses…

Journal Exercise

In two columns, list one example for each foundation of an HBFT approach that presents BOTH an advantage and a challenge to your work.

Components	Advantages	Challenges
Environment & context		
Family roles & expectations		
Therapist roles & expectations		
Focus of clinical work		
Therapeutic relationship		

Advantages and Challenges of HBFT

	Advantages	Challenges
Environment & context	• Accessibility to additional assessment information from the broadened context • Observations of natural family processes are enacted in the natural environment of the home • Observations of unpredictable events	• Multiple possible distractions • Safety concerns especially regarding challenging clients, reporting issues, etc.
Family roles & expectations	• Family accessibility to therapy • Accessibility and involvement of additional family members and friends • Generalizability of therapeutic skills	• Family Investment in therapeutic process

Adapted from Lindblad-Goldberg, M., Dore, M., & Stern, L. (1998). *Creating competencies from chaos: A comprehensive guide to home-based services. New York: Norton.*

Advantages and Challenges of HBFT

	Advantages	Challenges
Therapist roles & expectations	• Teachable moments are based on actual vs. reported events	• Therapist's power on someone else's turf • Maintaining professional boundaries within a collaborative relationship • Family readiness to change is not obvious
Focus of clinical work	• Opportunities for therapeutic spontaneity and creativity	• Managing distractions • Confidentiality issues
Therapeutic relationship	• Opportunity to become more strengths-focused • Increased experiences of cultural interplay between family and therapist	• Lack of trust in the system

Adapted from Lindblad-Goldberg, M., Dore, M., & Stern, L. (1998). *Creating competencies from chaos: A comprehensive guide to home-based services. New York: Norton.*

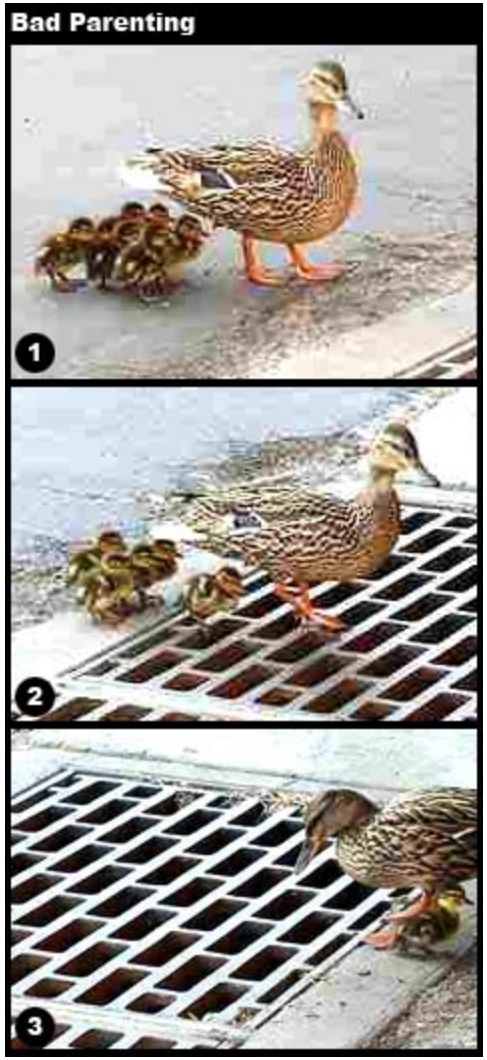
Journal Exercise

Consider one of your cases or your most recent HBFT case.

List the indicators that suggested HBFT was the appropriate modality with this family at this time.

Considerations When Determining to Use HBFT

- Family's previous treatment experiences
- Family issues
- Therapist factors



Indications for HBFT

- Family's previous treatment experiences
  - Other less-intensive treatments have not worked
  - Family has difficulty independently generalizing treatment strategies discussed in the office when they get home
- Family issues
  - Multiproblem families in perpetual crises
  - Child at risk of out of home placement
  - Limited treatment accessibility to important members of the family system
  - Impression that some information about family dynamics are missing
    - Seeing the family interact within the natural home environment
  - Examples addressing specific clinical issues
    - Children identified as SED
    - Children and adolescents exhibiting antisocial behavior
    - Children involved with the juvenile justice system
    - Children with autism
    - Key member diagnosed with agoraphobia
- Therapist factors
  - Comfortable in unfamiliar environments
  - Confident with the professional role required to structure a therapeutic environment in the family's home
  - Culturally competent
  - Established clear professional and personal boundaries

Contraindications for HBFT

- Family's previous treatment experiences
  - Past HBFT efforts have proven unsuccessful
  - Repeated HBFT efforts have contributed to, rather than relieving or transforming, the ongoing family crisis pattern
- Family issues
  - Conditions that apply to BOTH in-office and in-home therapy
    - Member's risk of exposure to abuse, violence or neglect suggesting additional safety concerns for therapist in the home
    - Necessary assessments, medical treatments, or substance-related issues have not been addressed
  - Family exhibits a pre-contemplative approach to the treatment process
- Therapist factors
  - Limited clinical experience who have difficulty constructing complex, multifaceted case conceptualizations
  - Negative perceptions of home environment
  - Limited time and resources necessary to manage additional case management responsibilities due to a large caseload
  - Inadequate supervision and agency support
  - Lacking cultural awareness and sensitivity

Lindblad-Goldberg et al. (1998) note,

> "The greatest clinical challenge is to create, in essence, a wide-angle therapeutic lens that allows the therapist to conduct a comprehensive assessment, and at the same time, a focusing mechanism to zoom in on the key elements requiring change within the defined treatment period" (p. 143).

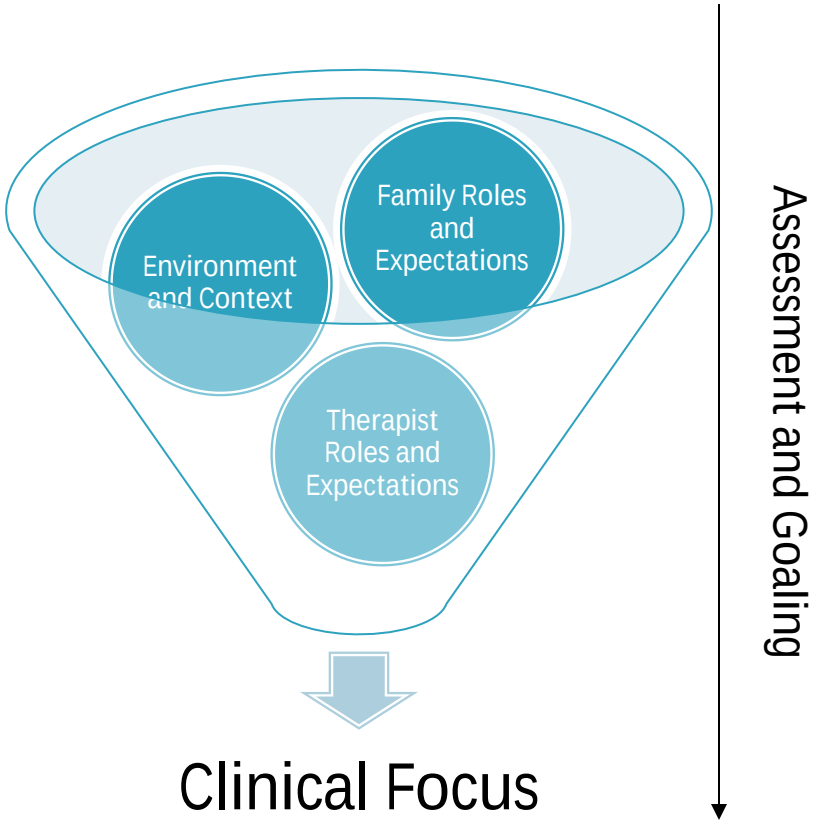
Lindblad-Goldberg, M., Dore, M., & Stern, L. (1998). *Creating competencies from chaos: A comprehensive guide to home-based services. New York: Norton.*

Focusing Therapy in the Home

v Introduction to and joining with the family

v Information gained from the family and the context

v Impact of the information and experiences on the therapist



Addressing the Unique Features of HBFT Through Case Examples

Exploring Multiple Views

- The challenge is to develop a multifaceted view of the family members and the family as a whole
- When we are tempted to settle on one view, this exercise challenges us to explore other possible views and explanations

The Matthews Family

Environment and Context

- What do you *know* about the family in this home?
- What do you *think* or *hypothesize* about the family in this home?
- Have you identified something that you believe to be a *clinical issue*?
  - How would you craft a question to ask about that issue?

- How do your thoughts and feelings associated with the family's story *influence you*?

Stuck Cases

Each table will discuss their case example then address the following questions:

- Roles and Expectations
  - Initial impressions
    - What do you *know* about the family?
    - What do you *think* or *hypothesize* about the family?
    - What are the *main issues* in the family?
- Clinical focus
  - Establishing therapeutic direction
    - What questions would you ask to *identify the clinical goals*?
    - How would you *incorporate elements from the home environment* into the development of the goals?

Cortes (2004) explained that the HBFT therapist who uses an office-based approach in a family's home…

> "focuses on the content and process of the interaction between client and therapist without considering the rich context of the client's environment. Consequently, *misusing or ignoring* (my emphasis) meaningful elements that the home environment provides in the counseling process, such as living conditions and resources, is a common phenomenon. In fact, Christensen (1995) found that this information was 'not usually used by therapists to develop treatment goals and intervention strategies'." (p. 310)

Cortes, L. (2004). Home-based family therapy: A misunderstanding of the role and a new challenge for therapists. *The Family Journal: Counseling and Therapy for Couples and Families, 12(2), 184-188.*

- Examine roles and expectations
  - What are ***your*** *roles and expectations* in your work with this family?
  - What are the ***family members'*** *roles and expectations* of their work in this process?
- Examine how self of the therapist influences clinical focus
  - How does the family description *influence* ***your*** *thoughts and feelings*?
  - How might supervision help you to *establish treatment priorities*?

Preparing self and family for therapy

- Self
  - Basic safety considerations
    - *Take precautions by preplanning* – **Think ahead!**
      - Leave early with good directions and plenty of gas
      - Cell phone is fully charged and has service
      - Inform someone where you are going and when you intend to return
      - Monitor the presence of animals
      - Be aware of your surroundings and a clear path to an exit
- *Family*
  - *Establish a therapeutic structure and expectations*
    - Creating a therapeutic environment
    - Discuss expectations of safety, trust, and respect for all members and the therapist
    - Establish rules that will ensure a measure of predictability to the process

Therapeutic Strategies and Techniques

Consider examples of strategies and techniques that you have used during each phase of therapy

- *Joining*
  - How do you transition from being a visitor/guest to being therapist offering leadership of treatment?
- *Assessment*
  - How do you determine whether you should provide protection or treatment?
- *Goaling*
  - How do you weave the elements of the home environment into the goaling process?
- *Interventions*
  - How do you use the home environment to create a teachable moment that connects with the family's values and daily living experiences?

Play therapy techniques are best used with purpose and when connected to the phases of therapy.

Ethical and Professional Practice

Therapists' Use of Supervision and Self-Care

Supervision

Supervision should provide the therapist support with the following

- Managing appropriate boundaries
- Accessing available resources
- Receiving guidance and support
- Simultaneously maintaining varying points of view
- Connecting therapist self-care and the supervision process
- Creating a relationship with your supervisor that involves vulnerability

What is Therapist Self-Care?

According to Carroll, Gilroy, and Murra (1999), a clinician's personal and professional self-care includes, but is not limited to, the following efforts:

- *Intrapersonal work*—clarifying your view of yourself as an adult and a clinician.
- *Interpersonal support*—seeking and receiving help and support from others, especially friends and family
- *Professional development and support*—attending continuing education workshops and conferences, and receiving support from colleagues and supervisors
- *Physical and recreational activities*—spending time engaged in hobbies and activities that refresh, rejuvenate and invigorate the mind and body

Carroll, L., Gilroy, P., & Murra, J. (1999). The moral imperative: Self-care for women psychotherapists. *Women & Therapy, 22(2), 133-143.*)

"My schedule requires that I burn the candle at both ends. Can you prescribe more candle?"

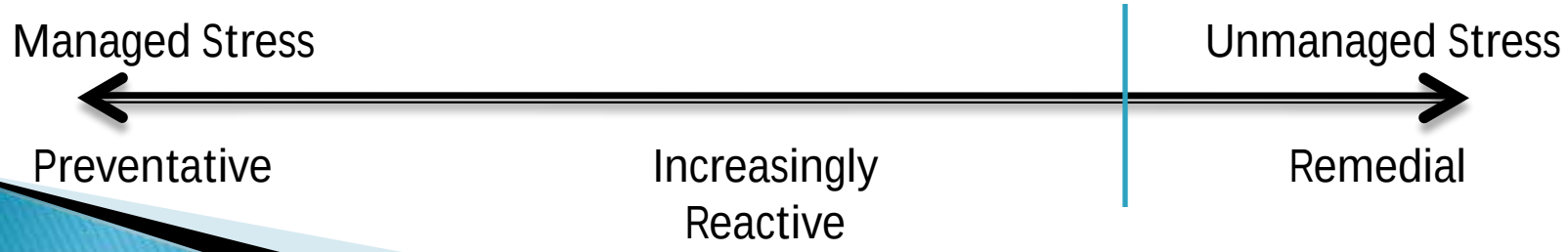
Therapist Self-Care

- Managing therapist anxiety
  - Monitoring levels of comfort visiting someone else's home
  - Reviewing personal expectations about one's own role in the therapeutic process
  - Responding to unexpected circumstances and issues with flexibility
- Monitoring therapist experiences of burnout
  - Balancing the demands of families in crisis, agency expectations, and personal life
- Proactively caring for self and personal relationships

Continuum of Therapist Self-Care

- Each therapist experiences varying degrees of personal and professional stresses
- Self-care varies along a continuum of stress management approaches

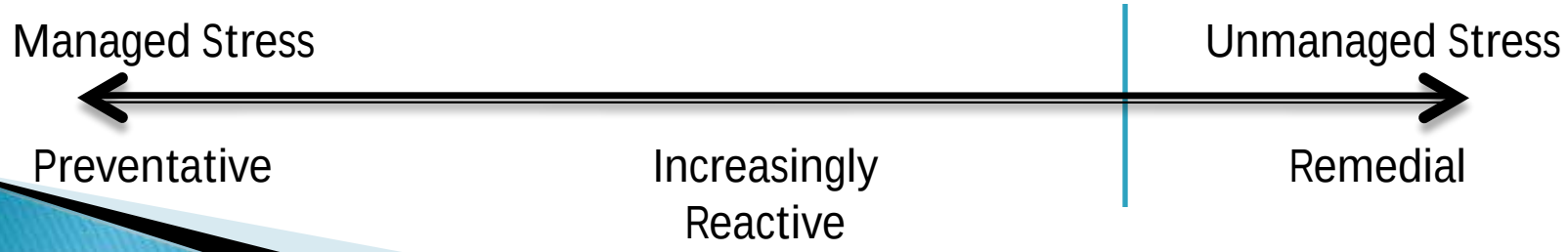
Consider your current stresses and determine where you are on the continuum of self-care based upon your own responses to those stresses.



Ongoing Activities of Self-Care

Effective self-care includes the following activities:

- ***Increase Awareness***
  - Engage in activities designed to help you identify personal and professional stressors
  - Identify the types of approaches you currently use
- ***Build Knowledge***
  - Learn about the impact of varying types of stressors on professional responsibilities
- ***Develop Skills***
  - Develop the tools necessary for maintaining a balance between our personal and professional lives



Adapted from Sue, D. W., & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice (4th ed.). New York: Wiley.*

Impact of Self-Care on Clinical Effectiveness

- Competently working with all family members
- Paying attention to and responding to safety considerations
- Knowing yourself and assessing your well-being
- Becoming increasingly aware of the impact the home environment is having on you
- Becoming increasingly aware of the impact your presence is having on the family
- Setting appropriate and manageable boundaries

Cortes, L. (2004). Home-based family therapy: A misunderstanding of the role and a new challenge for therapists. *The Family Journal: Counseling and Therapy for Couples and Families, 12(2), 184-188.*

www.hbftself-care.com

- Professional Quality of Life (ProQOL) – (Hudnall Stamm, B.(1997-2005).
  - This measure examines three domains of therapist experiences associated with providing therapeutic services:
    - *Compassion satisfaction* – the pleasure you experience associated with doing your work
    - *Burnout* – gradual onset of feeling so hopelessness and ineffectiveness associated with job performance
    - *Compassion fatigue/Secondary trauma* – the degree of impact you experience from exposure to stressful events and client stories of trauma
- Self-Care Strategies
  - Personal Self-Care
  - Collegial relationships and support
  - Supervisory Support and Accountability
  - Agency policies supportive of self-care activities.

Self-Care Strategies

- Skills
  - Take regularly scheduled breaks
  - Take regular vacations without work responsibilities
  - Nurture friendships
  - Engage in hobbies and other personal interests
  - Limit number of work hours and caseload
  - Participate in peer support and supervision
  - Engage in personal therapy as needed
  - Journaling
  - Attend to religious or spiritual needs
  - Participate in relaxing activities such as reading, prayer, meditation, listening to music

Barnett, J. (2005). Psychotherapist wellness as an ethical imperative. *Innovations in Clinical Practice, 257-271.*

Comments??

Questions??

CLINICIAN'S NEWEST STUCK CASES (5/08/2012)

- The family includes three children adopted by their grandmother after they experienced abuse and neglect from their parents. They live with their grandmother and uncle. The client is a 13 year old girl, and had a mood disorder. I have used play therapy techniques, cognitive behavioral therapy, "The Tree of Life" technique from narrative therapy, sand tray from play therapy, and other techniques to reach the client. The client's uncle participates in therapy and is narcissistic. He takes up a lot of the session talking about himself, and it is difficult to engage with the client or to get the client to talk about herself.

- I am working through the KU KIPP grant and practicing the PMTO model of treatment with families who have had their children removed from the home and the children have an SED diagnosis. I have a family that is trying to re-integrate three daughters into the bio dad's home because bio mom's husband, their stepfather, sexually abused one of the girls. I am not specifically working with the abuse victim, but with her sister who has ADHD and is ODD as well. The PMTO process has certain parental skills we work on such as good directions, monitoring, setting limits, and building on the families' strengths. It is a very positive and structured model of treatment.

- There is a case where I feel frustrated and are not sure what to do next. Workers have observed the mother abusing her children during a visit(pulling hair, almost slapping, covering childs mouth to keep her quiet) I have continued to report these episodes, which only get screened out to SFCS. Family therapy is difficult as the children do not feel comfortable talking about their feelings in front of their mother since she is unpredictable. Mother will not respond to therapy and her answer to every question is "good." Have met with the children without the mother present and sessions have been effective. Struggling with ways to engage mother into services.

- Bio mom recently got children back in her home. Children (age 4 and 10) are fearful they will be removed again. 4 year old is fearful of her mom dying. 10 year old is ADHD. It is hard to get the kids and mom to focus at the same time. Need help with how to engage them - I have tried some games which the kids enjoy, but they are still easily distracted. I am worried I am not effective. But I hold on to the fact that relationship is very important and I do have a very good relationship with all members of the family. Also, need help with what intervention to use.

- I'm only working with one family, as two have dropped out of the program. I use the Parent Management Training- Oregon Model which is based in Cognitive Behavioral theory. My main issue I have when working with this family is that the home life is very chaotic and it is very difficult to get the mom to focus during my sessions with her because of the other children in the home. Every session there is a significant amount of time that is not utilized because the kids are distracting mom or mom is getting up to do something for the kids, even if she has a babysitter. I am stuck on how to create a calmer environment during session but also helping mom to realize it is beneficial to her kids

PREVIOUS STUCK CASES

- One of the families that I work with is having a difficult time due to their current environment and life circumstances. The mother struggles with following through and setting structure in the home. The children continue to argue and fight on a daily basis. This I believe has to do with their age and past environment. The father continues to have problems with drug use. He has been in and out of jail, sold their belongings and caused financial hardships for the family. The mother does not engage in drug use, but is a victim of physical abuse. The father is currently in prison for two years. Each week we work on building self-esteem, building structure, and feeling safe in the home.

- Working with child with Autism and disruptive behavior that has a mom with significant medical issues. Behavioral treatment and help her in setting up rules and consequences in the home. Big issue with them meeting for sessions because of continual health issues.

- Sibling group of four. Two live with one great maternal aunt and two younger children live with another great maternal aunt. Oldest daughter, over-achiever, parentified was care giver for other children when they were placed with bio-mom. Next child, physically, emotionally abused by mom and her past boyfriends. Has severe learning disabilities, and is extremely oppositional and defiant. Third child was born with a cleft palate. Needed dental work, medical care and speech therapy (pre-school) didn't occur until she moved in with the great aunt. Difficulty talking for past five years. Youngest still a baby and mom's favorite. She appears to like the children while they are babies.

- Pre-adoptive family with two foster children in home. Attachment issues, disruptive behavior. Using play therapy, and narrative therapy, also working with foster parents on their self-care and respite so that they experience relief before crisis occurs. I am not stuck with this case but it is challenging.

- Family mix of Maternal grandmother 62yrs, daughter 45 , and two boys ages 13 and 7. 13 year old has had mental health tx/concerns since Kindergarten diagnosed with ADHD and BiPolar. Mother and Grandmother work opposite shifts to provided 24/7 supervision of the boys. Focus of treatment is due to the 13 year old beginning to explore sexually with concerns of inappropriate behaviors with the 7 year old. Life Span development, Bowen family systems, and the medical model inform my understanding of the family. Agency mandated assessments and other information gathering documents are the primary intervention tools and director of tx needs. Crises management with ambivalent readiness for change

- Single mom with 3 children, oldest child is male and has been very aggressive with siblings in the home. SRS and family preservation involvement in the home. Need help maintaining safety plan while also managing family dynamics effectively.

ProQOL R-IV

PROFESSIONAL QUALITY OF LIFE SCALE

Compassion Satisfaction and Fatigue Subscales—Revision IV

[Helping] people puts you in direct contact with their lives. As you probably have experienced, your compassion for those you *[help]* has both positive and negative aspects. We would like to ask you questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current situation. Select the number that honestly reflects how frequently you experienced these characteristics in the ***last 30 days***.

0=Never	1=Rarely	2=A Few Times	3=Somewhat Often	4=Often	5=Very Often

_____ 1. I am happy.
_____ 2. I am preoccupied with more than one person I *[help]*.
_____ 3. I get satisfaction from being able to *[help]* people.
_____ 4. I feel connected to others.
_____ 5. I jump or am startled by unexpected sounds.
_____ 6. I feel invigorated after working with those I *[help]*.
_____ 7. I find it difficult to separate my personal life from my life as a *[helper]*.
_____ 8. I am losing sleep over traumatic experiences of a person I *[help]*.
_____ 9. I think that I might have been "infected" by the traumatic stress of those I *[help]*.
_____ 10. I feel trapped by my work as a *[helper]*.
_____ 11. Because of my *[helping]*, I have felt "on edge" about various things.
_____ 12. I like my work as a *[helper]*.
_____ 13. I feel depressed as a result of my work as a *[helper]*.
_____ 14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
_____ 15. I have beliefs that sustain me.
_____ 16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
_____ 17. I am the person I always wanted to be.
_____ 18. My work makes me feel satisfied.
_____ 19. Because of my work as a *[helper]*, I feel exhausted.
_____ 20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
_____ 21. I feel overwhelmed by the amount of work or the size of my case*[work]*load I have to deal with.
_____ 22. I believe I can make a difference through my work.
_____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
_____ 24. I am proud of what I can do to *[help]*.
_____ 25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
_____ 26. I feel "bogged down" by the system.
_____ 27. I have thoughts that I am a "success" as a *[helper]*.
_____ 28. I can't recall important parts of my work with trauma victims.
_____ 29. I am a very sensitive person.
_____ 30. I am happy that I chose to do this work.

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Disclaimer

This information is presented for educational purposes only. It is not a substitute for informed medical advice or training. Do not use this information to diagnose or treat a health problem without consulting a qualified health or mental health care provider. If you have concerns, contact your health care provider, mental health professional, or your community health center.

Self-scoring directions, if used as self-test

1. Be certain you respond to all items.
2. On some items the scores need to be reversed. Next to your response write the reverse of that score (i.e. 0=0, 1=5, 2=4, 3=3). Reverse the scores on these 5 items: 1, 4, 15, 17 and 29. Please note that the value 0 is not reversed, as its value is always null.
3. Mark the items for scoring:
    a. Put an **X** by the 10 items that form the **Compassion Satisfaction Scale**: 3, 6, 12, 16, 18, 20, 22, 24, 27, 30.
    b. Put a **check** by the 10 items on the **Burnout Scale**: 1, 4, 8, 10, 15, 17, 19, 21, 26, 29.
    c. **Circle** the 10 items on the **Trauma/Compassion Fatigue Scale**: 2, 5, 7, 9, 11, 13, 14, 23, 25, 28.
4. Add the numbers you wrote next to the items for each set of items and compare with the theoretical scores.

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Your Scores On The ProQOL: Professional Quality of Life Screening

For more information on the ProQOL, go to http://www.isu.edu/~bhstamm

Based on your responses, your personal scores are below. If you have any concerns, you should discuss them with a physical or mental health care professional.

Compassion Satisfaction _____

Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 37 (SD 7; alpha scale reliability .87). About 25% of people score higher than 42 and about 25% of people score below 33. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 33, you may either find problems with your job, or there may be some other reason—for example, you might derive your satisfaction from activities other than your job.

Burnout_____

Most people have an intuitive idea of what burnout is. From the research perspective, burnout is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a non-supportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 22 (SD 6.0; alpha scale reliability .72). About 25% of people score above 27 and about 25% of people score below 18. If your score is below 18, this probably reflects positive feelings about your ability to be effective in your work. If you score above 27 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a "bad day" or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Compassion Fatigue/Secondary Trauma_____

Compassion fatigue (CF), also called secondary trauma (STS) and related to Vicarious Trauma (VT), is about your work-related, secondary exposure to extremely stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called VT. If your work puts you directly in the path of danger, such as being a soldier or humanitarian aide worker, this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work, such as in an emergency room or working with child protective services, this is secondary exposure. The symptoms of CF/STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 13 (SD 6; alpha scale reliability .80). About 25% of people score below 8 and about 25% of people score above 17. If your score is above 17, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional.

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Home-Based Family Therapy Advanced Core Training

Camille Lafleur, PhD, LCMFT
Nancy O'Conner, LCMFT
Kansas State University
HBFTPartnership.com

1

Upcoming HBFT Trainings

- ***Core Trainings***
  May 2 (Manhattan)
- ***Videoconferences***
  - Diagnosis: Diagnosing Autism Spectrum Disorder using DSM 5 (6 CEUs)
    - **Part I – March 14**
    - **Part II – April 11**

2

Group Training Kits

(Each Kit $25)

Agencies can host a staff training event for groups of 5 or more using a comprehensive training kit or individual therapists can earn CEUs

Kits Available:

- Ethics Series
  - Ethical Implications of Collaboration In HBFT
  - Ethical Controversies in Domestic Violence
  - Ethical Issues of Therapists' Involvement in Social Networking
- DSM Series
  - Assessment of Juvenile Bipolar Disorder
  - Treatment of Juvenile Bipolar Disorder
  - Addressing ADHD in HBFT Part I and II

Agencies with copies of the Group Training Kits:

- Horizons Mental Health Center
- Southwest Guidance Center
- Pawnee Mental Health Services
- Crawford County Mental Health

3

Online Learning Modules & Learning Companions (2 CEUs)

(Free)

- Therapeutic Skills
  - *Crisis Intervention and Management*
  - *Evaluating Models of Cultural Competence*
  - ***Integrating Play Therapy in the Home-Based Setting***

- Family Issues
  - ***Understanding and Working with Stepfamilies***
  - ***Families and Domestic Violence***
  - *Families and Chronic Illness*

- Therapist Self-Care
  - ***Challenges of Therapist Self-Care with In-Home Work***
  - *Balancing Professional and Personal Lives Through Self-Care*

- Supervision
  - ***Utilizing Supervision***

4

The HBFT Partnership

The Core Training signals the beginning of an ongoing partnership

Home-Based Family Therapy Partnership Update

The Connection

www.HBFTPartnership.com

facebook

HBFT Therapist Self-Care Website
www.hbftself-care.com

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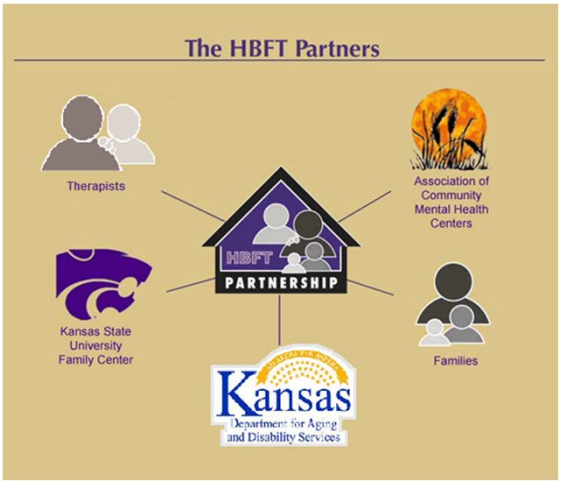
Multilevel Collaborative Partnership



6

Training Objectives

Participants will…

- be introduced to the web-based, clinical, collaborative *partnership*
- review effective approaches addressing *factors uniquely related* to home-based family therapy
- learn to construct and apply a conceptual *bridge* from in-office to in-home family work
- identify the challenges associated with *focusing* the work of therapy in the family's home
- explore ways to utilize *therapeutic interventions* to support their work with families using an in-home family therapy approach
- explore ways to utilize *supervision* to support the unique challenges related to home-based work
- discover ways to prioritize *therapist self-care* to support effective work

7

Overview of the Advanced Core HBFT Training

The questions that guide our training include:

- *How do you combine your training and experiences with HBFT to provide the most effective in-home treatment?*
  - Most training programs focus on office-based therapy
- *What specific theoretical approaches and techniques/interventions have been found to be effective for in-home family therapy?*
- *What are the unique supports HBFT therapists need to provide effective HBFT treatment?*
  - *Supervision*
  - *Self-Care*

8

What is HBFT and what do HBFT Therapists do?

- HBFT is
  - Theoretical approach of counseling
  - Family systemic focus of treatment
  - Services delivered in the home of the client
  - Requires planning, persistence, flexibility, patience and the ability to build trusting relationships
- HBFT Therapists are
  - Qualified mental health professionals
  - Capable of formulating interventions
  - Competent to work with both children and adults together and separately

Common Experiences of HBFT Evidence-Based Practice

10

Common Experiences in HBFT

Foundation	Common Experiences
Environment & context	• Natural environment of the home & community • Resources for therapy
Family roles & expectations	• Family members as hosts • Member familiarity with the environment • Ownership of the therapeutic process
Therapist roles & expectations	• Therapist as guest • Facilitate a collaborative leadership and structure to establish a safe, therapeutic space for all involved • Direct observations of family in natural environment • Link family work with larger social service system
Focus of clinical work	• Contextualized view of child's behavior • Broader approach to child's therapeutic issues
Therapeutic relationship	• Fluid relationship that transforms the home environment from visiting to therapy and back to visiting with each visit • Potential to increase mutual respect and trust with each encounter

11

Macchi, C. & O'Conner, N. (2010). Common components of home-based family therapy models: The HBFT Partnership in Kansas. *Contemporary Family Therapy*.

Advantages and Challenges of HBFT

	Advantages	Challenges
Environment & context	• Accessibility to additional assessment information from the broadened context • Observations of natural family processes are enacted in the natural environment of the home • Observations of unpredictable events	• Multiple possible distractions • Safety concerns especially regarding challenging clients, reporting issues, etc.
Family roles & expectations	• Family accessibility to therapy • Accessibility and involvement of additional family members and friends • Generalizability of therapeutic skills	• Family Investment in therapeutic process

12

Adapted from Lindblad-Goldberg, M., Dore, M., & Stern, L. (1998). *Creating competencies from chaos: A comprehensive guide to home-based services. New York: Norton.*

Advantages and Challenges of HBFT

	Advantages	Challenges
Therapist roles & expectations	• Teachable moments are based on actual vs. reported events	• Therapist's power on someone else's turf • Maintaining professional boundaries within a collaborative relationship • Family readiness to change is not obvious
Focus of clinical work	• Opportunities for therapeutic spontaneity and creativity	• Managing distractions • Confidentiality issues
Therapeutic relationship	• Opportunity to become more strengths-focused • Increased experiences of cultural interplay between family and therapist	• Lack of trust in the system

Adapted from Lindblad-Goldberg, M., Dore, M., & Stern, L. (1998). *Creating competencies from chaos: A comprehensive guide to home-based services. New York: Norton.*

13

Discussion

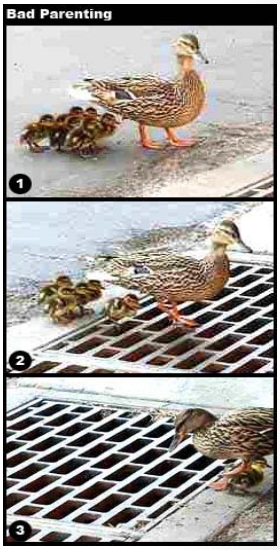
Consider one of your cases or your most recent HBFT case.

What indicators suggested HBFT was the appropriate modality with this family at this time?

14

Indications and Contraindications for HBFT

- Family's previous treatment experiences
- Family issues
- Therapist factors



15

Indications for HBFT

- Family's previous treatment experiences
  - Other less-intensive treatments have not worked
  - Family has difficulty independently generalizing treatment strategies discussed in the office when they get home
- Family issues
  - Multiproblem families in perpetual crises
  - Child at risk of out of home placement
  - Limited treatment accessibility to important members of the family system
  - Impression that some information about family dynamics are missing
    - Seeing the family interact within the natural home environment
  - Examples addressing specific clinical issues
    - Children identified as SED
    - Children and adolescents exhibiting antisocial behavior
    - Children involved with the juvenile justice system
    - Children with autism
    - Key member diagnosed with agoraphobia
- Therapist factors
  - Comfortable in unfamiliar environments
  - Confident with the professional role required to structure a therapeutic environment in the family's home
  - Culturally competent
  - Established clear professional and personal boundaries

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Contraindications for HBFT

- Family's previous treatment experiences
  - Past HBFT efforts have proven unsuccessful
  - Repeated HBFT efforts have contributed to, rather than relieving or transforming, the ongoing family crisis pattern
- Family issues
  - Conditions that apply to BOTH in-office and in-home therapy
    - Member's risk of exposure to abuse, violence or neglect suggesting additional safety concerns for therapist in the home
    - Necessary assessments, medical treatments, or substance-related issues have not been addressed
  - Family exhibits a pre-contemplative approach to the treatment process
- Therapist factors
  - Limited clinical experience who have difficulty constructing complex, multifaceted case conceptualizations
  - Negative perceptions of home environment
  - Limited time and resources necessary to manage additional case management responsibilities due to a large caseload
  - Inadequate supervision and agency support
  - Lacking cultural awareness and sensitivity

17

Lindblad-Goldberg et al. (1998) note,

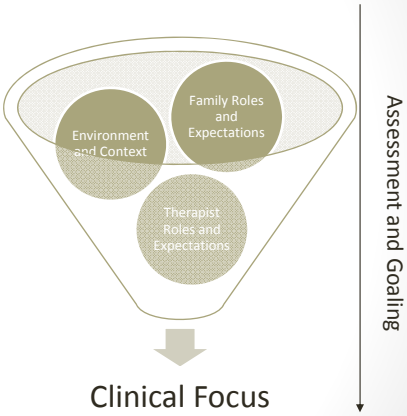
"The greatest clinical challenge is to create, in essence, a wide-angle therapeutic lens that allows the therapist to conduct a comprehensive assessment, and at the same time, a focusing mechanism to zoom in on the key elements requiring change within the defined treatment period" (p. 143).

Lindblad-Goldberg, M., Dore, M., & Stern, L. (1998). *Creating competencies from chaos: A comprehensive guide to home-based services. New York: Norton.*

18

Focusing Therapy in the Home

- ❖Introduction to and joining with the family
- ❖Information gained from the family and the context
- ❖Impact of the information and experiences on the therapist



19

Cortes (2004) explained that the HBFT therapist who uses an office-based approach in a family's home…

> "focuses on the content and process of the interaction between client and therapist without considering the rich context of the client's environment. Consequently, *misusing or ignoring* (my emphasis) meaningful elements that the home environment provides in the counseling process, such as living conditions and resources, is a common phenomenon. In fact, Christensen (1995) found that this information was 'not usually used by therapists to develop treatment goals and intervention strategies'." (p. 310)

Cortes, L. (2004). Home-based family therapy: A misunderstanding of the role and a new challenge for therapists. *The Family Journal: Counseling and Therapy for Couples and Families, 12(2), 184-188.*

20

K-State HBFT Model

Theoretical Foundations

- Self of the Therapist
- Ecological Perspective
- Family Systems Theory
- Family Resilience Framework

Self of the Therapist

- Assumption: every therapist, every person has a worldview; that worldview influences how that person (therapist) constructs, experiences, and behaves within his or her world – whether that person is aware of it or not
- Relationship in therapy seems to be influenced by:
  - The degree to which therapists and clients know themselves
  - The openness of the therapists to know their clients as they are, rather than as social or personal prejudice depicts them
  - Therapists' investment in learning about their clients' social norms and social systems
  - Therapists' and clients' acquaintance with the larger systems to which each party is connected

23

Baker, K. A. (1999). The importance of cultural sensitivity and therapist self-awareness when working with mandatory clients. *Family Process*.

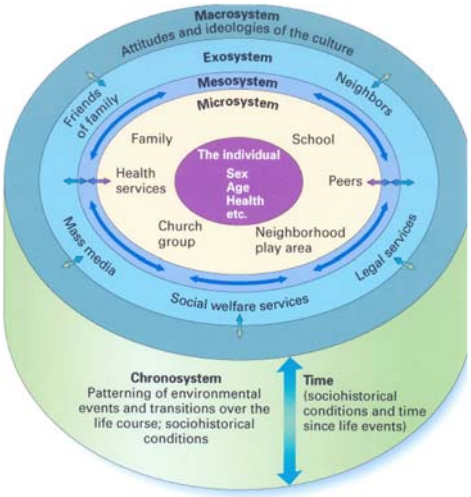
Self of the Home Based Family Therapist

- The effective use of self is the most powerful technique that a family therapist can learn.
  - Based on a therapist's good understanding of herself or himself
- Work with low-income families calls for an active approach to understanding of self because therapists put more of themselves into the work to repair the effects of social deprivation and damage to the psyche and family.
- "Poor families whose boundaries can be diffuse and confusing need therapists who are going to be actively involved with them *and* anchored in their own personal lives." (Aponte, 1994)

24

Aponte, H.J. (1994). Bread & spirit: Therapy with the new poor; diversity of race, culture, and values.

Ecological Perspective



Family Systems Theory

- Family Systems…
  - have interrelated elements and structure
  - interact in patterns
  - have boundaries and can be viewed on a continuum from open to closed
  - the Whole is More than the Sum of Its Parts
  - use messages and rules to shape members
  - have subsystems

Family Resilience Framework

- Belief Systems
  - Make meaning of adversity
  - Positive outlook
  - Transcendence and Spirituality
- Organizational Patterns
  - Flexibility
  - Connectedness
  - Social and Economic Resources
- Communication/Problem-Solving
  - Clarity
  - Open Emotional Expression
  - Collaborative Problem-Solving

Family Therapy Techniques

- Assessment/Joining
- Experiential Therapy
- Play Therapy Techniques
- Solution Focused Therapy
- Structural

Therapeutic Strategies and Techniques

Consider examples of strategies and techniques that you have used during each phase of therapy

- *Joining*
  - How do you transition from being a visitor/guest to being therapist offering leadership of treatment?
- *Assessment*
  - How do you determine whether you should provide protection or treatment?
- *Goaling*
  - How do you weave the elements of the home environment into the goaling process?
- *Interventions*
  - How do you use the home environment to create a teachable moment that connects with the family's values and daily living experiences?

29

Play therapy techniques are best used with purpose and when connected to the phases of therapy.

Joining Techniques
(Solution-Focused Approach)

- Goal: help clients become comfortable with you; build trust
- Set aside personal feelings
- Use everyday language, avoid professional jargon; use friendly, positive words
- Look for key words and use the client's language
- Behave as though you accept his/her way of doing things even though is may not seem logical
- Do not confront the client directly; take a "one-down" position – client is the expert
- Compliment the positive
- Empower the family, avoid taking sides

Engaging Family in Play and Art Activities

- Inform parents
- Ask parents about their expectations of therapy
- Explain benefits of techniques

Managing Sessions

- Scheduling the Appointments
- Interruptions and Distractions
- Pacing

Lawson, G. (2005). Special considerations for the supervision of home-based counselors. The Family Journal: Counseling and therapy for couples and families. 13(4).

Using the Home Environment

- Be humble but prepared
- Learn from what is said and unsaid

Lawson, G. (2005). Special considerations for the supervision of home-based counselors. *The Family Journal: Counseling and therapy for couples and families*. 13(4).

Safety Issues

- Keeping the family safe
- Keeping the counselor safe
  - Risk Assessment
- Safety Session

Lawson, G. (2005). Special considerations for the supervision of home-based counselors. The Family Journal: Counseling and therapy for couples and families. 13(4).

Ethical and Professional Practice

Therapists' Use of Supervision and Self-Care

35

Supervision

Supervision should provide the therapist support with the following

- Managing appropriate boundaries
- Accessing available resources
- Receiving guidance and support
- Simultaneously maintaining varying points of view
- Connecting therapist self-care and the supervision process
- Creating a relationship with your supervisor that involves vulnerability

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Supervision Structure

- Observation is important
  - Supervisor needs to be active
  - Work as a team; paired with more experienced therapist
- Assessment of skills sets standards for competent professional behavior
  - Inexperienced focus on managing key HBFT skills, monitoring abilities, safeguarding clients
  - Experienced case consultation focused on safety, systems thinking, using the home environment, and managing sessions.
- Attention to therapist's worldview and impact on clinical work

Lawson, G. (2005). Special considerations for the supervision of home-based counselors. The Family Journal: Counseling and therapy for couples and families. 13(4).

What is Therapist Self-Care?

According to Carroll, Gilroy, and Murra (1999), a clinician's personal and professional self-care includes, but is not limited to, the following efforts:

- *Intrapersonal work*—clarifying your view of yourself as an adult and a clinician.
- *Interpersonal support*—seeking and receiving help and support from others, especially friends and family
- *Professional development and support*—attending continuing education workshops and conferences, and receiving support from colleagues and supervisors
- *Physical and recreational activities*—spending time engaged in hobbies and activities that refresh, rejuvenate and invigorate the mind and body

38

Carroll, L., Gilroy, P., & Murra, J. (1999). The moral imperative: Self-care for women psychotherapists. *Women & Therapy, 22(2), 133-143.*)

Therapist Self-Care

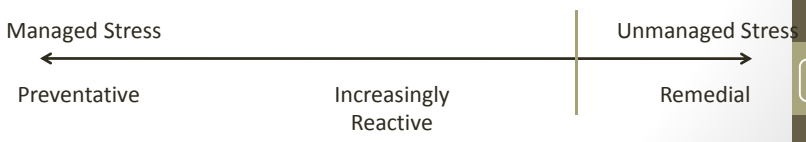
- Managing therapist anxiety
  - Monitoring levels of comfort visiting someone else's home
  - Reviewing personal expectations about one's own role in the therapeutic process
  - Responding to unexpected circumstances and issues with flexibility
- Monitoring therapist experiences of burnout
  - Balancing the demands of families in crisis, agency expectations, and personal life
- Proactively caring for self and personal relationships

39

Continuum of Therapist Self-Care

- Each therapist experiences varying degrees of personal and professional stresses
- Self-care varies along a continuum of stress management approaches

Consider your current stresses and determine where you are on the continuum of self-care based upon your own responses to those stresses.



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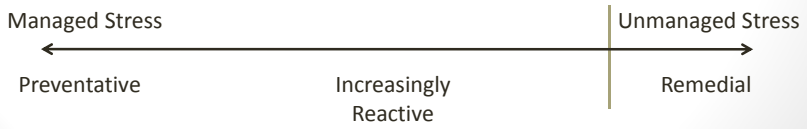
Ongoing Activities of Self-Care

Effective self-care includes the following activities:

- ***Increase Awareness***
  - Engage in activities designed to help you identify personal and professional stressors
  - Identify the types of approaches you currently use
- ***Build Knowledge***
  - Learn about the impact of varying types of stressors on professional responsibilities
- ***Develop Skills***
  - Develop the tools necessary for maintaining a balance between our personal and professional lives



41

Adapted from Sue, D. W., & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice (4th ed.). New York: Wiley.*

Impact of Self-Care on Clinical Effectiveness

- Competently working with all family members
- Paying attention to and responding to safety considerations
- Knowing yourself and assessing your well-being
- Becoming increasingly aware of the impact the home environment is having on you
- Becoming increasingly aware of the impact your presence is having on the family
- Setting appropriate and manageable boundaries

42

Cortes, L. (2004). Home-based family therapy: A misunderstanding of the role and a new challenge for therapists. *The Family Journal: Counseling and Therapy for Couples and Families, 12(2), 184-188.*

www.hbftself-care.com

- Professional Quality of Life (ProQOL) – (Hudnall Stamm, B.(1997-2005).
  - This measure examines three domains of therapist experiences associated with providing therapeutic services:
    - *Compassion satisfaction* – the pleasure you experience associated with doing your work
    - *Burnout* – gradual onset of feeling so hopelessness and ineffectiveness associated with job performance
    - *Compassion fatigue/Secondary trauma* – the degree of impact you experience from exposure to stressful events and client stories of trauma
- Self-Care Strategies
  - Personal Self-Care
  - Collegial relationships and support
  - Supervisory Support and Accountability
  - Agency policies supportive of self-care activities.

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Self-Care Strategies

- Knowledge
  - Read articles and books that address ways to further your own self-care
  - Discuss themes from your readings with your colleagues while sharing self-care strategies that have worked

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Self-Care Strategies

- Awareness
  - Establish a baseline measuring your personal quality of life using ProQOL to determine levels of…
    - Compassion satisfaction
    - Burnout
    - Compassion fatigue/secondary trauma
  - Share the ProQOL with colleagues and share your results with each other

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Self-Care Strategies

- Skills
  - Take regularly scheduled breaks
  - Take regular vacations without work responsibilities
  - Nurture friendships
  - Engage in hobbies and other personal interests
  - Limit number of work hours and caseload
  - Participate in peer support and supervision
  - Engage in personal therapy as needed
  - Journaling
  - Attend to religious or spiritual needs
  - Participate in relaxing activities such as reading, prayer, meditation, listening to music

46

Barnett, J. (2005). Psychotherapist wellness as an ethical imperative. *Innovations in Clinical Practice, 257-271.*

Comments??

Questions??

VIDEOCONFERENCES

VIDEOCONFERENCES

"The HBFT coordinating committee's goal is to encourage sharing between clinicians from all over Kansas. Each videoconference is limited to 80 total participants, and each is informed by partnership participants' ongoing threaded Discussions on this site and the guidance of the HBFT coordinating committee. Participants receive a certificate of completion and CEUs following each event. Two types of videoconferences are offered each year. One focuses on the diagnostic and assessment of a DSM, while the other addresses an ethical issue related to in-home family therapy. DSM videoconferences span two 3-hour sessions: Part I discusses assessment and diagnosis of a DSM condition; Part II explores the therapeutic adaptations that address the DSM using HBFT. The separate Ethics Videoconference addresses the unique ethical challenges involved in providing home-based family therapy. Since 2007, 139 practioners have received CEUs via an HBFT videoconference."

-HBFTPartnership.com

Videoconference Site Addresses and Map of Locations

Colby
Colby Community College
Student Union, Room 107
1255 South Range
Colby, KS 67701
(785) 462-3984 ext. 212

Dodge City
Dodge City Community College
Learning Resource Center, Room 101
2501 N 14th
Dodge City, KS 67801
(620) 227-9287

Hays
Fort Hays State University
Library
CTELT, Room 45
600 Park Street
Hays, KS 67601
(785) 628-4452

Manhattan
Kansas State University
Dole Hall, Room 137
Mid Campus Drive
Manhattan, KS 66506
(785) 532-5995

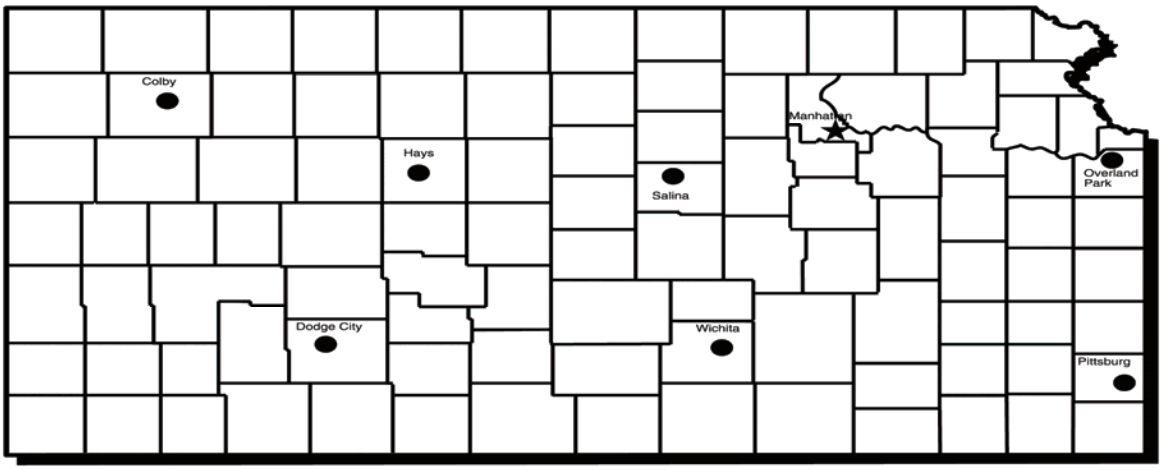
Overland Park
Kansas University - Edwards Campus
Regents Center Building, Room 22
12600 Quivira Rd
Overland Park, KS 66213
(913) 897-8400

Pittsburg
Pittsburg State University
Leonard H. Axe Library, Room 109
1701 South Broadway
Pittsburg, KS 66762
620) 235-4879

Salina
Kansas State University – Salina
College of Technology
TAC Building, Room 116
2310 Centennial Rd
Salina, KS 67401
(785) 826-2633

Wichita
Wichita State University
(Media Resources Center
1845 Fairmount
Wichita, KS 67260
(316) 978-773

TELENET 2 Locations



DSM Topics

Autism Spectrum Disorders

Juvenile Post-Traumatic Stress Disorder

Attention Deficit/Hyperactivity Disorder

Fetal Alcohol Spectrum Disorders

Juvenile Bipolar Disorder

Reactive Attachment Disorder

Using DSM-5 in HBFT

Autism Spectrum Disorders

Autism Spectrum Disorders

Autism Spectrum Disorders

Nancy O'Conner, MS, LCMFT
C.R. Macchi, PhD, LCMFT
The Family Center
Kansas State University

Training Objectives

<u>Part I</u>

- Participants will learn the definitions and descriptions of the Autistic Spectrum Disorders (ASDs)
- Participants will differentiate ASDs from other disorders within the Pervasive Developmental Disorders (PDD) category
- Participants will review the areas examined during diagnostic and assessment of ASDs
- Participants will explore conceptual frameworks for understanding families' experiences of chronic conditions

<u>Part II</u>

- Participants will explore ways the phases of family therapy relate to working with families managing living with ASD
- Participants will learn family assessments and interventions addressing boundary ambiguity and associated levels of psychosocial distress
- Participants will identify resources available to clinicians, families, and teachers

Review of Diagnostic Criteria and Assessment for ASDs

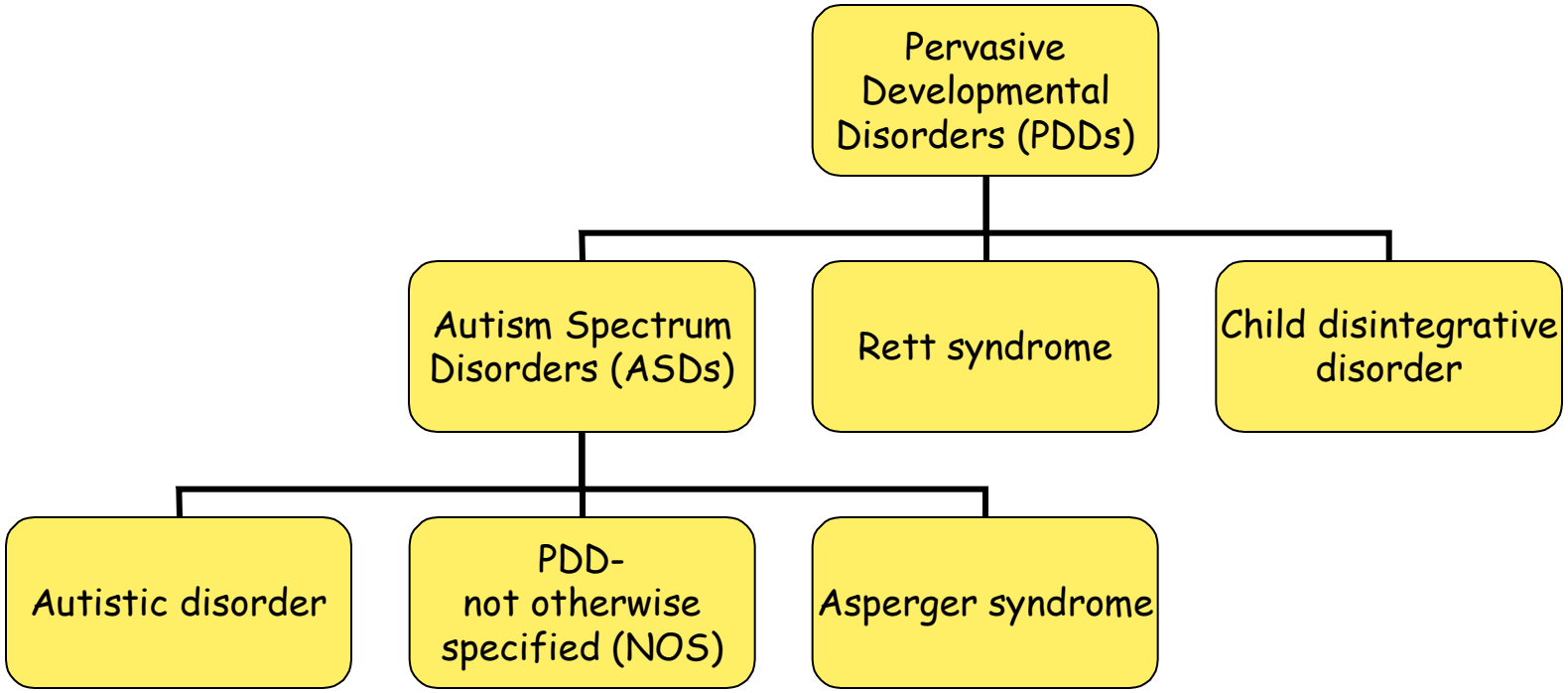
Pervasive Developmental Disorders (PDDs)

PDDs Defined

- "Group of disorders characterized by delays in the development of socialization and communication skills"
  - Typical age of onset is before age 3
  - *Symptoms*: using and understanding language; difficulty relating to people, objects, events; unusual play with toys and other objects; difficulty with routine changes, repetitive body movements or behavior patterns

    (National Institute of Neurological Disorders and Stroke, 2007, retrieved from www.ninds.nih.gov/disorders/pdd/pdd.htm)
- Estimated to affect one of every 500 children

Pervasive Developmental Disorders



Centers for Disease Control and Prevention. (2007). *Autism information center.* Retrieved 2/15/2007, from http://www.cdc.gov/ncbddd/autism/overview.htm

Differential Diagnosis for Retts

- Child's loss of functioning after a period of normal growth and development involving ALL of the following:
  - Approximately 5-48 months
  - Deceleration of head growth
  - Loss of purposeful hand skills replaced by stereotyped hand movements
  - Loss of social engagement early in the course (although often social interaction develops later)
  - Appearance of poorly coordinated gait or trunk movements
  - Severely impaired expressive and receptive language development with severe psychomotor retardation
- Affects almost exclusively females
  - One out of 10,000 to 15,000 female children

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.-Text Revision). Washington, D.C.: American Psychiatric Association.

Differential Diagnosis for Childhood Disintegrative Disorder

- Child's loss of functioning after a period of normal development
  - At least 2 years
  - Clinically significant loss of at least TWO of the acquired skills:
    - Expressive or receptive language
    - Social skills or adaptive behavior
    - Bowel or bladder control
    - Play
    - Motor skills
  - Abnormalities in functioning in at least TWO of the following:
    - Social interaction
    - Communication
    - Restrictive, repetitive, and stereotyped patterns of behavior, interests, activities
- Strong male preponderance
- Fewer than 2 children per 100,000 diagnosed with PDD

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.-Text Revision). Washington, D.C.: American Psychiatric Association.

Autism Spectrum Disorders (ASDs)

ASDs Defined

"Autism spectrum disorders (ASDs) are a group of developmental disabilities defined by significant impairments in social interaction and communication and the presence of unusual behaviors and interests. Many people with ASDs have unusual ways of learning, paying attention, or reacting to different sensations. The thinking and learning abilities of people with ASDs can vary – from gifted to severely challenged. ASD begins before age of 3 and lasts throughout a person's life."

Severe symptoms may be diagnosable in first years of life or less severe symptoms may not be diagnosed until school age or later

Centers for Disease Control and Prevention. (2007). *Autism information center.* Retrieved 2/15/2007, from http://www.cdc.gov/ncbddd/autism/overview.htm

First, M., & Tasman, A. (Eds.). (2004). *DSM-IV-TR mental disorders: Diagnosis, etiology, and treatment.* West Sussex, England: Wiley.

ASDs Compared

	Autistic disorder	Asperger syndrome	PDD-NOS
Social interaction	Qualitative impairment in social interaction	Same as autistic disorder	Combination of features from any of the three domains identified
Communication	Qualitative impairment in communication	No clinically significant delay in language	
Behavior	Restrictive, repetitive and stereotyped patterns of behavior	Same as autistic disorder	
Exclusions	Disturbance not better accounted for by Rett's disorder or Childhood Disintegrative Disorder	Criteria are not met for another PDD or schizophrenia	

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.-Text Revision). Washington, D.C.: American Psychiatric Association.

Autistic Disorder

- *Age of Onset:* delays in social interaction, language or play by age 3
- *Social Interaction:* Two of following:
  - Marked impairment in use of multiple nonverbal behaviors (eye-to-eye gaze, facial expression, body postures, gestures to regulate social interaction);
  - Failure to develop peer relationships appropriate to developmental level;
  - Lack of spontaneous seeking to share enjoyment with others
  - Lack of social or emotional reciprocity
- *Communication:* Two of the following:
  - Delay in or total lack of the development of a spoken language;
  - Impairment in initiating or sustaining conversation;
  - Repetitive language (echolalia) or idiosyncratic language
  - Lack of varied, spontaneous make-believe or imitative play
- *Behavior*: repetitive motions (arm flapping, twisting)
  - Thrive on routine – difficulty with transition

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.-Text Revision). Washington, D.C.: American Psychiatric Association.

Asperger Syndrome

- *Age of Onset*: Typically recognized later than Autistic Disorder
- *Social Interaction*: (at least two of following)
  - Marked impairment in use of multiple nonverbal behaviors (eye-to-eye gaze, facial expression, body postures and gestures) to regulate social interaction
  - Failure to develop peer relationships appropriate to developmental level
  - Lack of spontaneous seeking to share enjoyment, interests, or achievements with others (lack of showing, bringing, pointing out objects of interest to others)
  - Lack of social reciprocity
- *Restricted repetitive or stereotyped patterns of behavior, interests and activities (one of the following)*
  - Encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
  - Inflexible adherence to specific, nonfunctional routines or rituals
  - Stereotyped and repetitive motor mannerisms
  - Persistent preoccupation with parts of objects
- *Communicatio*n: Normal intelligence and adequate language skills (vocabulary & grammar)
  - No clinically significant delay in language, cognitive development
- *Behavior*: no clinically significant delay in development of age-appropriate self-help skills, adaptive behavior or curiosity about the environment in childhood

PDD-NOS

- Category used if a child has symptoms of either Autistic Disorder or Asperger Syndrome but does not meet the specific criteria for either
- Neurological abnormality but no specific cause has been identified
- No set pattern of symptoms and signs with children with PDD-NOS

National Dissemination Center for Children and Disabilities (NICHCY) (2003). *Pervasive Developmental Disorders.* Retrieved on April 18, 2007, http://www.nichcy.org/resources/pddnos.asp

Other Disorders sharing features with ASD

- Developmental language disorder
- Mental retardation
- Acquired epileptic aphasia
- Fragile X syndrome
- Schizophrenia
- Selective mutism
- Psychosocial deprivation
- Hearing impairment
- Visual impairment
- Traumatic brain injury
- Dementia
- Metabolic disorders

Screening, Assessment, and Diagnostic Experiences

Stages of Diagnosis

- Pre-diagnostic period
- Assessment and diagnostic process
- Ongoing review of diagnosis

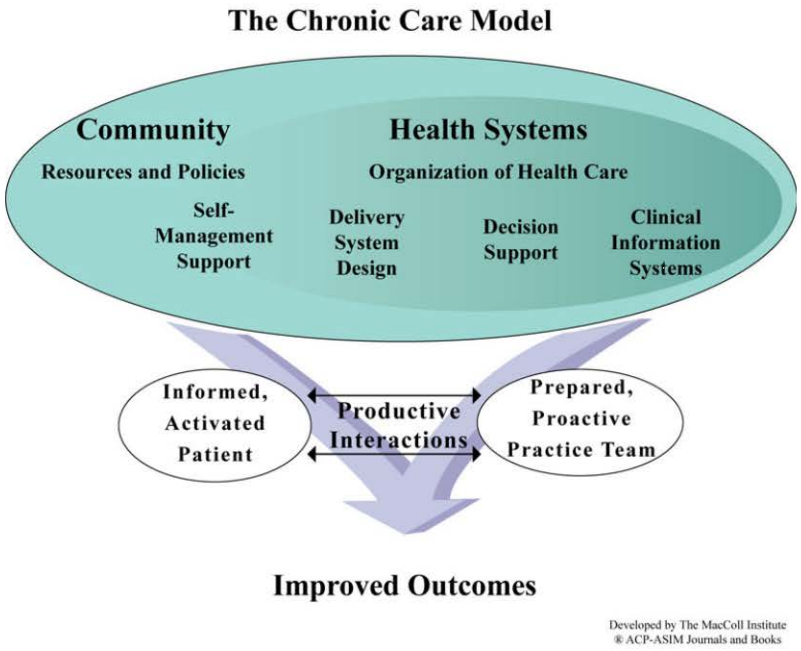
Process of Diagnosis

- Who is involved?
- Who offers resources?
- Who is impacted by the condition, diagnosis, and management?
- How are various efforts integrated?
- How are various perspectives integrated?

Chronic Care Model

A *chronic* condition is "…any condition that requires ongoing adjustments by the affected person and interactions with the health care system"*

- Transforming medical care
  - Proactive approach
  - Patient self-management
  - Collaborative
  - Broad system of community and health care resources



*Improving Chronic Illness Care (2007). *Chronic care model*. Retrieved April 14, 2007 http://improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2

Pre-Diagnostic Experiences

- Vague awareness that "something doesn't seem right"
- General uncertainty regarding child's differences – personality or disorder
- Challenging personal intuition and judgment
- Critical responses of child's social interactions
- Variable and unpredictable attachments with the child

Diagnostic Period

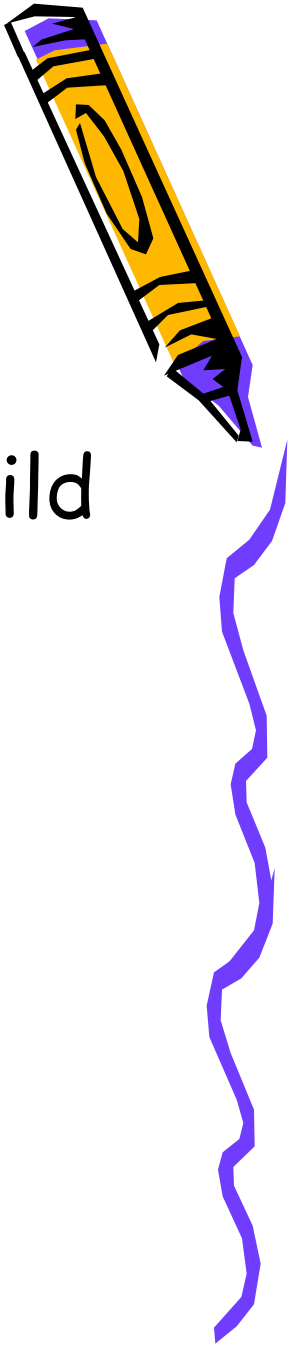
- Collaborative team approach
  - Patient
  - Parent(s)
  - Mental health professionals
  - Health care professionals
  - School officials
- Facilitative of family progression through diagnostic process
- Variable impacts of diagnosis

Confirmatory and relief ⟷ Realization and grief

- Diagnosis is a snapshot in an ongoing process that must be periodically reviewed to factor in changes of context, circumstance, condition progression, and individual and family development

Systemic Framework for Working with Families

Broadening Scope and Focus to Include the Family



The family's involvement with the child involves…

- Caregiving and nurturing
- Affiliations and interactions
- Resourcing and support
- Historical connections

Interactive Processes

Between…

- Psychosocial demands of the condition

and..

- Family processes needed to meet the demands

Rolland, J. (1994). *Families, illness, and disability: An integrative treatment model*. New York: BasicBooks.

The Family Systems-Illness Model (Rolland, 1984)

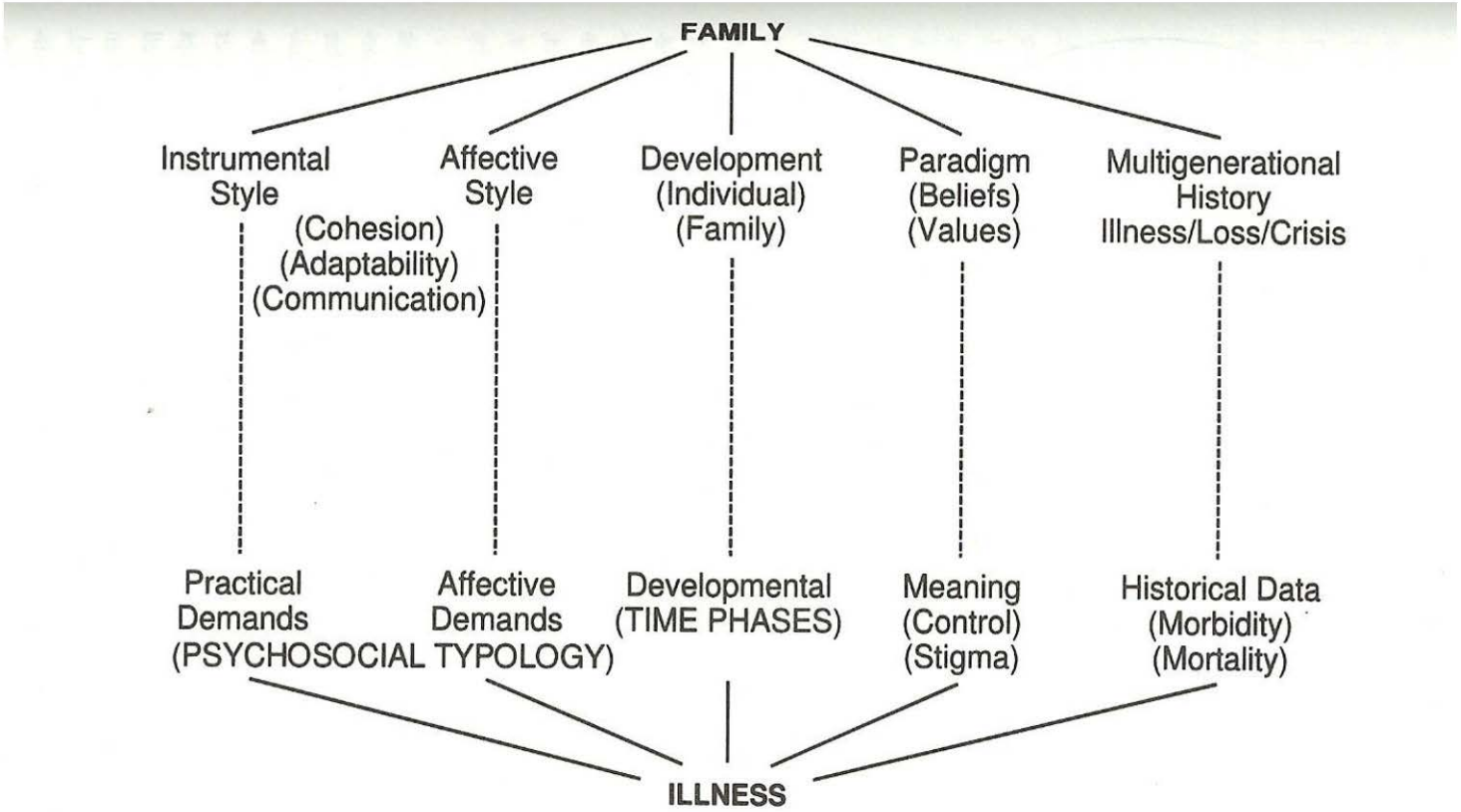


Figure 1.1
Interface of Chronic Illness and the Family
Source: Reprinted by permission from Rolland, J. S. (1984). Family systems and chronic illness: A typological model. *Journal of Pyschotherapy and the Family*, 3, 144.

Psychosocial Demands of a Condition

- Psychosocial demands
  - Onset – acute/gradual
  - Course – progressive/constant/relapsing
  - Outcome – nonfatal/shortened life span/fatal
  - Incapacitation – none/mild/moderate/severe
  - Uncertainty or predictability
  - Symptom visibility
  - Likelihood and severity of crises
- Time phases
  - Condition development
    - Crisis - prediagnosis/diagnosis/intial adjustment period
    - Chronic
    - Terminal – preterminal/death/loss and mourning

Systemic Assessment of ASDs

Psychosocial Demands and Family Responses Associated with Managing ASDs

Onset – gradual	Unfolding discovery occurs as child develops
Course - constant	Recognition of ongoing impairment
Outcome - nonfatal	Nonfatal
Incapacitation – varied	Social, communication, and behavioral engagement
Uncertainty/predictability - varied	Prognosis effected by early intervention
Symptom visibility - yes	Social and communication impairments; repetitive or patterned behaviors

Rolland, J. (1994). *Families, illness, and disability: An integrative treatment model*. New York: BasicBooks.

Family Processes

- Focus on family functioning
- Processes include:
  - Family structural/organizational patterns
  - Communication processes
  - Multigenerational patterns and family life cycle
  - Family belief systems

- Mechanisms for more fully exploring and understanding family processes:
  - Proactive approach
  - Patient self-management
  - Collaborative
  - Broad system of community and mental health care resources

Family Processes Needed to Respond to ASDs

Instrumental	Time; role negotiation and adjustments; social support; financial resources
Affective	Internal locus of control; conflict resolution; coping styles
Individual Development	Awareness and responsiveness to the child's developmental trajectory
Family Development	Maintaining family cohesion while adapting to the condition; life events; and individual and family developments
Paradigm	Family members' meaning relating the understanding and impact of the disorder
Multigenerational History	Family's past experiences with illness or other conditions

Rolland, J. (1994). *Families, illness, and disability: An integrative treatment model*. New York: BasicBooks.

Impact of Chronic Condition on the Participants in Therapy

Impact on Siblings

- Lack of understanding of what autism means
  - Based on developmental stage
  - Glasberg Study
- Less attention
  - Need for perfection for attention
  - Diminished feelings of uniqueness
- Emotional reactions
  - Shame-based feelings
  - Fear
  - Anger
  - Sadness
- Interference with social development
  - Over identify with sibling and feel responsible for disability
- Parental protection from own feelings may maintain the mystery of ASD

Harris, S., & Glasberg, B. (2003). *Siblings of children with autism: A guide for families* (2nd ed.). Bethesda, MD: Woodbine House.

Impact on Parents

- Stress and coping
- Role strain
- Blaming, guilt, shame
- Depression
- Resilience
- Redefining expectations for child
- Ambiguous loss

Ambiguous Loss

- Relational issue
- Two types of ambiguous loss
  - Physically absent, psychologically present
    - Missing person or mysterious disappearance
  - Physical present, emotionally or cognitively absent
    - Conditions such as Alzheimer's, brain injury, autism
- Boundary ambiguity
- Identity ambiguity
- Ongoing trauma that has no definable resolution

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Impact on Therapists

The therapist finds a way to address the distress that arises from ambiguity related to the chronicity of a condition

Addressing the Psychosocial Demands

According to the Family Systems-Illness Model, early work with the family members can accomplish the following therapeutic tasks:

- Establishes the systemic-oriented therapist as part of the health-care team,
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Termination

What will it take to equip and empower the family members with the skills needed for meeting the long-term demands of ASD management?

Interventions

What is the immediate need of the family? Does the family recognize their collaborative role in the process of therapy?

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How are family members responding to the tasks needed to manage the ASD?

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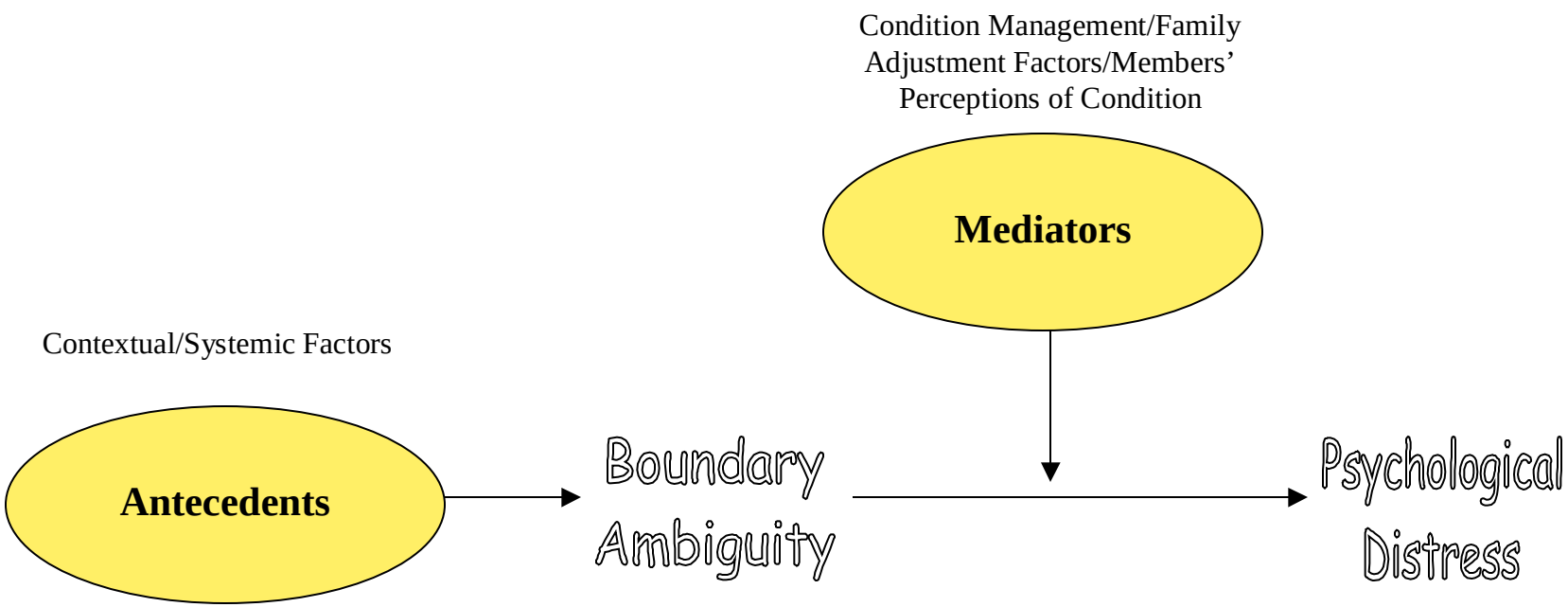

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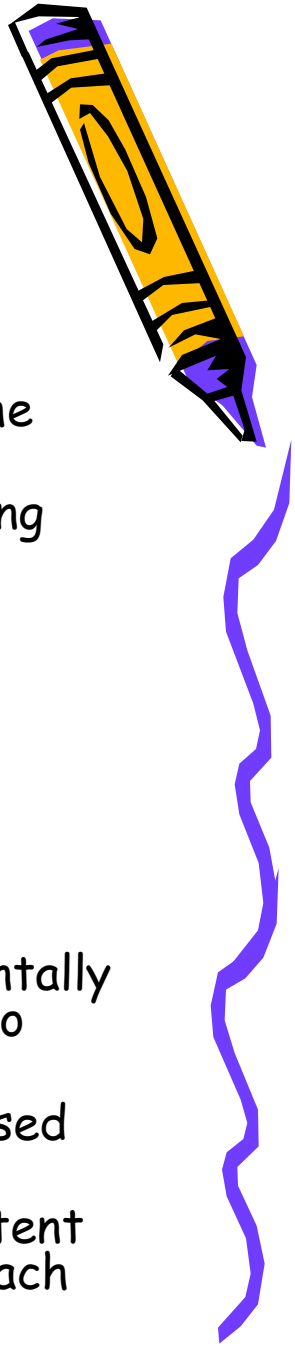

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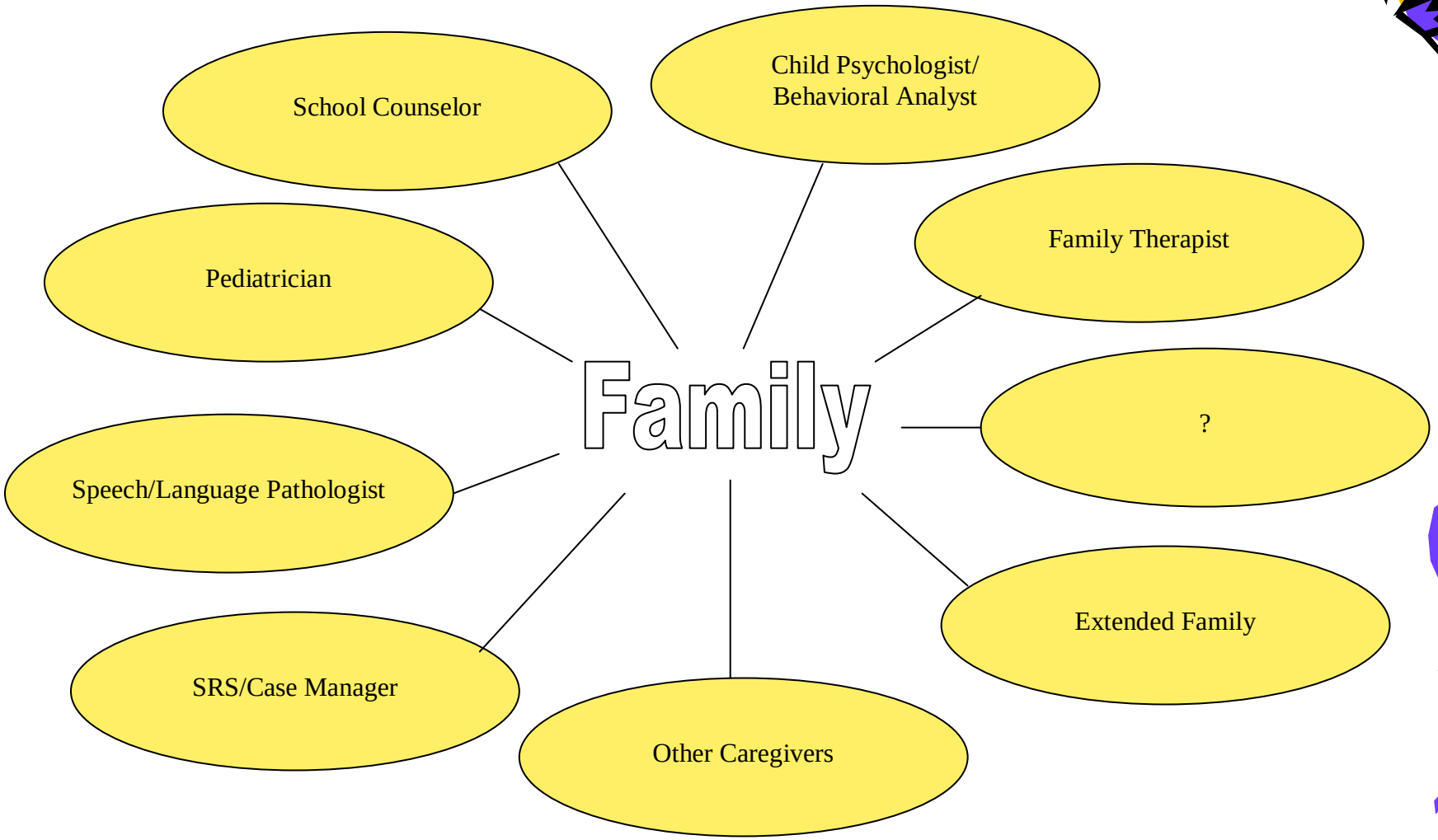

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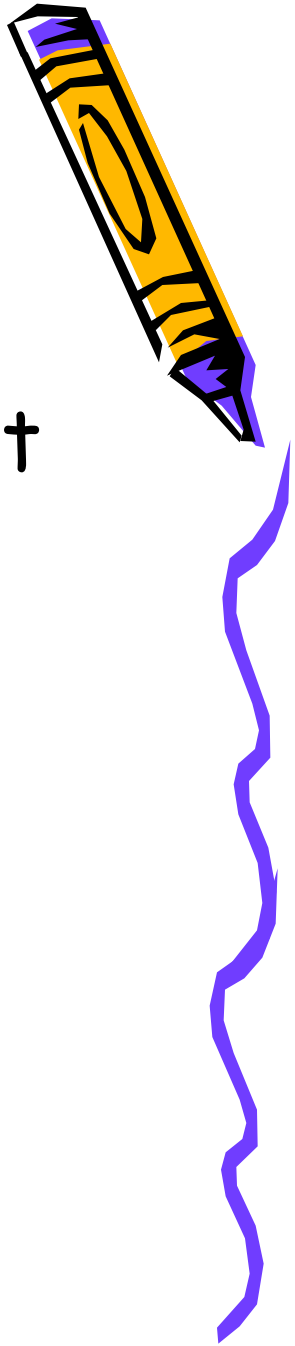

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- Videos
- Books
- Websites
- Associations and support groups

The HBFT Partnership

www.HBFTPartnership.com
Learning Modules
Access to Resources
Interactions with Colleagues throughout Kansas

Workshops/Teleconferences

Consultations

Please let us know how we can support your important work.

Questions?

Autism Spectrum Disorders

Nancy O'Conner, MS, LCMFT
C.R. Macchi, PhD, LCMFT
The Family Center
Kansas State University

Training Objectives

<u>Part I</u>

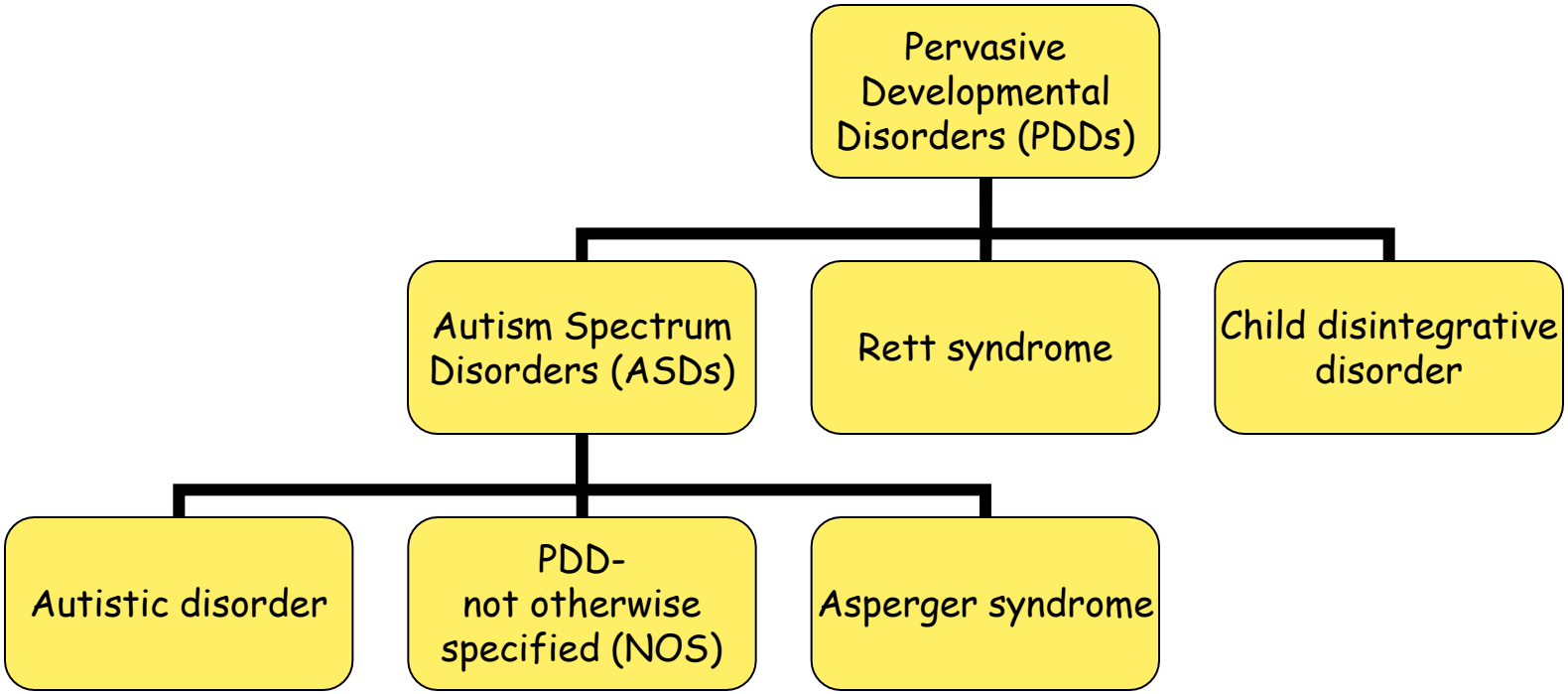
- Participants will learn the definitions and descriptions of the Autistic Spectrum Disorders (ASDs)
- Participants will differentiate ASDs from other disorders within the Pervasive Developmental Disorders (PDD) category
- Participants will review the areas examined during diagnostic and assessment of ASDs
- Participants will explore conceptual frameworks for understanding families' experiences of chronic conditions

<u>Part II</u>

- **Participants will explore ways the phases of family therapy relate to working with families managing living with ASD**
- **Participants will learn family assessments and interventions addressing boundary ambiguity and associated levels of psychosocial distress**
- **Participants will identify resources available to clinicians, families, and teachers**

Review of Diagnostic Criteria and Assessment for ASDs

Pervasive Developmental Disorders



Centers for Disease Control and Prevention. (2007). *Autism information center.* Retrieved 2/15/2007, from http://www.cdc.gov/ncbddd/autism/overview.htm

ASDs Compared

	Autistic disorder	Asperger syndrome	PDD-NOS
Social interaction	Qualitative impairment in social interaction	Same as autistic disorder	Combination of features from any of the three domains identified
Communication	Qualitative impairment in communication	No clinically significant delay in language	
Behavior	Restrictive, repetitive and stereotyped patterns of behavior	Same as autistic disorder	
Exclusions	Disturbance not better accounted for by Rett's disorder or Childhood Disintegrative Disorder	Criteria are not met for another PDD or schizophrenia	

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed.-Text Revision). Washington, D.C.: American Psychiatric Association.

Screening, Assessment, and Diagnostic Experiences

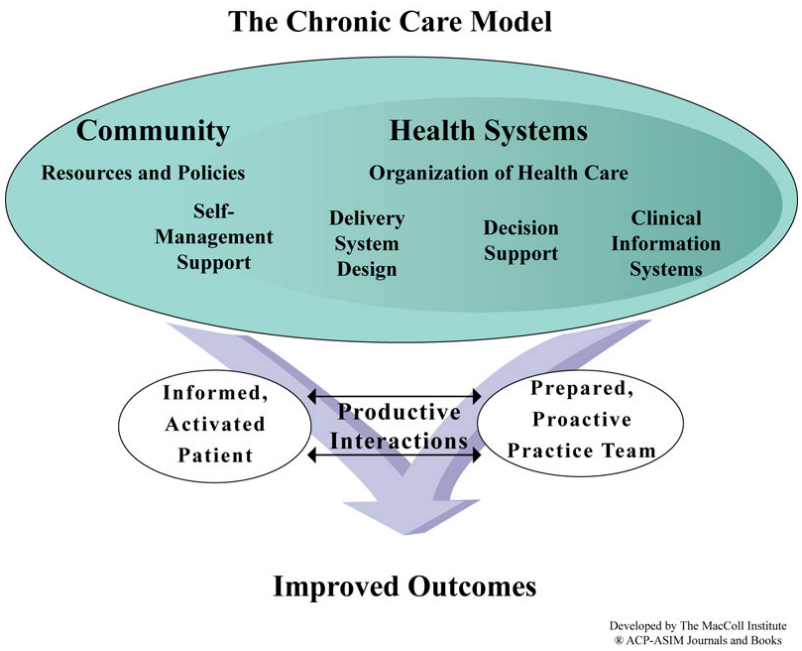
Stages of Diagnosis

- Pre-diagnostic period
- Assessment and diagnostic process
- Ongoing review of diagnosis

Chronic Care Model

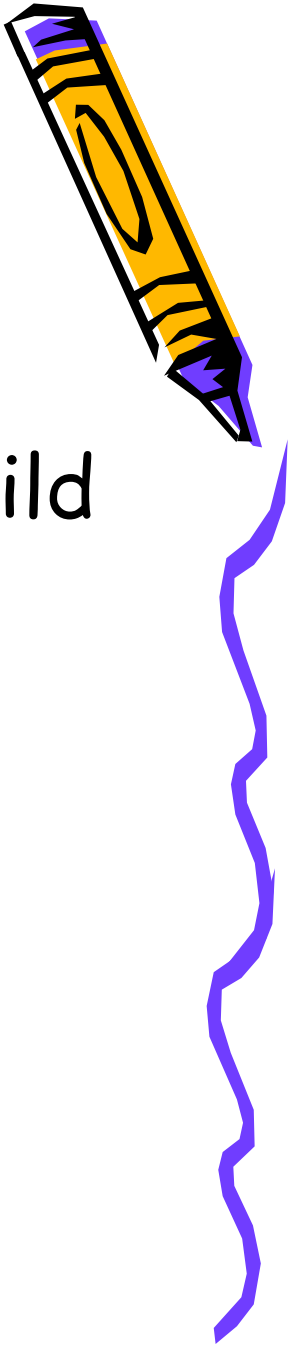
A *chronic* condition is "…any condition that requires ongoing adjustments by the affected person and interactions with the health care system"*

- Transforming medical care
  - Proactive approach
  - Patient self-management
  - Collaborative
  - Broad system of community and health care resources



*Improving Chronic Illness Care (2007). *Chronic care model*. Retrieved April 14, 2007 http://improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2

Broadening Scope and Focus to Include the Family



The family's involvement with the child involves…

- Caregiving and nurturing
- Affiliations and interactions
- Resourcing and support
- Historical connections

Systemic Assessment of ASDs

Psychosocial Demands and Family Responses Associated with Managing ASDs

Onset – gradual	Unfolding discovery occurs as child develops
Course - constant	Recognition of ongoing impairment
Outcome - nonfatal	Nonfatal
Incapacitation – varied	Social, communication, and behavioral engagement
Uncertainty/predictability - varied	Prognosis effected by early intervention
Symptom visibility - yes	Social and communication impairments; repetitive or patterned behaviors

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Family Processes Needed to Respond to ASDs

Instrumental	Time; role negotiation and adjustments; social support; financial resources
Affective	Internal locus of control; conflict resolution; coping styles
Individual Development	Awareness and responsiveness to the child's developmental trajectory
Family Development	Maintaining family cohesion while adapting to the condition; life events; and individual and family developments
Paradigm	Family members' meaning relating the understanding and impact of the disorder
Multigenerational History	Family's past experiences with illness or other conditions

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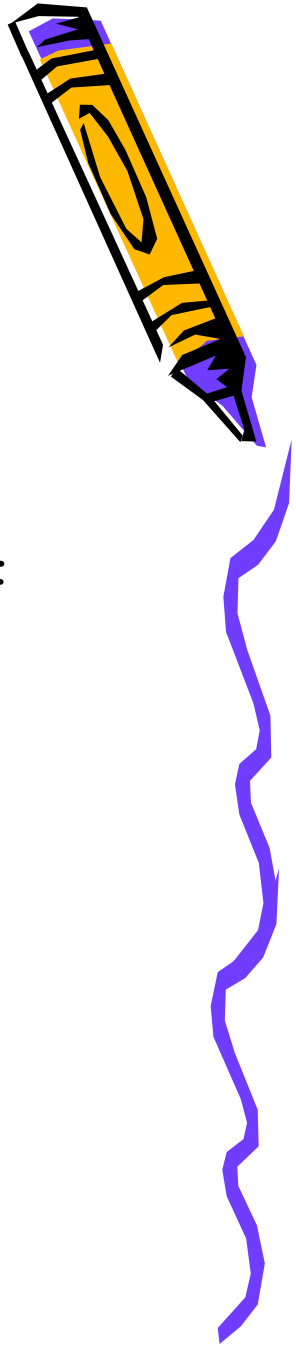

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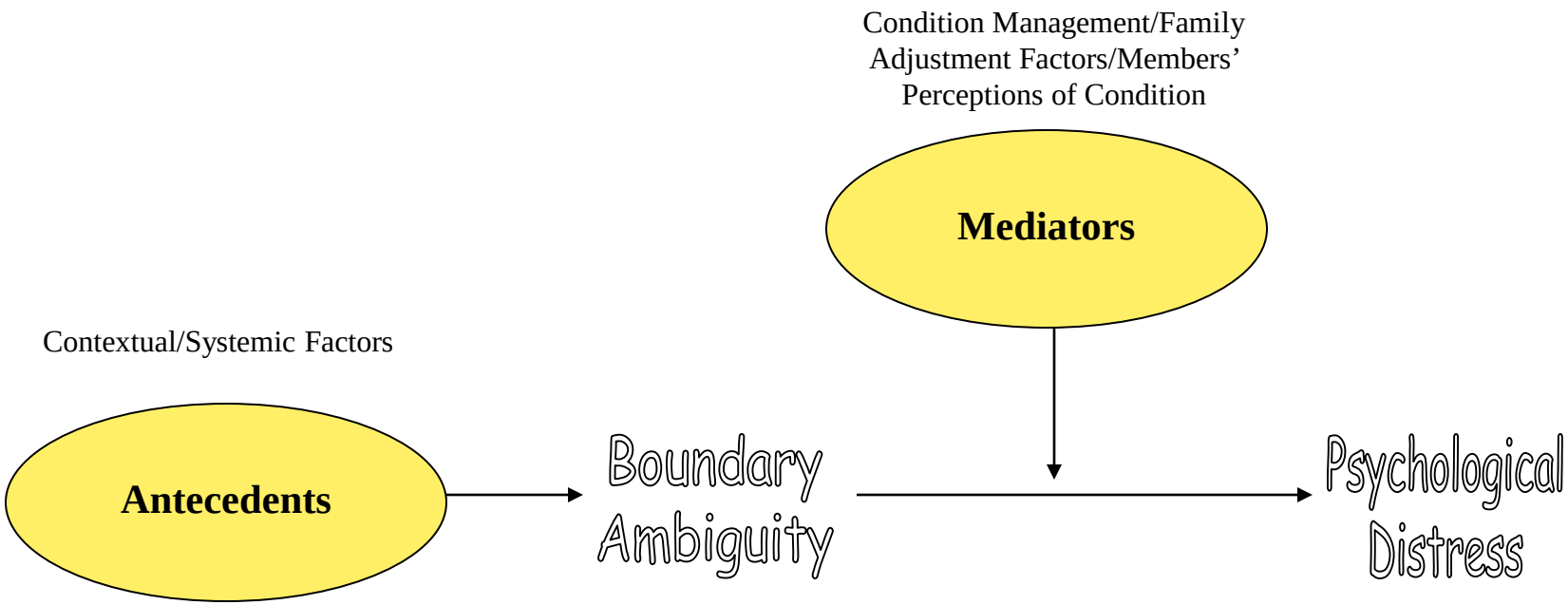

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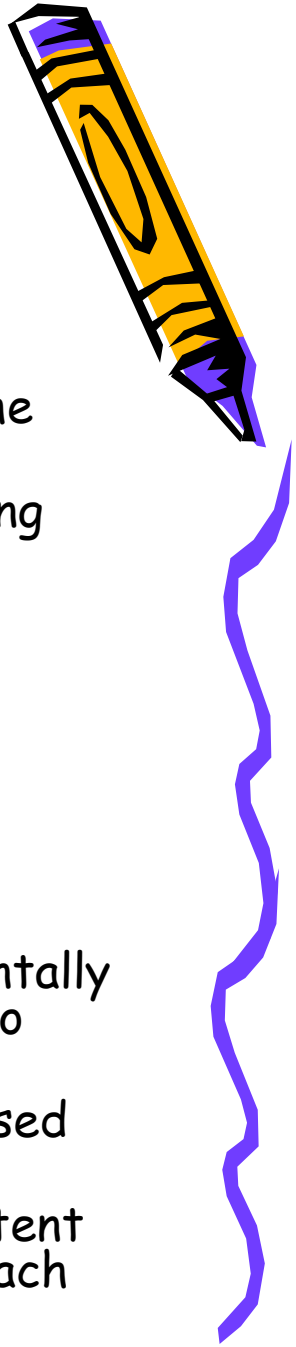

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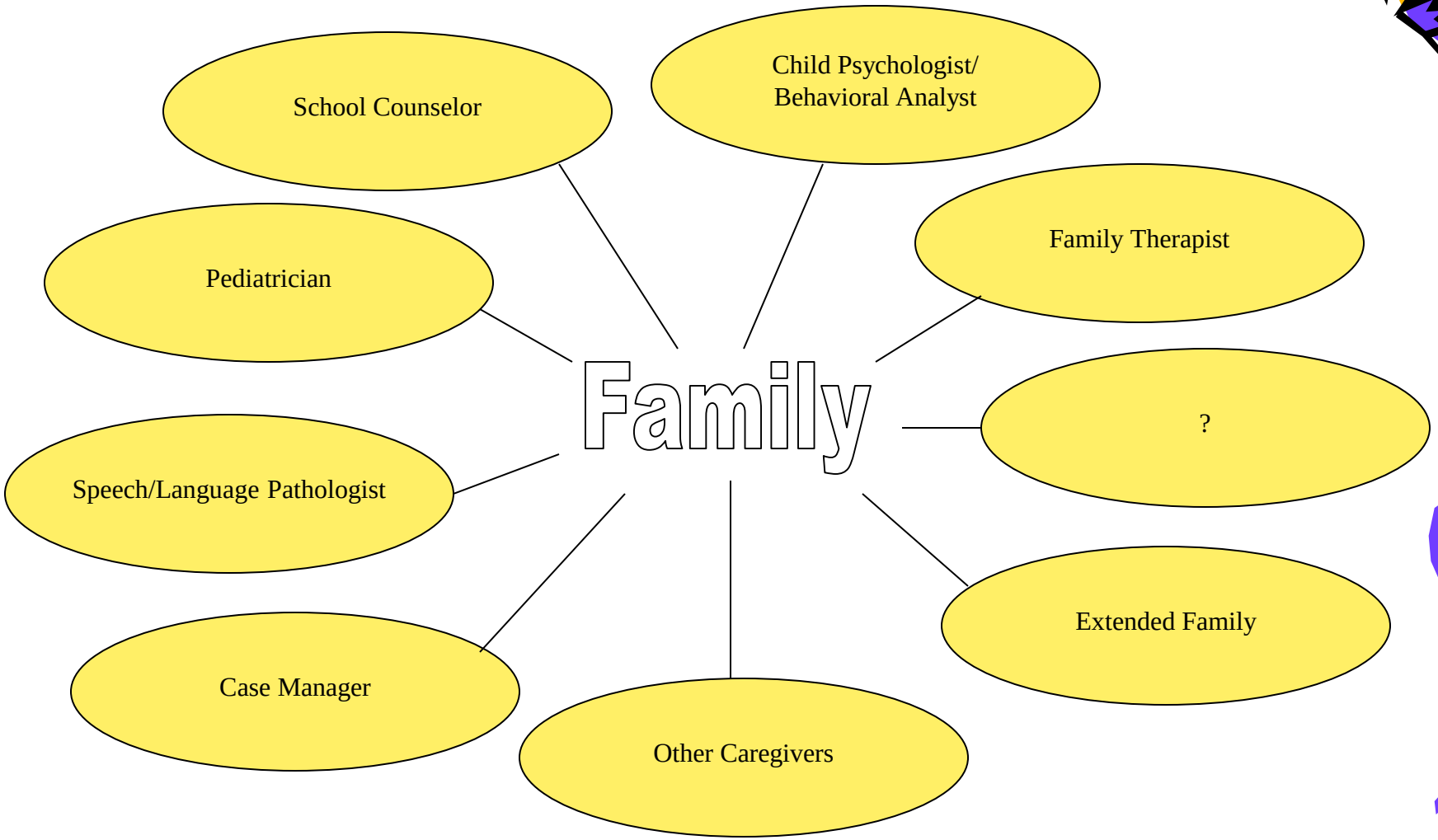

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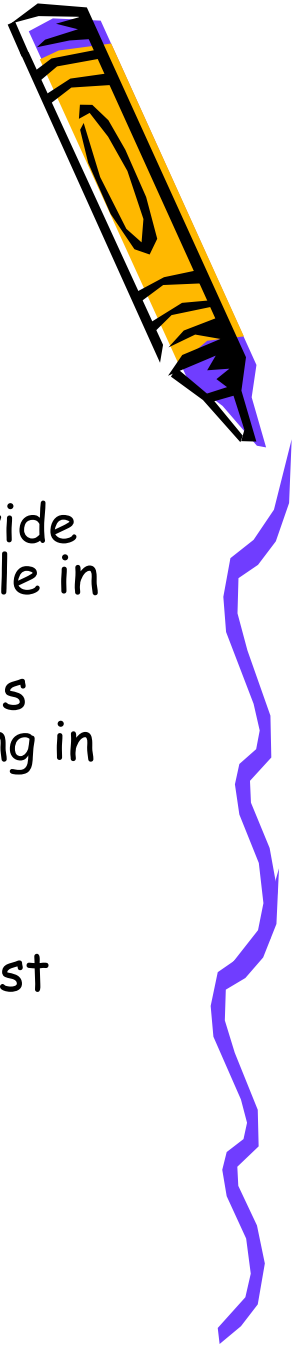

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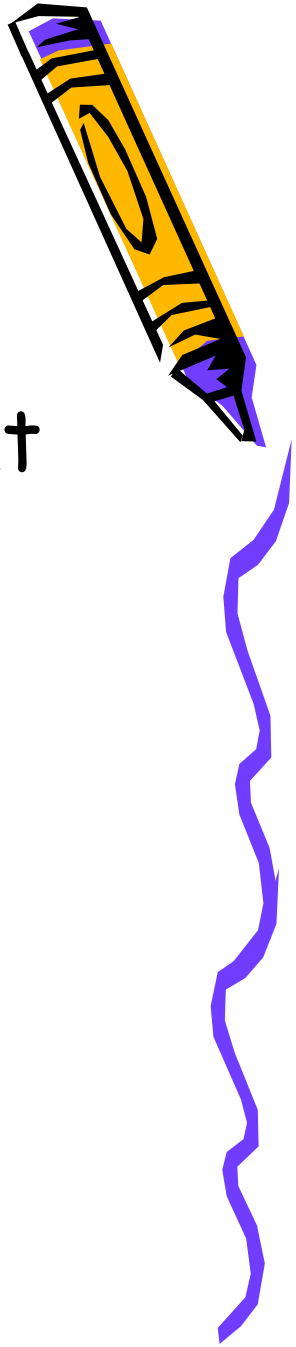

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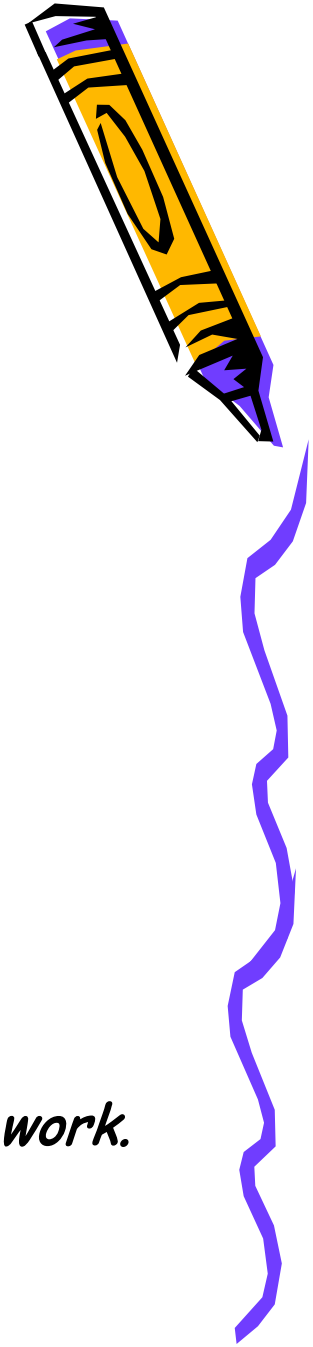

www.HBFTPartnership.com

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Access to Resources

Interactions with Colleagues throughout Kansas

Workshops/Teleconferences

Consultations

Please let us know how we can support your important work.

Questions?

Juvenile Post-Traumatic Stress Disorder

HBFT Treatment of Children with PTSD and Depression: Part I – Assessment and Diagnosis

Nancy O'Conner, MS, LCMFT
C.R. Macchi, PhD, LCMFT
Family Studies and Human Services
Kansas State University

Objectives

As a result of attending this videoconference, participants will…

- …know the prevalence of the co-morbidity of PTSD and depression in children and adolescents
- …identify the features of the family context that contribute to a child's PTSD and depression
- …review the diagnostic features of PTSD and depression
- …understand a child or adolescent's experiences of the relationship between PTSD and depression
- …learn ways to incorporate elements from the home environment into the treatment goals

What is trauma?

"... the development of characteristic symptoms following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or witnessing an event that involves death, injury, or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate" (DSM-IV, 1994, p. 424)

What is PTSD?

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- …is a normal response by normal people to an abnormal, overwhelming situation
- …traumatic events that lead to PTSD are typically so extraordinary or severe that they would distress almost anyone

Schiraldi (2000)

People with PTSD often report feeling…

- Shattered, broken, wounded, ripped, torn apart, damaged
- Like they will never get put back together
- Bruised to the soul, devastated, fallen apart, crushed

Humpty Dumpty sat on a wall
Humpty Dumpty had a great fall
All the king's horses and all the king's men
Couldn't put Humpty Dumpty together again

Potentially Traumatic Events

- Intentional Human
  - Man-made, deliberate, malicious
- Unintentional Human
  - Accidents, technological disasters
- Acts of Nature
  - Natural events that result in human catastrophe

Intentional Human Events

- Acts of Nature
  - Natural War, Conflict, Resistance Fighting
- Abuse
  - Sexual
    - *Abuse and Incest*
  - Physical
    - *Violence or Force*
  - Emotional and Verbal
    - *Neglect, Threats, Degradation*

Diagnostic Criteria for PTSD

- Exposure to Stressor
- Re-experiencing
- Avoidance
- Arousal

After a Traumatic Event

- Initial Response
  - Involves intense fear, helplessness, or horror
  - Children may exhibit
    - Disorganized and agitated behavior
- Re-experiencing the event
  - Memories, dreams, flashbacks
- Avoidance of stimuli (triggers, negative feelings) associated with the event and or emotional numbing (detachment and alienation from others, loss of interest in activities, restricted range of affect)

Nelson Goff, B., & Schwerdtfeger, K. (2004). The systemic impact of traumatized children. In D. Catherall (Ed.), *Handbook of stress, trauma, and the family. Hove, East Sussex: Brunner-Routledge.*

After a Traumatic Event (Continued)

- Arousal
  - Persistent symptoms of increased arousal
  - Hypervigilance, irritability, anger outbursts
- Duration of symptoms over one month
- Life is Disrupted
  - Clinically significant distress or impairment in social, occupational, or other important areas of functioning

Examples of Trauma Symptoms

- Often symbolic of the event or experience
- Range from mood disturbance to somatic (body) complaints
- Can be categorized as:
  - Emotional/affective
  - Cognitive
  - Physical
  - Social

Brain Responses to Anxiety

- A threat is perceived
- Physical changes are set into motion
- Body is prepared for "fight or flight" stress response
- Nervous system is sensitized
- A traumatic event can change the structure and function of a nerve cell

What is depression?

Depression…

- …may result from exposure to any situation where the person experiences dissatisfaction, shame, or uncontrollability
- …may result from internal mechanisms in the brain that are exacerbated by other external factors
- …reflects experiences everyone has at one time or another when they feel down, blue, listless, or discouraged
- …is a clinical condition when the feels persist and lead to impairment

Depression Symptoms Common to Adults and Children

- Persistent sadness and/or irritability
- Feelings of worthlessness guilt and low-self-esteem
- Loss of interest in previously enjoyed activities
- Unexplained change in appetite or weight (either increase or decrease)
- Restlessness
- Fatigue and/or loss of energy
- Difficulty concentrating
- Suicidal thoughts or attempts

Diagnostic Criteria for Depression

- Major depression
  - Onset – episodic periods of mood disorder
  - Duration – episode occurring over at least two weeks
  - Persistence – periodic depressive episodes
  - Severity – more severe and debilitating symptoms
- Dysthymia
  - Onset – enduring depressed mood
  - Duration – over at least two years
  - Persistence – constant state
  - Severity – chronic, less severe depressive symptoms

Diagnosing Co-Morbid Conditions: PTSD and Depression

PTSD

- Exposure and threat of actual event – direct or secondary
- Persistent re-experiencing
- Avoidance of stimuli and numbing of general responsiveness related to the trauma
- Persistent symptoms of arousal

Co-morbidity

- Studies suggest that co-morbidity must include a precipitating event or series of events; vulnerability to stress; and varying cognitive, affective, behavioral capacities to respond

Depression

- Depressed mood or episode
- Changes in eating and weight
- fatigue
- anhedonia
- feelings of worthlessness or excessive guilt
- Inability to concentrate
- Suicidal ideation

ASSESSMENT OF PTSD AND DEPRESSION IN CHILDREN

Factors to Consider in a Diagnostic Assessment of Children

- Developmental level
  - Cognitive
  - Affective
  - Behavioral
- Relational/contextual
  - Current level of interaction
  - Impact of environment
  - Influence of parental figures
  - Role of context

Depressive Symptoms with Children

- Feeling sad
- Feeling unhappy
- Feeling bored or disinterested in usual activities
- Angry or irritable
- Appear sad or tearful

Additional Depressive Symptoms

- Frequent vague physical complaints
- Decrease in school attendance or performance
- Talk of or efforts to run away from home
- Outbursts of unexplained irritability/anger, shouting, complaining, or crying
- Chronic boredom
- Reckless behavior

Summary of Behavioral Indicators

1. Demonstrates sad or flat affect
2. Reports a preoccupation with the subject of death
3. Reports suicidal thoughts and/or actions
4. Exhibits moody irritability
5. Isolates self from family and/or peers
6. Deterioration in academic performance
7. Lacks interest in previously enjoyed activities
8. Refuses to communicate openly
9. Demonstrates low energy
10. Makes little or no eye contact
11. Frequently expresses statements reflecting low self-esteem
12. Exhibits a reduced appetite
13. Demonstrates an increased need for sleep
14. Exhibits poor concentration and indecision
15. Expresses feelings of hopelessness, worthlessness, or inappropriate guilt
16. Reports unresolved feelings of grief
17. Uses street drugs to elevate mood

Diagnostic Process with Children

- Collateral information is emphasized
  - Parental psychological condition may influence reports
- Direct, clinical interviews are limited by verbal and cognitive abilities
- Structured and semi-structured diagnostic interviews
  - From child and adult informant perspectives
- Carefully assess chronology and course of symptoms over time

Interview Question Examples

- Child
- Parent
- Other Informant

Prevalence of the Co-Morbidity of
PTSD and Depression in Children

INTERNALIZED TRAUMA

PTSD and Depression Together: Internalized Trauma

Consider the child's experience of PTSD and depression as a unconscious attempt to manage the effects of a past traumatic experience(s). The child turns his/her efforts inward as he/she emotionally and psychologically retreats to create a protective insulation from the potential effects of additional, real or imagined, traumatic experiences.

Shattered Assumptions

	Pre-Trauma Assumptions	Post-Trauma Assumptions
Views of Self	I see myself in a positive light (decent, worthwhile, good, competent, guiltless).	I'm bad, unworthy, shameful ("tramp mentality"), incompetent, weak, different from others, permanently damaged. Self-questioning. I can't count on myself anymore. Abused people conclude, "I'm an object existing for the needs of others– my needs are irrelevant." Self-denigration, shattered identity (don't know who I am anymore; identity split into before and after trauma).

Schiraldi, G. (2000). The post-traumatic stress disorder sourcebook. *Lincolnwood, IL: Lowell House.*

Shattered Assumptions (continued)

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Contexts of Family and Home

CHILDHOOD PTSD AND DEPRESSION

Trauma Membrane

- "Imposed by the family system of the traumatized child can:
  - Provide needed protection

    Or
  - May block outside resources from entering the system ("become trauma organized systems")

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Contextual Factors

The family context is an environment that contributes to and mediates childhood PTSD and depression

- Family member chronic illness
- Social isolation, extreme sensitivity to rejection or failure
- Family financial stressors
- Loss of a family member or loved one
- Family member alcohol or substance abuse
- Abuse or neglect – including child's personal experiences and/or observations of another member's experiences such as DV
- Multiple unexpected and disruptive transitions – moving repeatedly

Trauma Triggers

- Triggers are cues that have become associated with the original trauma.
- They often are harmless by themselves.
- They produce a recollection of trauma or traumatic memories or images.
- They often result in responses against the will of the trauma survivor.
- Recognizing triggers may help to control symptoms of PTSD.

Examples of Triggers

- Visual
- Sound
- Scent
- Taste
- Physical or body, tactile, pain
- Significant dates or seasons
- Stressful events
- Strong emotions
- Thoughts
- Behaviors
- "Out of the blue"
- Combinations (Season, location, and sound together)

Traumatic Events and Triggers

Current experience - dark clouds, strong winds

Prior experience - Tornado

Current experience - firecracker, popcorn Popping

Prior experience - Gun shots

Current experience - pretzels, ice cream

Prior experience - Eaten at party before abuse

Resiliency

- Certain individuals manage to succeed in spite of the odds
- Interconnection between the child's basic traits and the environment

Resiliency Factors

- Personality factors
  - Agreeable
  - Social
  - Compassionate
  - Internal locus of control
- Cognitive factors
  - Creativity
  - Insight
  - Initiative

Resiliency Factors continued

- Affective factors
  - Ability to manage affective reactions
  - Broad range of emotions
  - Sense of humor
- Behavioral factors
  - Persistence
  - Ability to generate relationships with peers/adults
  - Resourcefulness

Part II – Treatment Process

- Treatment goals
- Interventions
- Treatment strategies

- Friday, April 25th

HBFT Treatment of Children with PTSD and Depression: Part II – Treatment Goals and Interventions

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- …develop treatment strategies and interventions to facilitate individual and family change

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Family Resilience Framework

"A family resilience framework can serve as a valuable conceptual model in orienting the a wide range of human services. A systemic view of resilience is important in all efforts to help individuals, couples and families to cope and adapt through crisis and adversity… A narrow focus on individual resilience has led clinicians to attempt to salvage individual 'survivors' without exploring their families' potential, and even write off many families as hopeless… A clinical stance calls for

- Compassionate understanding of parental life challenges
- Encourages reconciliation
- Searches for strengths in the network of family relationships."

Walsh, F. (1998). *Strengthening family resilience.* New York: Guilford, p. 22-23.

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Resiliency Factors continued

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- Behavioral factors
  - Persistence
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  - Resourcefulness

Key Family Processes

- Family belief systems (COHERENCE)
  - Shared beliefs
    - How the world operates
    - A person's place within the world
  - Appraising of crises and challenges
    - Distress and recovery
- Organizational processes (SHOCK ABSORBERS)
  - Balancing flexibility and stability
  - Balancing connection and separation
- Communication processes (FACILIATION)
  - Clarity of the message
  - Open emotional expression
  - Collaborative problem-solving

Walsh, F. (1998). *Strengthening family resilience.* New York: Guilford,.

TREATMENT GOALS

Prioritizing Therapeutic Direction

- How do you prioritize treatment?
  - PTSD

  OR
  - Depression

Prioritizing Therapeutic Direction

- Factors influencing a child's reaction to trauma:
  - Age
  - Personal strengths
  - Support system
  - Frequency of traumatic experiences
  - Extent of the trauma/abuse
  - Reaction of family members
  - Relationship to the abuser (if trauma is person focused)
  - Pre-abuse functioning

Prioritizing Therapeutic Direction

- Clinician must understand
  - Child's past and present functioning
  - Specific traumatic events leading to the conditions for which treatment was sought
  - Experience and meaning of the events to the child
  - Child's strengths and problem areas
  - Resources available to the child

Integrating Family into Treatment Process

- Individual
  - Development
  - Needs
  - Involvement
- Family
  - Development
  - Needs
  - Involvement

SYSTEMIC TREATMENT STRATEGIES AND INTERVENTIONS

"Interventions that enhance positive interactions, support coping efforts, and build extrafamilial resources are more effective in reducing stress, enhancing pride and competence, and promoting more effective functioning."

Walsh, F. (1998). *Strengthening family resilience.* New York: Guilford, p. 241.

Issues to consider regarding course of treatment

- Treatment can only go as far as the child is developmentally able to go
- Treatment moves at child's speed
- Careful selection of treatment modality
- Avoid leading questions
  - Empathy vs. probing comments/questions
- Educate and support parents (non-offending parent)

Strategies and Interventions Addressing Depressive Symptoms

	Child-Focused Approach	Family-Focused Approach
Strategies	•Multiple ways to express emotions and stressors •Self-regulation •Broaden the emotional expression •Develop coping strategies •Externalize the depressive feelings •Create an opportunity to gain mastery over the depressive conflicts •Stabilization of mood through med management	•Stabilization of mood through med management •Improve parental awareness and understanding of child's depressive symptoms •Enhance family members' shared meaning around common experiences •Increase parental support and involvement of child's efforts to reach out to family and develop friendships
Interventions	•Filial play therapy •Art and drawing tasks •Color your heart •Pocket Count •Responsibility Pie •Sandtray about an event/experience or relationship •Group therapy •Theraplay	•Filial play therapy •Child-Parent Relationship Training (C-P-R) – Parent Group •Family art tasks (done individual family members and as a group) •Color your heart •Pocket count •Parent education about child's feelings and depression •Family Sandtray •Theraplay

Strategies and Interventions Addressing PTSD Symptoms

	Child-Focused Approach	Family-Focused Approach
Strategies	•Use a metaphorical expression of trauma experiences •Increase child's overall sense of safety •Provide a wide range of ways of expressing their fears •Self-regulation •Recognize differences in intensity of the fears and develop means to respond accordingly •Develop appropriate attachment experiences and expressions	•Increase parental awareness of the connection between current triggers of distress and past trauma •Improve differentiation of current experience(s) from past traumatic experience(s) •Assist parents to establish "safe spaces" for the child •Slow the pace of parents' automatic responses to triggers •Increase personal coping mechanisms
Interventions	•Story Telling With Objects •Fish Box •Helping Hands Feeling Stickers •Feeling Balloons •Superheroes and villains; secret box; hula hoop; puppets and dolls (storytelling and nurturing) •Cartoon boards •Theraplay	•Family Drawings •Story Telling with Objects •Puppet Stories •Theraplay

Interpersonal Psychotherapy (IPT)

- Link affect with interpersonal event and context
- IPT suggests that depression is composed of the following factors
  - Symptom formation
  - Social functioning
  - Personality
- Young and Mufson (2008) suggest using the following series of interventions to provide families with an opportunity to expand the scope of awareness and interventions leading to new solutions
  1. Select an interpersonal situation
  2. Generate solutions
  3. Evaluate pros and cons
  4. Select one possible solution
  5. Role play use of the solution
  6. Return to therapy reporting on attempted solution

Young, J., & Mufson, L. (2008). Interpersonal psychotherapy for treatment and prevention of adolescent depression. In J. Abela & B. Hankin (Eds.), *Handbook of depression in children and adolescents*. New York: Guilford.

ASSESSING TREATMENT OUTCOMES

Behavioral Markers of Healthy Personal Functioning

- Eradication of symptoms
- Assessing current situations based upon the present experiences
- Increased confidence in one's self demonstrated through
  - Confident expression of self interacting in current relationships/activities
  - Exploration of new circumstances
  - Adaptations to new situations
- Recognition of one's domains of personal control
  - Appropriate regulation of thoughts and emotions
  - Making good choices
  - Development of social skills
- Accomplishing developmentally appropriate tasks
- Expressing a broad range of emotions
- Demonstrating joy and satisfaction through play
- Appropriately requesting support as needed

Markers of Healthy Relational Functioning

- Balancing between protective and permeable boundaries between family members
- Balancing between protective and permeable boundaries with those outside of the family
- Flexibly addressing unique circumstances through collaboration
- Parental adaptations to child's growth and development
- Family adaptations to family life cycle experiences
- Generalizing learning to new and unique circumstances
- Use of family relationship strengths to address challenges

QUESTIONS???

Attention Deficit Hyperactivity Disorder

Addressing ADHD in HBFT

Nancy O'Conner, MS, LCMFT
C.R. Macchi, PhD, LCMFT
Home-based Family Therapy Partnership
The Family Center
Kansas State University
HBFTPartnership.com

Learning Objectives

Participants will…

Part I

- Identify the child and other family member experiences of Attention-Deficit Hyperactivity Disorder (ADHD)
- Review the context of ADHD along the continuum of behavior disorders
- Review the diagnostic criteria of ADHD and the varying presentations of the diagnosis
- Identify common co-morbidities associated with ADHD
- Develop greater awareness of the controversies associated with the diagnosis of ADHD

Part II (March 27th)

- Explore effective individual and family-focused treatments for ADHD
- Understand the suspected and known *treatment* side-effects
- Review ways to collaborate with medical and school officials to help families manage the effects of ADHD

The Experience of ADHD
Noelle Demo's Story

Public Broadcasting Service. (2001). Medicating kids. In S. Audette (Ed.), *Frontline and Rain Media, Inc.*

Historical Development of ADHD Diagnosis

- BRAIN DYSFUNCTION (1900s to 1960s)
  - Defective moral control of behavior
  - Brain damage syndrome
  - Minimal brain dysfunction (MBD)
    - Inclusion of inattention and impulsive behavior
- BEHAVIORAL SYNDROME (1950s to 1970s)
  - Hyperactivity/hyperkenesis
- ATTENTION DEFICIT DISORDER (1980s to present)
  - Attention deficit
  - Behavioral inhibition
- MOTIVATIONAL DEFICIT DISORDER (1990s to present)
  - Insensitivity to behavioral consequences

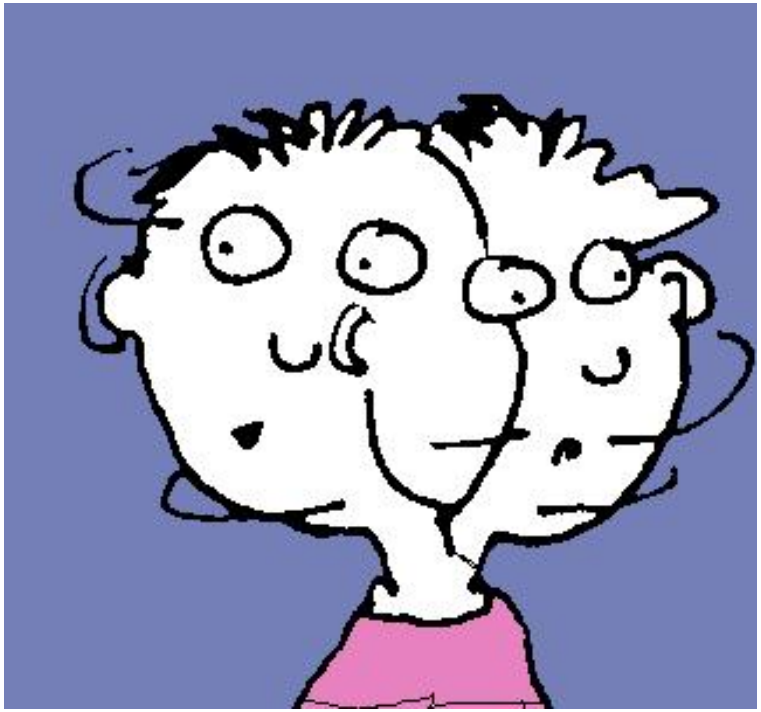
Barkley, R. (2006). *Attention-deficit hyperactivity disorder: A handbook for diagnosis and treatment (3rd ed.).* New York: Guilford.

Etiology of ADHD

- Neurological factors
  - Brain composition and functioning
  - Neurochemical imbalance
- Genetic factors
- Psychosocial ecological
  - Technological developments
  - Enculturation
  - Child rearing
- Environmental factors
  - Toxins
  - Diet
  - Nutrition

Hyperactivity

Poor filtering and lower threshold of stimulation



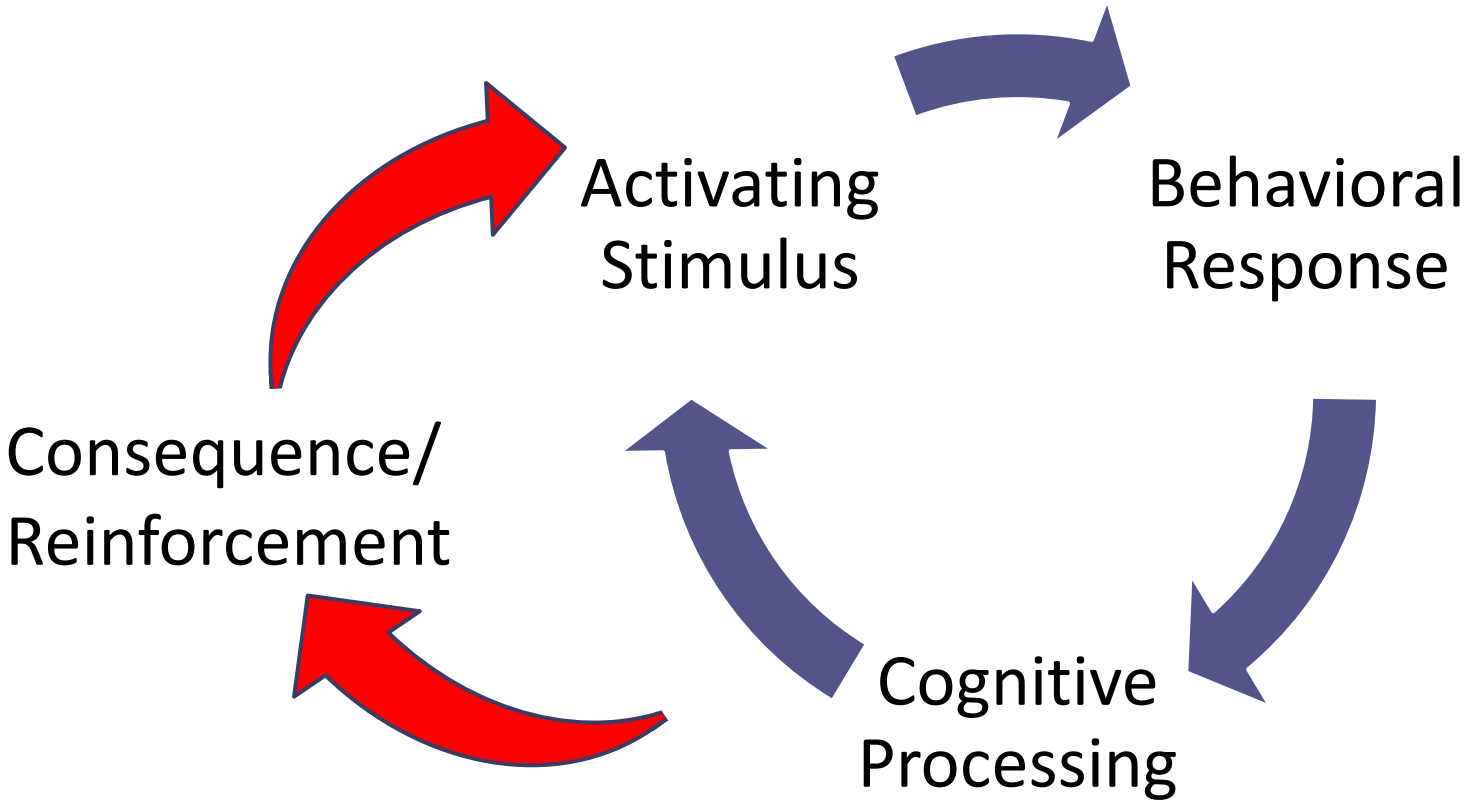
Attention-Deficit

Diminished brain activity in the brain's behavioral inhibition system (BIS) resulting in decreases of self-regulation and executive functioning

Motivational Deficit

Neurological conditions produce an insensitivity to consequences

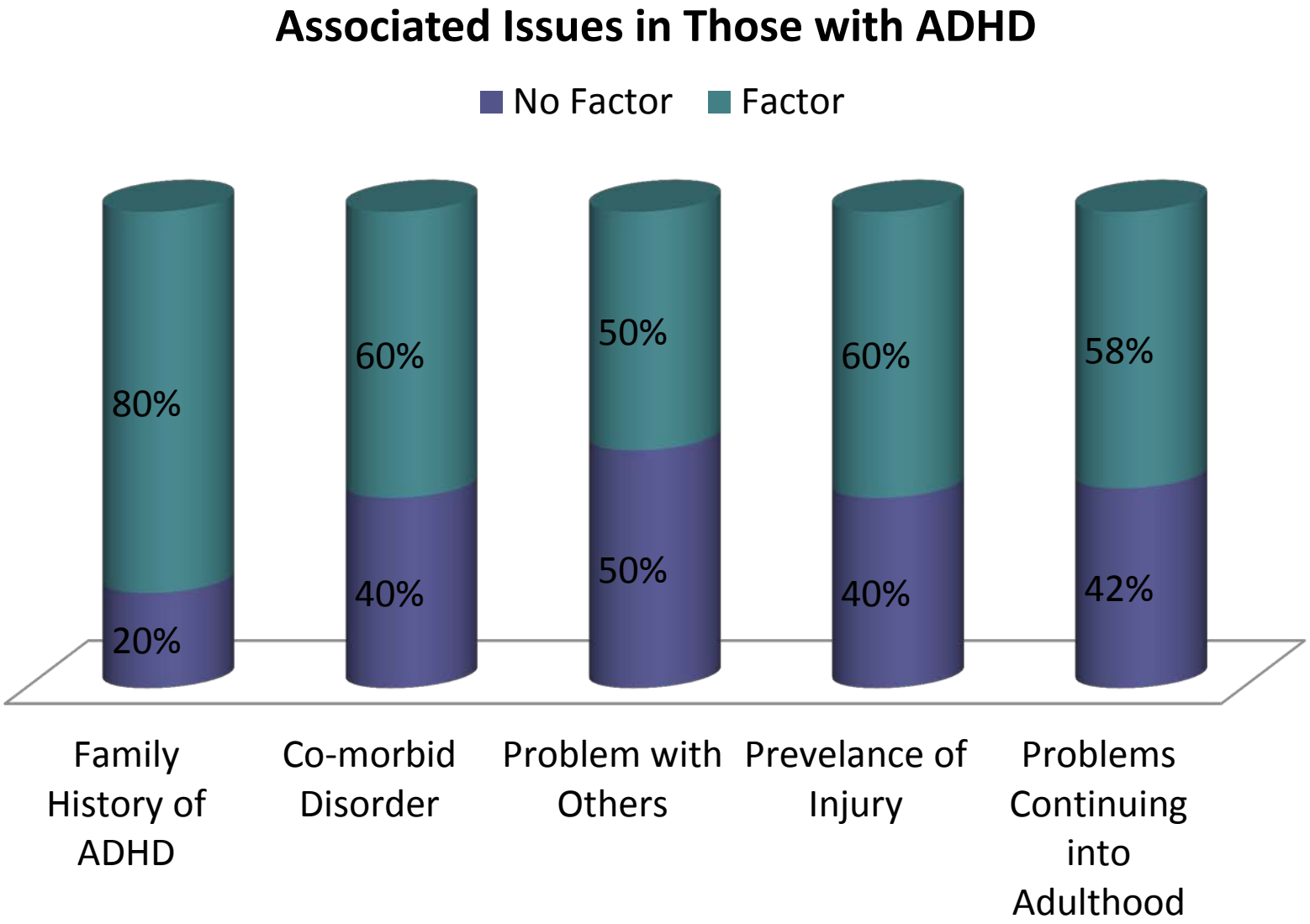
Motivational Deficit Framework



ADHD Prevalence Rates

- An estimated 3%-7% of children suffer from ADHD
  - Some studies suggest higher rates in community samples
  - 4:1 ratio of boys to girls with ADHD
  - Diagnosed approximately three times more often in boys than girls
  - 30-50% of those diagnosed with Predominantly Inattentive type of ADHD have what is known as “sluggish cognitive tempo” (SCT)
- Approximately 44% can be diagnosed with an additional psychiatric disorder (comorbidity)
  - Approximately 35% of children have major depression
  - 40% of children and 65% of adolescents with ADHD also meet criteria for ODD

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders (4th, text revision ed.).* Washington, D.C.: American Psychiatric Association.


Associated Issues in Those with ADHD
No Factor
Factor
80%
20%
60%
40%
50%
50%
60%
40%
58%
42%
Family History of ADHD
Co-morbid Disorder
Problem with Others
Prevelance of Injury
Problems Continuing into Adulthood

ADHD Statistics

- 50% have problems in relationships with others
- There is a 25-35% probability that if one person in a family is diagnosed with ADHD, another person within the family has it as well
- Research indicates that children with ADHD are significantly more likely to be injured (injured while riding bicycle, head injury, injure multiple parts of the body, and accidental poisoning) than those without the diagnosis
- Children with ADHD seem to have significantly higher medical costs

Barkley, R. (2006). *Attention-deficit hyperactivity disorder: A handbook for diagnosis and treatment (3rd ed.). New York: Guilford.*

Continuum of Diagnoses

	Childhood Disruptive Behavior			Pervasive Adult Disorder
Normal Behavior & Adjustment	ADHD	Oppositional Defiant Disorder	Conduct Disorder	Antisocial Personality Disorder
• Task-focused • Delayed gratification • Compassionate • Cooperative • Personal responsibility	• Hyperactivity • Inattention • Impulsivity	• Defiance • Anger • Blaming	• Aggression/Cruelty • Destruction • Theft	*Egosyntonic/Enduring* • Aggression/Cruelty • Destruction • Theft

DSM Criteria for ADHD

Types of ADHD

- Inattentive Type
- Hyperactive-Impulsive Type
- Combined Type

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders (4th, text revision ed.).* Washington, D.C.: American Psychiatric Association.

General Criteria for All Types of ADHD

- Symptom occurrence
  - Persisted for 6 months or longer
  - Maladaptive and inconsistent with developmental level
  - Some of the symptoms that caused the impairment were present before 7 years old
  - Some impairment is present in two or more settings
  - Clear evidence of clinically significant impairment in social, academic or occupational functioning
- Types of the symptoms which often apply (six or more)
- Each criteria is prefaced with the word "*often*" underscoring the unusual frequency of the presenting symptoms

Criteria for ADHD

Symptoms of Inattention

- Fails to give close attention to details
- Makes careless mistakes in schoolwork, work, or other activities
- Difficulty sustaining attention in tasks or play activities
- Does not seem to listen when spoken to directly
- Does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
- Difficulty organizing tasks and activities
- Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
- Loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
- Easily distracted by extraneous stimuli
- Forgetful in daily activities

Clinical Examples of *Inattention*

- What are the variety of presentations you have noticed in a child who has attention difficulties?

- What are the implications of using a *motivational deficit framework* for understanding the child's inattention?

Criteria for ADHD

Symptoms of Hyperactivity-Impulsivity

- Hyperactivity
  - Fidgets with hands or feet or squirms in seat
  - Inappropriately leaves seat in classroom or in other situations
  - Inappropriately runs or climbs (in adolescents and adults, may be limited to subjective feelings of restlessness)
  - Difficulty playing or engaging quietly in leisure activities
  - “On the go” or often acts as if “driven by a motor”
  - Talks excessively
- Impulsivity
  - Blurts out answers before questions have been completed
  - Difficulty awaiting turn
  - Interrupts or intrudes on others (e.g., butts into conversations or games)

Clinical Examples of *Hyperactivity-Impulsivity*

- What are the variety of presentations you have noticed in a child who has hyperactivity-impulsivity issues?

- What are the implications of using a *motivational deficit framework* for understanding the child's hyperactivity-impulsivity issues?

BREAK

Behavioral and Social Features of ADHD

- Low frustration tolerance
- Rejection by peers
- Poor self-esteem
- Academic achievement impaired
- Family relationships often characterized by resentment and antagonism

Differential Diagnoses

- Age-appropriate behaviors
- Anxiety Disorders – PTSD, Generalized Anxiety Disorder
- Environments
  - Understimulating (i.e. classroom)
  - Disorganized, chaotic
- Learning disorders
- Medication reactions effecting behaviors (e.g., bronchodilator for asthma)
- History of trauma
- Bipolar Disorder
- Schizophrenia

Other Conditions that Mimic ADHD

- Hypoglycemia
- Allergies
- Learning disabilities
- Hyper or Hypothyroidism
- Hearing and vision problems
- Early onset diabetes
- Heart disease and other cardiac conditions
- Early onset Bi-Polar disorder
- Exposure to some toxins

Other Conditions that Mimic ADHD

- CAPD (Central Auditory processing Disorder)
- Worms
- Viral or bacterial infections
- Malnutrition or improper diet
- Head injuries
- Streptococcus
- FAS or FAE
- Trauma

Co-morbidity of Disorders

- Higher prevalence of the following
  - Mood Disorders
  - Anxiety Disorders
  - Learning Disorders
- Oppositional Defiant Disorder
- Conduct Disorder
- Substance-related Disorders

Assessment of ADHD

ADHD Assessment

- Interviewing the child
- Interviewing the parents
  - Parent observations of the child's experiences with ADHD
  - Assess for ADHD in the parent(s)
- Providing a teacher assessment of child classroom behaviors and peer relationships

TABLE 1.1
Differential Diagnosis Criteria

Diagnostic Criteria for Disruptive Behavior Disorders			
ADHD 314.01 Hyper-Impulsive Type	**ADHD 314.00 Inattentive Type**	**ODD 313.81 Oppositional**	**CD 312.90 Conduct Disorder**
❑ Fidgets, squirms	❑ Lacks attention to detail	❑ Often loses temper	❑ Bullies
❑ Leaves seat	❑ Lacks sustained attention	❑ Argues with adults	❑ Initiates fights
❑ Runs and climbs	❑ Not listening	❑ Actively defiant	❑ Used a weapon
❑ Difficulty with leisure	❑ Lacks follow-through	❑ Deliberately annoys	❑ Cruel to people
❑ Always on the go	❑ Not organized	❑ Blames others	❑ Cruel to animals
❑ Talks excessively	❑ Avoids mental effort	❑ Touchy	❑ Stolen with confrontation
❑ Blurts out answers	❑ Loses things	❑ Angry and resentful	❑ Forced sex
❑ Difficulty waiting turn	❑ Easily distracted	❑ Spiteful, vindictive	❑ Fire setting
❑ Often interrupts	❑ Forgetful		❑ Destroyed property
			❑ Broken into house
			❑ Often lies
			❑ Stolen without confrontation
			❑ Stays out late
			❑ Has run away
			❑ Often truant
__ of 9 (6+ = dx)	**__ of 9 (6+ = dx)**	**__ of 8 (4+ = dx)**	**__ of 15 (3+ = dx)**

Behavioral Severity Scales

Behavioral Symptoms
Attention Deficit/Hyperactivity Disorder
Attention Deficit/Hyperactivity Disorder NOS
(severity index: 1, mild; 2, moderate; 3, intense)

	Severity
Attention:	
1. Fails to pay close attention to details in school or social situations	_____
2. Does not seem to listen when spoken to directly	_____
3. Does not follow through on instructions	_____
4. Fails to finish tasks	_____
5. Has difficulty organizing tasks and activities	_____
6. Avoids or dislikes tasks that require sustained mental effort	_____
7. Loses things that are necessary for tasks and activities	_____
8. Is easily distracted by extraneous stimuli	_____
9. Is forgetful in daily activities	_____

Hyperactivity-Impulsivity

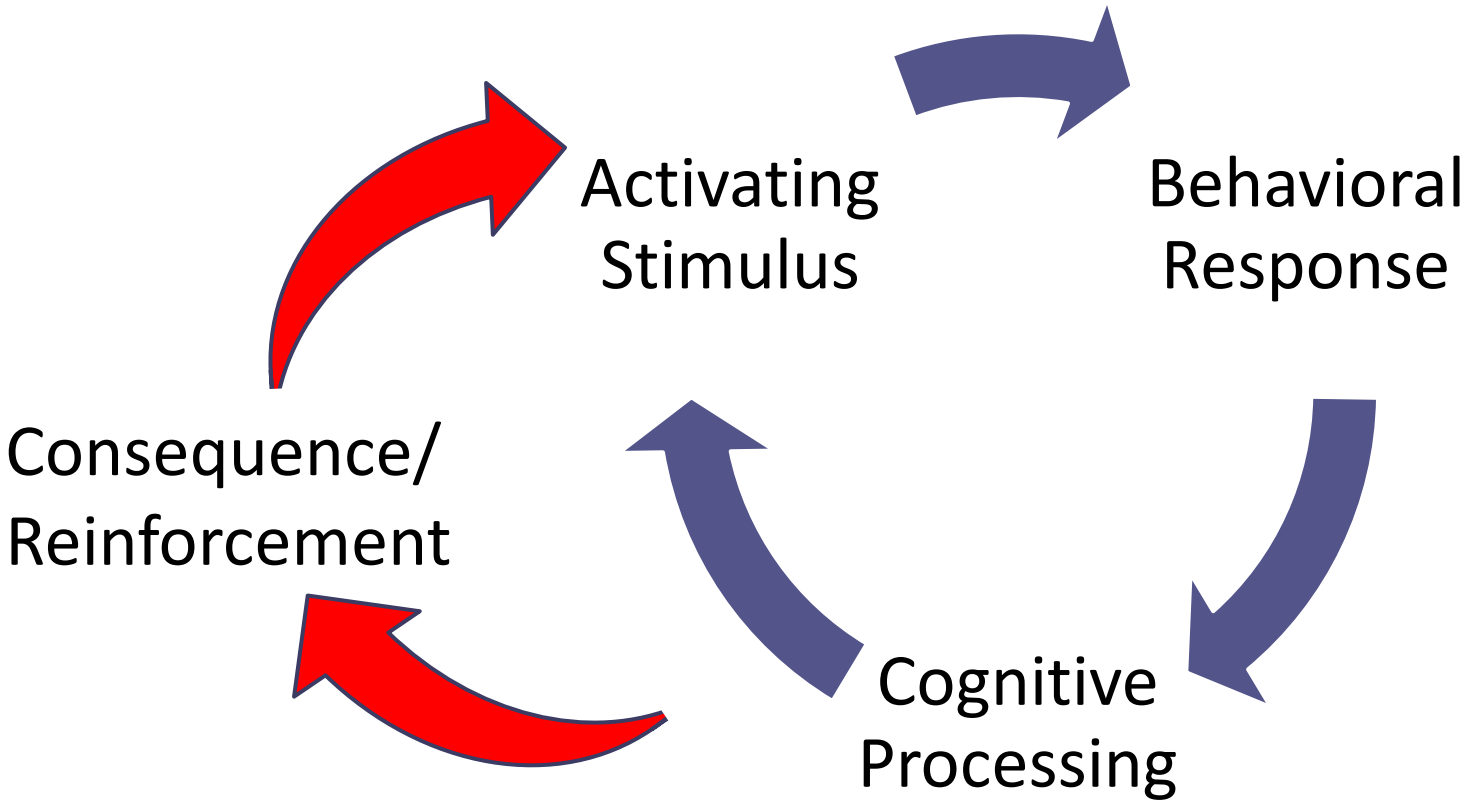
1. Fidgets or squirms in seat	_____
2. Cannot remain in seat when expected	_____
3. Is inappropriately overactive	_____
4. Has subjective feelings of restlessness	_____
5. Has difficulty engaging appropriately in leisure activities	_____
6. Feels or acts "driven by a motor"	_____
7. Talks excessively	_____
8. Blurts out answers before questions are completed	_____
9. Has difficulty awaiting turn	_____
10. Interrupts or intrudes on conversations or activities of others	_____

Other Diagnostic Considerations

Conduct Disorder NOS (312.8)
Disruptive Behavior Disorder NOS (312.9)
Generalized Anxiety Disorder (300.02)
Major Depressive Disorder (296.xx)
Obsessive-Compulsive Disorder (300.3)
Oppositional Defiant Disorder (313.8)
Substance Abuse (*see Substance*)

Warren, M. (2002). *Behavioral management guide: Essential treatment strategies for the psychotherapy of children, their parents, and families. Northvale*, NJ: Jason Aronson.

Motivational Deficit Framework



Motivational Assessment

- Determine the child's…
  - Level of sensitivity to external stimuli
  - Degree of internal locus of control
  - Level of perceived responsibility for behaviors
  - Level of responsiveness to behavioral reinforcements
  - Emotional connection to parents

Motivational Assessment

- Determine the parents'…
  - Maintenance of environmental stability
  - Types and uses of natural consequences
  - Level of responsiveness to child's needs
  - Attempts to reinforce child's internal locus of control
  - Emotional connection to the child
  - Interpretations of child behaviors

Discuss Implications of Motivational Focus

- Assessment
- Treatment planning
- Interventions

** *Email facilitators with specific clinical presentations.* We will integrate our discussion of treatment planning and interventions to address those specific issues during Part II.

Controversies Over ADHD Diagnosis

- Neurological factors
- Medical factors
- Behavioral factors
- Social factors

Part II – Treatment and Interventions of ADHD

- March 27th, 9:00am-Noon
- Learning objectives – Participants will…
  - Explore effective individual and family-focused treatments for ADHD
  - Understand the suspected and known *treatment* side-effects
  - Review ways to collaborate with medical and school officials to help families manage the effects of ADHD

Addressing ADHD in HBFT

Nancy O'Conner
Kelli Stubenhofer
Home-based Family Therapy Partnership
The Family Center
Kansas State University
HBFTPartnership.com

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Review

Types of ADHD

Criteria for ADHD

Motivational Framework

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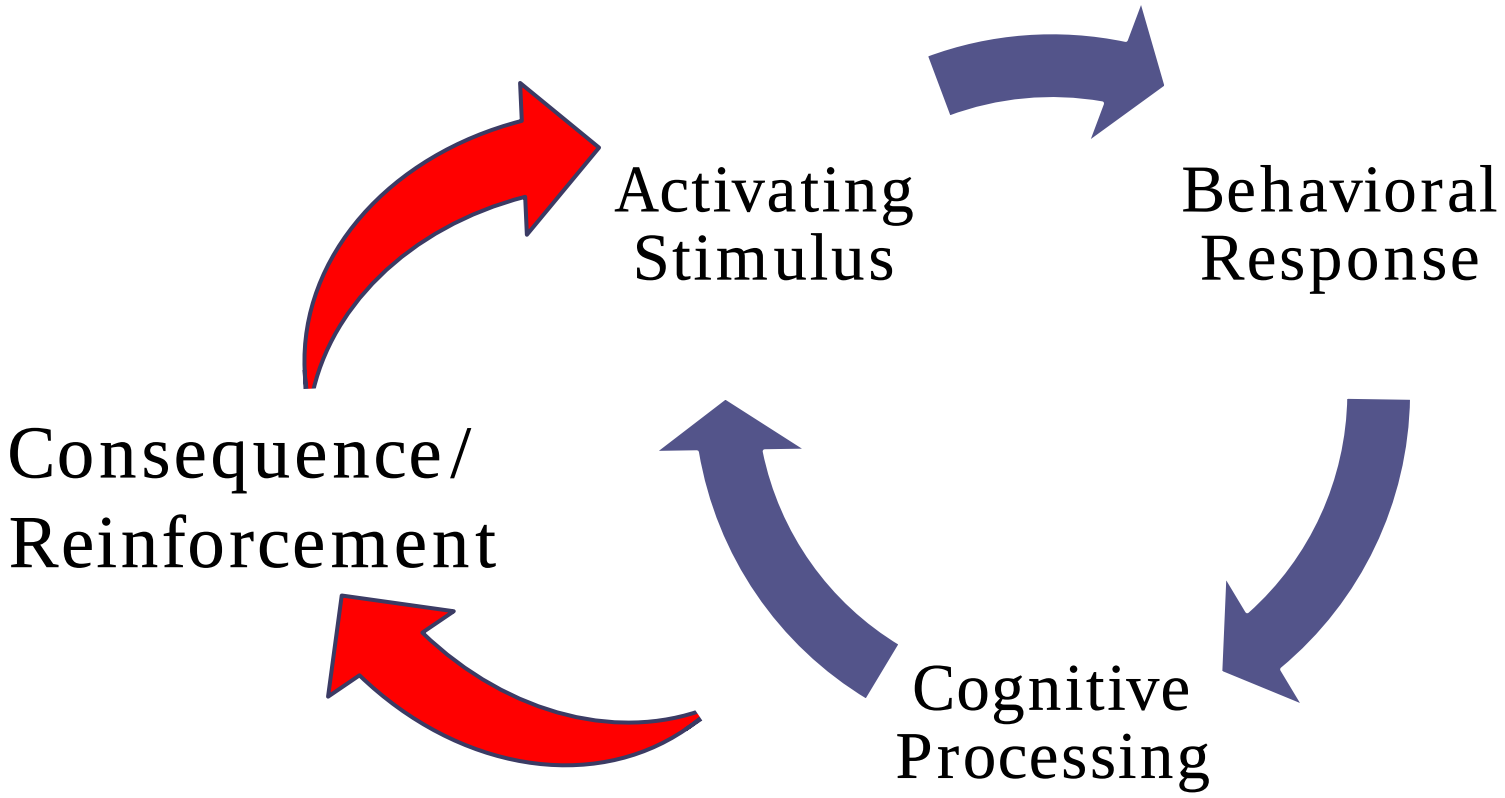
Motivational Deficit Framework



Discussion Question

- ADHD is the primary reason for referral to mental health services among school age children. Surveys suggest that 2-6% of preschoolers also meet the diagnostic criteria for ADHD.

- What are the implications for an ADHD diagnosis as early as preschool?

ADHD Prevalence Rates

- An estimated 3%-7% of children suffer from ADHD
  - Some studies suggest higher rates in community samples
  - 4:1 ratio of boys to girls with ADHD
  - Diagnosed approximately three times more often in boys than girls
  - 30-50% of those diagnosed with Predominantly Inattentive type of ADHD have what is known as “sluggish cognitive tempo” (SCT)
- Approximately 44% can be diagnosed with an additional psychiatric disorder (comorbidity)
  - Approximately 35% of children have major depression
  - 40% of children and 65% of adolescents with ADHD also meet criteria for ODD

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders (4th, text revision ed.)*. Washington, D.C.: American Psychiatric Association.

Effective Individual and Family Focused Treatments for school-aged children

Developmental Psychopathology

- "Developmental appropriateness is critical in
  - arriving at a diagnosis of ADHD,
  - setting appropriate goals for treatment, and
  - appreciating environmental demands…"

  - Treatment should be modified at developmental transitions
  - Treatment should use developmentally sensitive behavioral strategies
  - Children exist in multiple contexts

Chronis, A.M., Jones, H.A. & Raggi, V.L. (2006).Evidenced-based psychosocial treatments for children and adolescents with attention-deficit/hyperactivity disorder. Clinical Psychology Review, 26, 486-502. (p. 487)

Integrating Frameworks: Self-Regulation

- Attachment Theory
  - Attachment provides safety and protection for a child and from this a child learns to self-regulate
  - Self-regulation is being able to modulate the intensity, frequency, and duration of emotions and behavior in social settings
- Motivational Deficit
  - Child does not make the connection between behavior and consequences
- Developmental Psychopathology

Child's Developmental Trajectory RE: Self-Regulation Development

- Age 5
  - attachment --> parents provide safe, secure, structured, predictable base
  - developmental --> egocentric, industry stage, behaviorally-focused tasks
  - motivational --> immediate, natural, behaviorally-focused reinforcements/consequences; family-focused value system

  Age 12
  - attachment --> parents invite/encourage peer involvements; parents provide secure base through predictable and stable emotional availability and structured expectations
  - developmental --> emerging exploration of personal identity as separate from parental identity; affinity for exploring peer relationships and the opportunities to compare self with others; beginning development of abstract thinking skills
  - motivational --> increasing internal locus of control, self-regulation, and a family-referencing but increasingly internalized value system; explore behavioral and cognitive approaches to the connections of behaviors and consequences

Child's Developmental Trajectory RE: Self-Regulation Development

- Age 17
  - attachment --> parents assist child exploring the value of varying
  peer relationships and the impact of those relationships on the young person's developing self; parents provide increased opportunities for exploration and independence while exploring and reinforcing the consequences (+/-) associated with decisions and behaviors.

- - developmental --> exploring personal identity while accessing a greater degree of abstract reasoning and levels of meaning

- - motivational --> explore behavioral, cognitive, ethical approaches to the connections of behaviors and consequences; established internal locus of control, self-regulation, and an internalized value system

Discussion Question

- Discuss the issues that parents, children and therapists face regarding the use of medication for ADHD in children.

To Medicate or Not to Medicate: A Decision-making process.

- Stage 1: Parents' grieving over the loss of their child's "normal" status
  - Denying the diagnosis through guarded acceptance
- Stage 2: Parental cynicism of society's dichotomous attitude towards ADHD and the use of medication as the preferred treatment option

To Medicate or Not to Medicate: A Decision-making process.

- Stage 3: “Doing the right thing by my child” – adopting proactive parenting practices
  - Assume responsibility for the titration of child’s medication
  - Educating others

Commonly Prescribed Medications

Brand Name/ Generic	Approved Age
Adderall® amphetamine	3 and older
Concerta® methyphenidate (long acting)	6 and older
Dexoxyn® methamphetamine hydrochloride	6 and older
Dexedrine® dextroamphetamine	3 and older
Focalin® dexmethylphenidate	6 and older
Metadate ER® methylphenidate (extended release)	6 and older
Ritalin® methylphenidate	6 and older
Straterra® atomoxetine (SNRI not a stimulant)	6 and older
Datrana® methylphenidate (transdermal system)	6 and older
Vyvanse® lisdexamfetamine dimesylate (long acting)	3 and older

Evidence-based Approaches

- Multimodal Programs
  - Stimulant medication
  - Family therapy or parent training
  - School-based behavioral programs
  - Coping skills training for children
  - Combined Behavioral-Pharmacological

Summary of Behavioral Management Ideas

1. Reduce time delays and externalize time
2. Externalize important information
3. Externalize motivation
4. Externalize problem-solving
5. Use immediate feedback
6. Increase frequency of consequences
7. Increase accountability to others
8. Use more salient and artificial rewards
9. Change rewards periodically
10. Touch more, talk less

Summary of Behavioral Management Ideas cont.

1. Act, don't yak
2. Negotiate rather than dictate
3. Keep your sense of humor
4. Use rewards before punishment
5. Anticipate problem settings
6. Keep a sense of priorities
7. Maintain a disability perspective
8. Practice forgiveness

Barkley, R. A. & Murphy, K.R. (2006) Attention-deficit hyperactivity disorder: A clinical workbook (3rd ed.) New York: Guilford Press, p. 84-86

Combined Behavioral-Pharmacological Interventions

- Medication management effective in reducing ADHD symptoms
- Combined treatment more effective than medication alone in:
  - Social skill development
  - Improving parent-child relationships
  - Also may allow for lower doses of medication

School-based Interventions

- Classroom behavior management
  - Behavioral Modification System
    - regular consultation with teacher regarding behavior
    - identifying target behaviors
    - DRC (Daily Report Card)
      - provides parents with feedback regarding child's behavior and performance
      - create challenging, yet attainable goals

Chronis, A.M., Jones, H.A. & Raggi, V.L. (2006).Evidenced-based psychosocial treatments for children and adolescents with attention-deficit/hyperactivity disorder. Clinical Psychology Review, 26, 486-502.

School-based Interventions

- Classroom Behavior Management (cont.)
  - classrooms need clear rules and predictability of routines and schedules
  - continually provide positive comments and reinforcement
    - focus on good behavior
  - minimize distracters
  - visual prompting and private cues between the student and teacher (see video)

Rief, S.(2004). ADHD & LD: Powerful teaching strategies and accommodations [VHS]. San Diego: Educational Resource Specialists.

School-based Interventions

- Academic interventions
  - Target homework problems through:
    - structuring of homework time
      - reducing task length, dividing large tasks, use different forms of stimulation (markers, colored pencils)
    - use of goal setting
    - organize subjects and materials in a binder
      - color code different subjects

Rief, S.(2004). ADHD & LD: Powerful teaching strategies and accommodations [VHS]. San Diego: Educational Resource Specialists.

Discussion Question

- Identify some strategies you believe are important in collaborating with schools.
- Identify some strategies you use to coach a parent in collaborating with schools on behalf of their child.

Collaboration with the School

- Parent-Teacher Collaboration
  - have teachers share their concerns and discuss follow up plans and strategies together
- Parents are key members to the team!
- Essential that schools provide information about the child's functioning
  - this helps the physician and therapist monitor child's medication and symptoms

Rief, S.(2004). *ADHD & LD: Powerful teaching strategies and accommodations* [VHS]. San Diego: Educational Resource Specialists.

Special Considerations

Special Considerations

- Preschoolers
  - 2-6% meet the criteria for ADHD (hyperactivity)
  - Clinicians must balance the potential benefits of early identification and intervention with the risks of over-identification and potential use of non-FDA approved pharmacotherapies
  - Home-based Play Therapy
  - Parent Training
- Treatment Selection
  - Based on parent's ability to implement strategies regardless of age of child

Special Considerations

- Adolescents
  - Include them in the treatment process
  - Modify the rewards and consequences
  - Increase self-monitoring strategies
  - Focus more on time management and organizational skills

Special Considerations

- Collaboration with medical profession
  - Don’t be part of the mental health “black hole”
  - State of Kansas requires it
    - Physician waiver or release
  - Regular communication regarding:
    - side effects
    - parents ability to titrate medicine

QUESTIONS????

COMMENTS!!!!

Fetal Alcohol Spectrum Disorder

Fetal Alcohol Disorder
Part I: Focus on the Mother

Nancy O'Conner, MS, LCMFT

C.R. Macchi, PhD, LCMFT

Home-based Family Therapy Partnership

The Family Center

Kansas State University

HBFTPartnership.com

Objectives

Participants will…

- Explore the models of alcohol use
- Recognize the effects of alcohol use on the fetus
- Understand the diagnostic criteria for Alcohol Dependency and FAS
- Explore various methods of identifying/screening at risk populations

Laying the Foundation:

Impact of Alcohol on Women

Alcoholism-Definition

- Alcoholism is a primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by continuous or periodic impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial.

Alcohol Abuse
DSM IV Criteria

- One of more of the following occurring in the past twelve months:
  - Role failure (interference with homework or school obligations).
  - Risk of bodily injury.
  - Drinking while driving (operating machinery or swimming).
  - "Run-ins" with the law (arrests or near arrests).
  - Relationship trouble (with friends and family).

If yes to one or more, your patient ***abuses alcohol***

Alcohol Dependency
DSM IV Criteria

One or more of the following occurring in the past twelve months:

- Tolerance
- Withdrawal
- Impaired control
- Drank more or longer than intended
- Spent a lot of time drinking
- Neglect of activities
- Kept drinking despite problems

If yes to three or more, your patient has ***alcohol dependency***

Categories of Alcohol Use in Women

- Statistics show that
  - Over 50% of women report alcohol use
  - One in eight women report binge drinking
  - 10% of pregnant women report any alcohol use; 2-4% of them report binge drinking
- Standard drink: contains about 14 grams of pure alcohol which is equivalent to:
  - One 12-ounce beer or wine cooler
  - One 5-ounce glass of wine
  - 1.5 ounces of 80-proof distilled spirits

Drinking Patterns and Risk of Alcohol Dependence

1: Abstainers (0%)

2: Low-risk drinking (<1 in 100)

3: At-risk drinking (1 in 5)

4: Problem drinking (1 in 2)

5: Alcohol dependent drinking (100%)

Alcohol Metabolism and Pharmacology

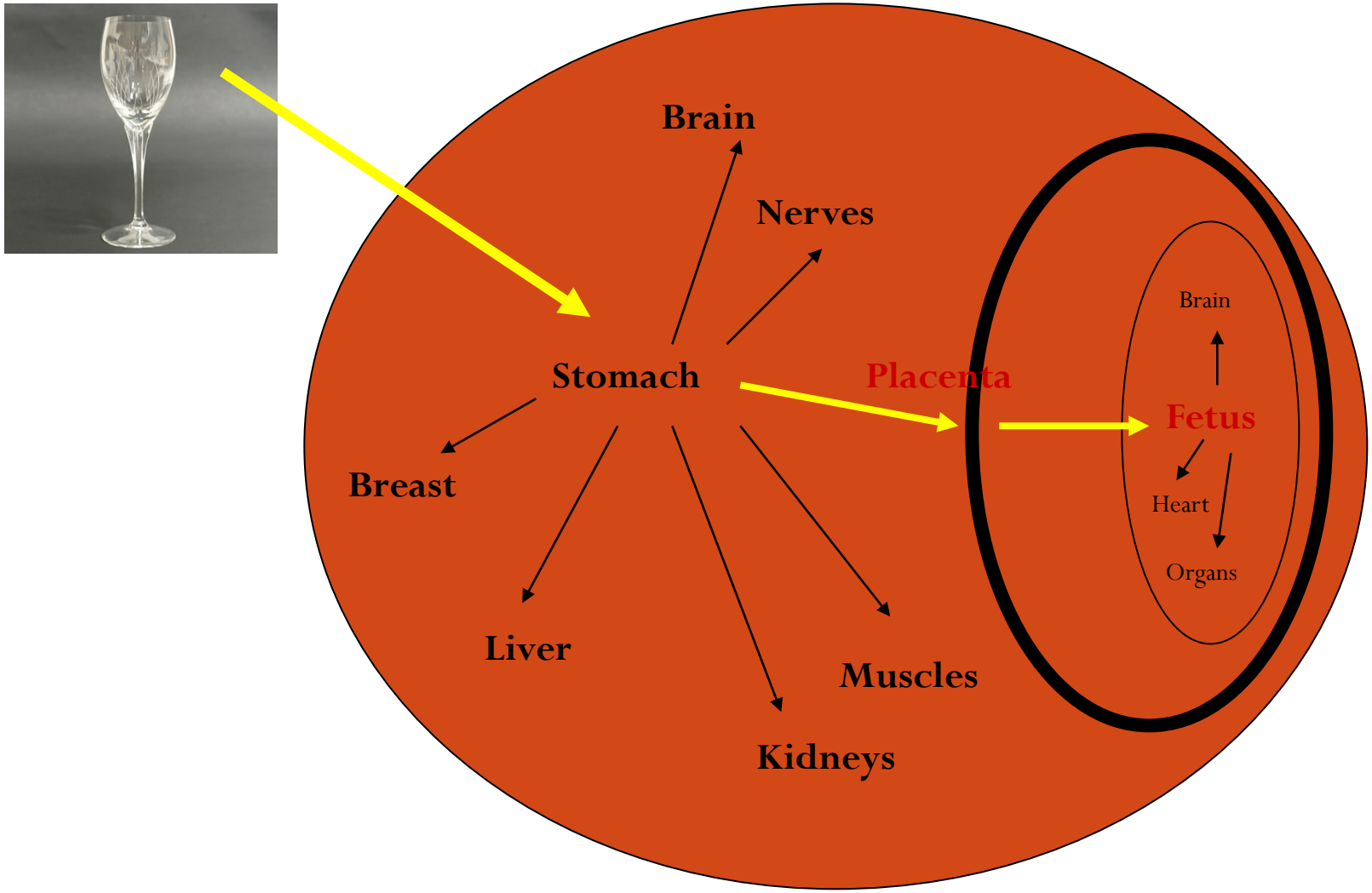
- Absorption
- Distribution
- Metabolism and elimination

Absorption

- Woman takes a drink→introduced into the stomach→absorption/metabolism of the molecule (C_2H_5OH) occurs rapidly
- Peak blood ethanol concentrations attained approx 1 hour after consumption
- Women attain consistently higher blood ethanol concentrations than men following equivalent amounts of ethanol consumption

Distribution

- Compartmentalization
  - Because of alcohol's rapid solubility in water, it can easily cross cell membranes into the cell (which is 98% water)
  - Alcohol is less soluble into lipids and compartments with substantial lipids
- Placental effects and fetal distribution
  - The placenta acts as a selective barrier
  - Alcohol is easily passed by diffusion from the maternal blood into the fetal blood


Brain
Nerves
Stomach
Placenta
Fetus
Brain
Heart
Organs
Breast
Liver
Muscles
Kidneys

Metabolism and Elimination

- Alcohol is metabolized by enzymes as it is available by concentration
- Most ethanol is metabolized in the liver

Effects of Alcohol on the Fetus

- Miscarriage
- Premature birth
- Low birth weight
- Development complications
- FASD

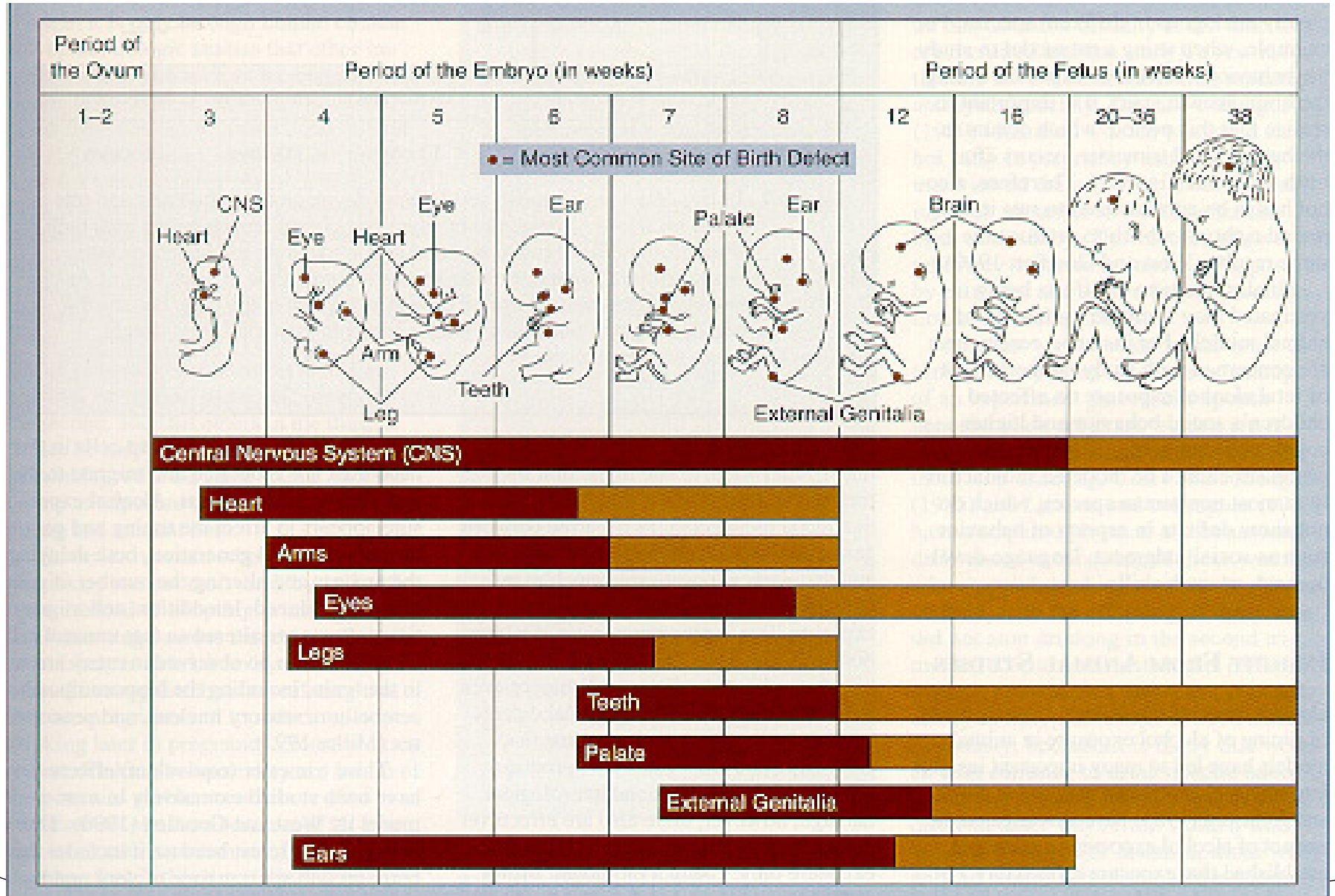
Effects of Alcohol on the Fetus

- Central Nervous System
- Craniofacial defects
- Growth retardation
- Cardiovascular defects
- Renal defects
- Skeletal defects

Sensitivity to Alcohol During Development

When is the embryo or fetus most susceptible to alcohol exposure?

Development of the Embryo



Cognitive and Behavioral Impairments

- *Memory*
- *Attention*
- *Learning*
  - Verbal
  - Visual-spatial
- *Reaction time*
- *Executive functions*

Cognitive

- The effects of alcohol might cause organic disturbance to the formation and function of the brain and its cellular components
- Streissguth et al. found the average IQ of 178 individuals with FAS was 79 (range 20-120) which is below the general population range of 85-115

Psychiatric/Behavioral

- Behavioral deficits
  - Attention and memory problems, hyperactivity
- Memory and learning impairments
  - Verbal learning
  - Visual-spatial learning
  - Attention
  - Reaction time
  - Executive functions
- Secondary conditions
  - Mental health problems
  - Disrupted school experiences
  - Trouble with the law
  - Confinement and/or incarceration
  - Inappropriate sexual behavior
  - Alcohol or other drug problems

BREAK

Importance of Screening

GROUP ACTIVITY

- If you currently assess for alcohol use, abuse, or dependence…
  - What types of paperwork do you use that guide your interview?
  - What types of screens do you use?
  - What types of assessments do you use?

Severity

- Severity depends on alcohol:
  - Dosage
  - Pattern of exposure
  - Timing of exposure
  - Duration of exposure

Why Screen?

- Alcohol use during pregnancy is one of the leading preventable causes of birth defects and childhood disabilities in the United States!
- Even low levels of alcohol during pregnancy can have negative developmental consequences
- Recommended by the US Preventive Services Task Force and the CDC

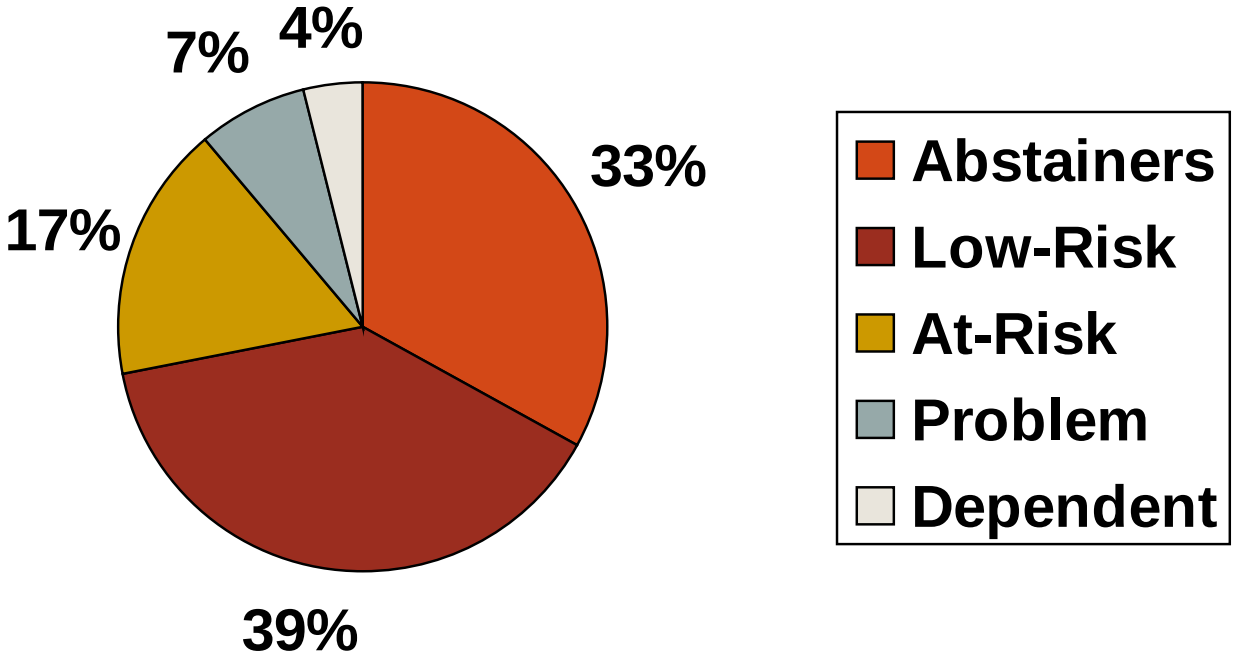
Who Should We Screen?

- All women of child-bearing age
- Pregnant women
- Nursing mothers

Why Screen Women of Child-Bearing Age?

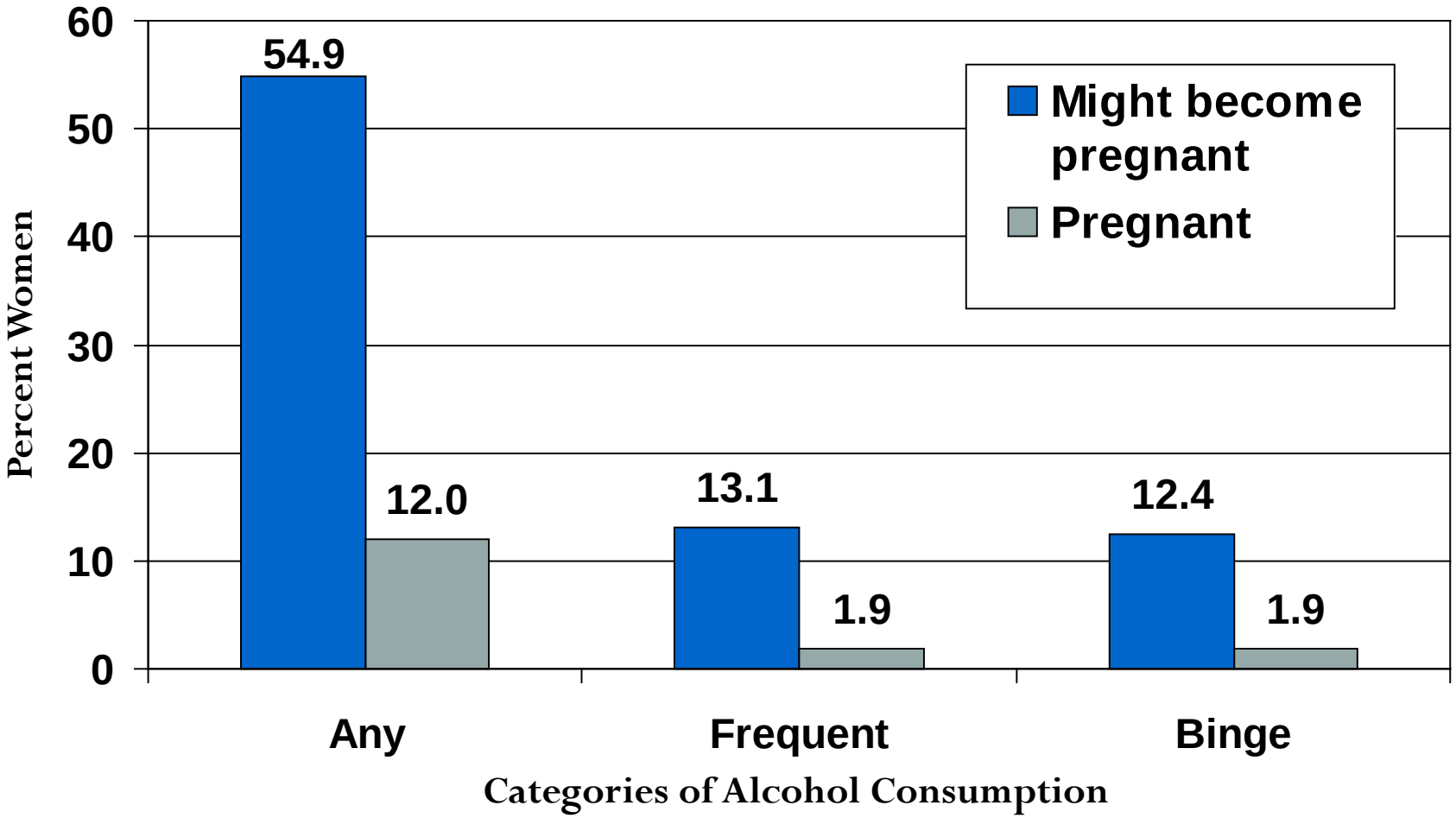
- Women who drink prior to pregnancy more likely to drink during pregnancy
- 53% of non-pregnant women drink, 12% binge drink
- Women may not volunteer information on alcohol intake
- Half of childbearing age women do not use birth control
- Many women do not realize they are pregnant until after the 4th – 6th week of gestation

Alcohol Consumption by Women – Primary Care Data



Alcohol use among women ages 18-30

Alcohol Consumption Among Women



Why Screen Pregnant Women?

- 12% of women continue to drink while pregnant despite efforts to educate on its dangers
- Alcohol use during pregnancy, even at low intake levels, has been associated with significant negative consequences, including FASD

Why Screen Nursing Mothers?

- Infants consume less milk when mothers consume alcohol before breastfeeding
- Exposure to alcohol in mother's milk results in infant motor development delay
- Exposure to alcohol in mother's milk shown to interrupt an infant's sleep/wake pattern
- Early alcohol exposure may increase a child's risk of addiction to alcohol

Are Women Being Screened?

- Despite potential risks and established clinical guidelines, some individuals are not screened for problem drinking
- Physicians are less likely to detect alcohol problems in patients that they do not expect to have alcohol problems

Risk Factors
Who is Likely to Drink ?

- Those who are alcohol dependent or previously abused alcohol while pregnant
- Previous biologic child with FASD
- Partner/Family member heavy drinker
- Associated depression
- Other drug or tobacco use

Risk Factors
Who is Likely to Drink ?

- Low socioeconomic status
- Unmarried
- African-American and American-Indian/Alaska-Native ethnicity
- Younger maternal age

Assessment

NIAAA Quantity/Frequency Screen

1. Do you drink alcohol?
2. On average, how many days a week do you drink?
3. On a day when you drink alcohol, how many drinks do you have?
4. What is the maximum number of drinks you consumed on any given occasion in the past month?

National Institute on Alcohol Abuse and Alcoholism of the NIH (2005)

Recommended Alcohol Screening Instruments

- Best instruments should be:
  - Brief
  - Easy to administer and score
  - Reliable/accurate in target population
- To be effective they must be:
  - Used routinely with EVERY patient
  - With pregnant patients, must be administered multiple times

Recommended Alcohol Screening Instruments

CLIENT	SCREEN TYPE
Women	TWEAK, T-ACE
Pregnant Women	TWEAK, T-ACE
Adolescents	CRAFFT

National Institute on Alcohol Abuse and Alcoholism of the NIH (2005)

TWEAK

1. A How many drinks does it take to feel effects of alcohol? ***[Tolerance]*** (3 or more drinks = 2 points)
2. Have friends/relatives *Worried* about your drinking in the past year? ***[Worried]*** (yes = 2 points)
3. Ever drank first thing in the morning? ***[Eye-opener]*** (yes = 1 point)
4. Ever drank but can't remember what you said or did in am? ***[Amnesia]*** (yes = 1 point)
5. Ever feel the need to cut down on your drinking? ***[K(C)ut down]*** (yes = 1 point)

T-ACE

1. Does it take more than it used to for you to get high? ***[Tolerance]*** (yes = 2 points)
2. Have you become ***Angry*** *or* ***Annoyed*** when others express concern about your use? (yes = 1 point)
3. Have you tried to ***Cut down*** or quit? (yes = 1 point)
4. Have you ever had a drink first thing in the am? ***[Eye opener]*** (yes = 1 point)

CRAFFT

1. Have you ever ridden in a ***Car*** driven by someone (including yourself) who was high or had been using alcohol or drugs? (Yes = 1 point)
2. Do you ever use alcohol or drugs to ***Relax***, feel better about yourself, or fit in? (Yes = 1 point)
3. Do you ever use alcohol or drugs while you are by yourself *(**Alone**)*? (Yes = 1 point)
4. Do you ever ***Forget*** things you did while using alcohol or drugs? (Yes = 1 point)
5. Do your ***Family or Friends*** ever tell you that you should cut down on your drinking or drug use? (Yes = 1 point)
6. Have you ever gotten into ***Trouble*** while you were using alcohol or drugs? (Yes = 1 point)

Comparison of Screens

	CRAFFT	T-ACE	TWEAK
Tolerance		Does it take more than it used to for you to get high?	How many drinks does it take to feel effects of alcohol?
Reactions to or from others	Do your ***family or friends*** ever tell you that you should cut down on your drinking or drug use?	Have you become ***angry*** *or* ***annoyed*** when others express concern about your use?	Have friends/relatives *worried* about your drinking in the past year?
Coping tool	Do you ever use alcohol or drugs to ***relax***, feel better about yourself, or fit in? Do you ever use alcohol or drugs while you are by yourself?	Have you ever had a drink first thing in the am?	Ever drank first thing in the morning?
Attempted reduction		Have you tried to ***Cut down*** or quit?	Ever feel the need to cut down on your drinking?
Forgetfulness	Do you ever ***forget*** things you did while using alcohol or drugs?		Ever drank but can't remember what you said or did in am?
Risk-taking	Have you ever ridden in a ***car*** driven by someone (including yourself) who was high or had been using alcohol or drugs? Have you ever gotten into ***Trouble*** while you were using alcohol or drugs?		

Conclusions

Questions??
Comments!!

Fetal Alcohol Disorder

Part II: Focus on the Child

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Kansas State University
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FAS

- Screening
- Diagnosis
- Treatment

FAS Screening

- Morphological examination
  - Height (centiles)
  - Weight (centiles)
  - Head circumference (centiles)
  - Palpebral fissure measurement
  - Philtral assessment

FAS Screening

- When in doubt, suspicious or screen positive, consult:
  - Dysmorphologist or clinical geneticist
  - Neuropsychologist
  - Developmental pediatrician
- Diagnosis best made by a dysmorphologist or clinical geneticist with experience in FASD

FAS Screening

- Cognitive
- Adaptive/Functional
- Language
- Motor
  - Gross
  - Fine
- Social skills
- Emotional development
- Academic Achievements

- Choosing the proper type of testing is best performed by a developmental physician, pediatric clinical psychologist or neuropsychologist

FAS

- Screening
- Diagnosis
- Treatment

FAS Diagnostic Criteria

- Fetal alcohol syndrome is a **clinical** diagnosis
- CDC criteria (2004) are used as they are based upon the most current data and National Task Force on Fetal Alcohol Syndrome and Fetal Alcohol Effect definitions

FAS Diagnostic Criteria

- Rule out other possible diagnoses
- Facial features not unique to FAS so differential diagnosis important

FAS Diagnostic Criteria

- Clear diagnostic criteria can help health care providers identify children
- With diagnosis, children can get care and services they need
- Early identification can help prevent secondary disabilities

FAS Diagnostic Criteria

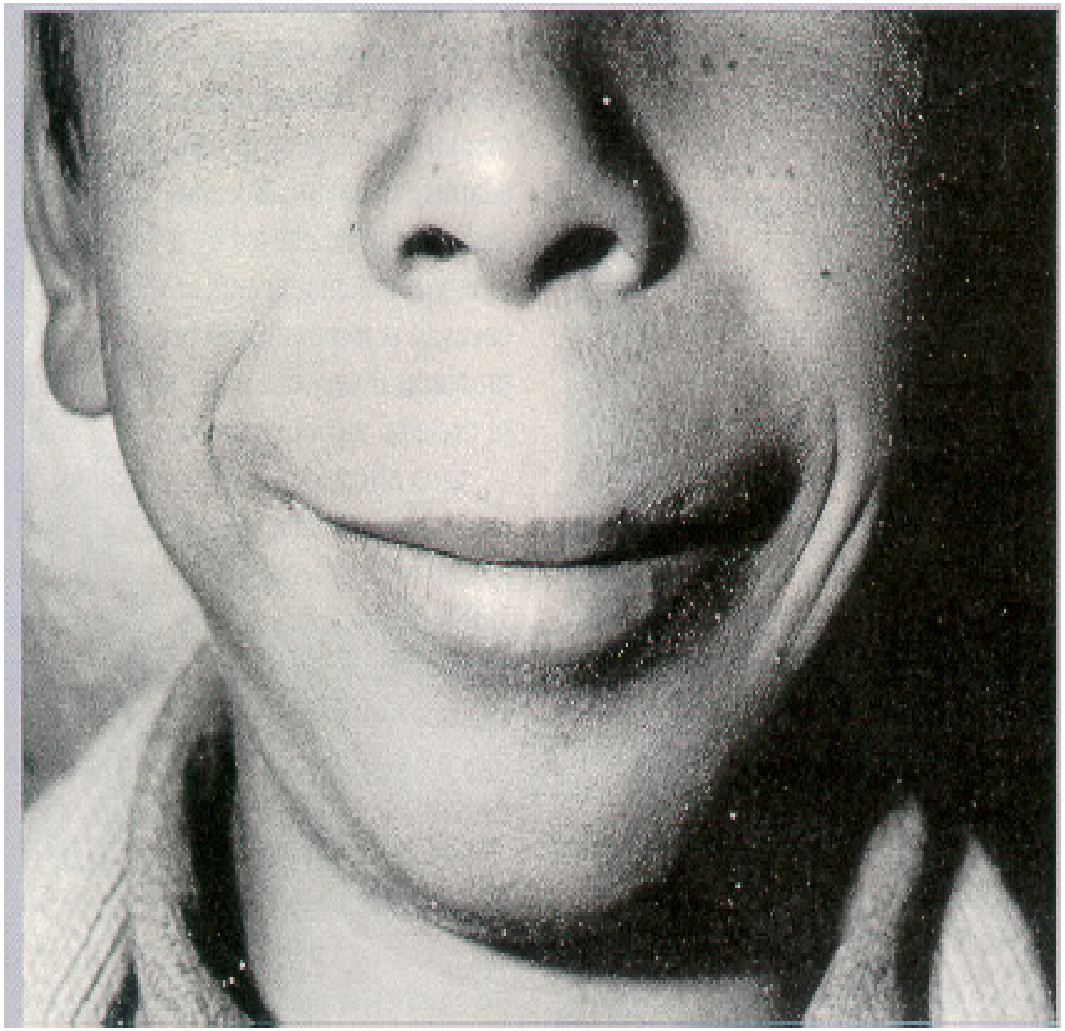
- Documenting maternal alcohol exposure is critical, but often difficult to obtain
- Maternal alcohol use not essential to making FAS diagnosis
- Can make diagnosis 2 ways
  - Confirmed prenatal alcohol exposure
  - Unknown maternal alcohol exposure

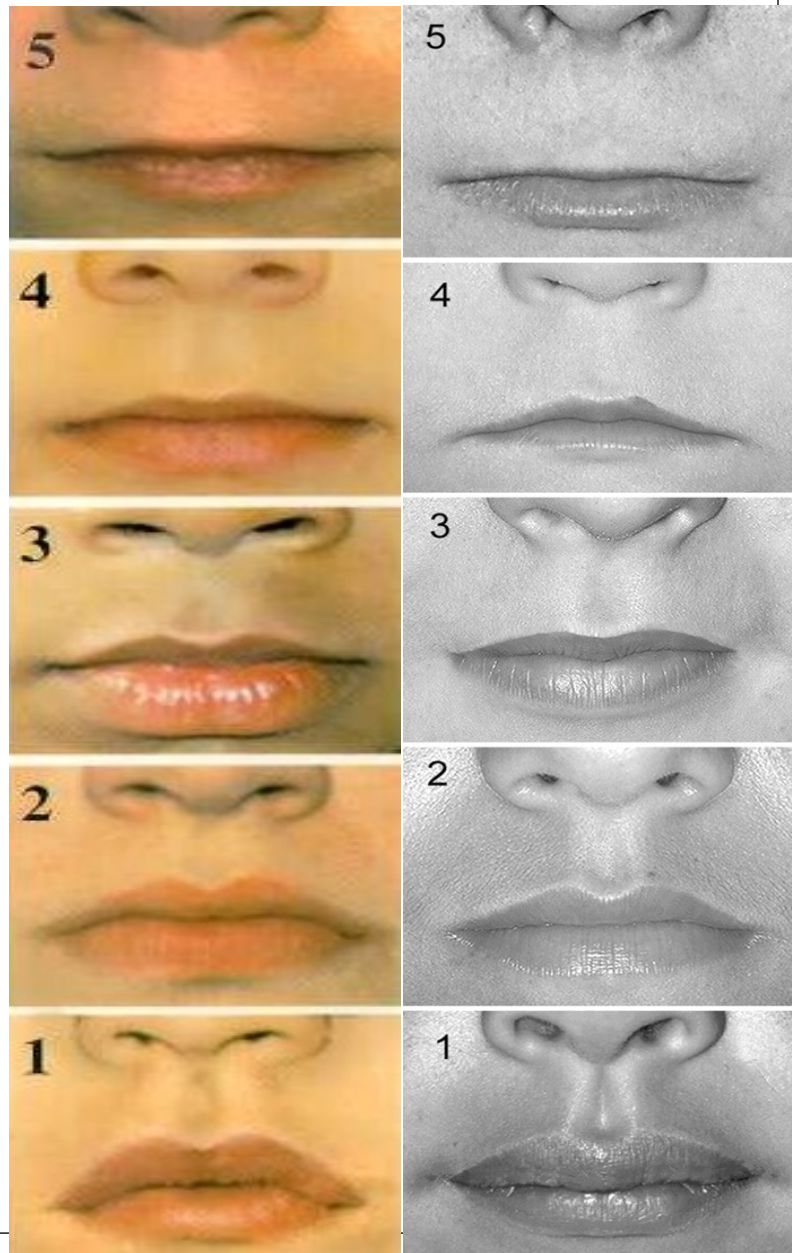
FAS Diagnostic Criteria

- Documentation of all 3 facial abnormalities
  - Smooth philtrum
    - Lip philtrum guide 4 or 5
  - Thin vermillion
    - Lip philtrum guide 4 or 5
  - Small palpebral fissures
    - $\leq 10^{th}$ percentile
- Documentation of growth deficits
- Documentation of CNS or neurobehavioral disorders

*CDC/NCBDDD Scientific Working Group, 2004

Philtrum and Vermilion





Facies in Fetal Alcohol Syndrome

Discriminating Features

short palpebral fissures

indistinct philtrum

thin upper lip

Associated Features

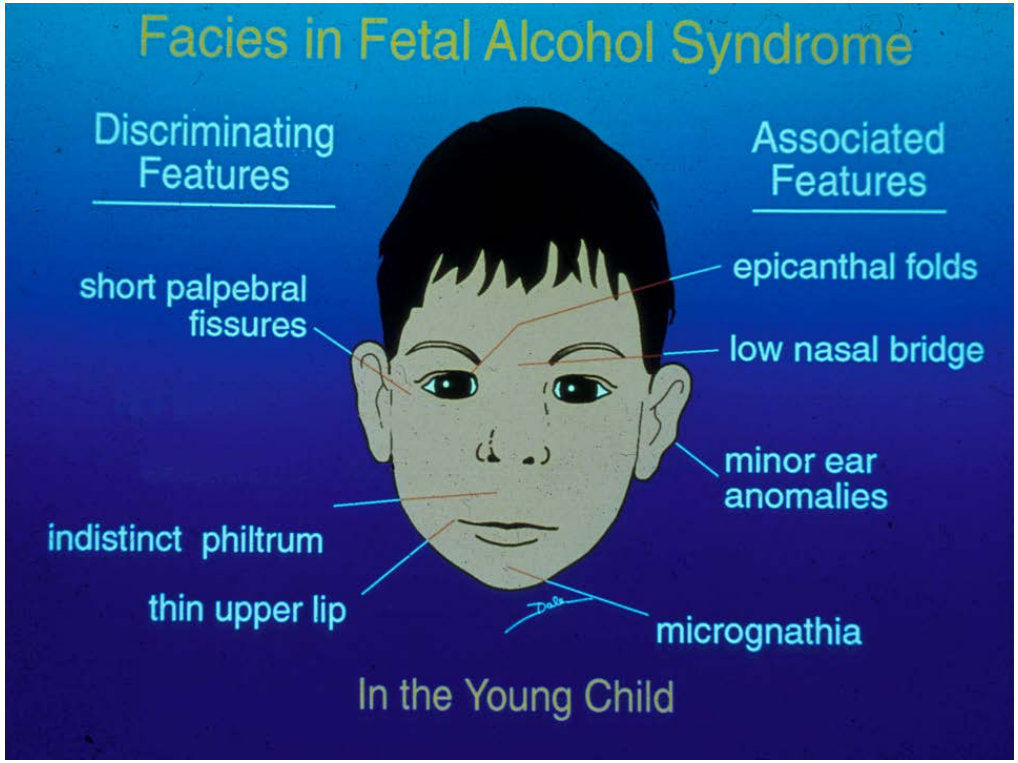
epicanthal folds

low nasal bridge

minor ear anomalies

micrognathia

In the Young Child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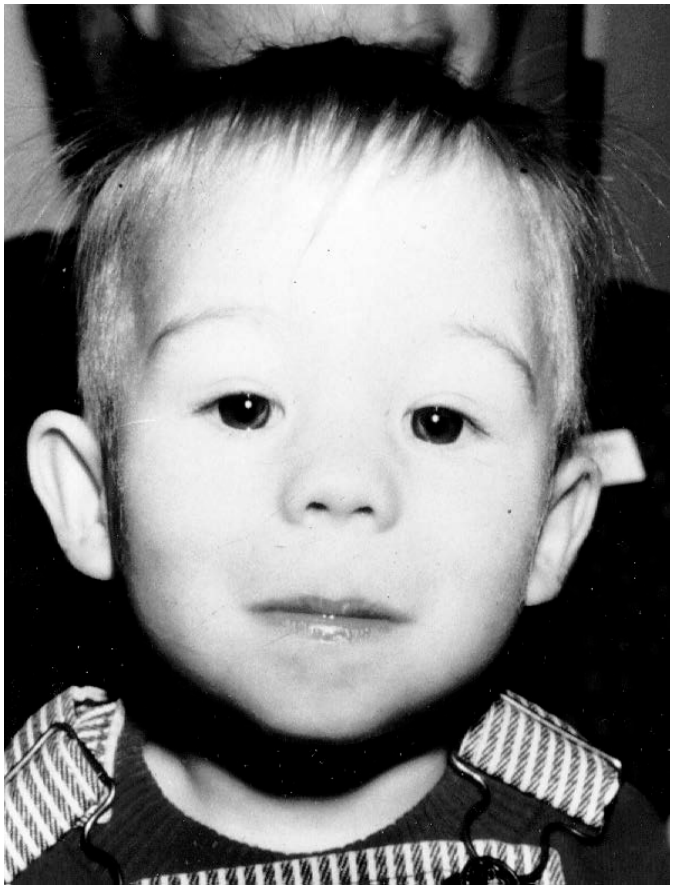

FAS Diagnostic Criteria

- Documentation of Central Nervous System or Neurobehavioral Disorders
  - Structural
  - Neurological
  - Functional

FAS Diagnostic Criteria

- Structural disorders
  - Head circumference (OFC) $\leq 10^{th}$ percentile
  - Brain abnormalities observed via
    - Imaging
    - Seizures
    - Impaired motor skills

FAS Diagnostic Criteria

- Neurological disorders
  - Seizures not due to postnatal insult
  - Impaired motor skills
  - Sensorineural hearing loss
  - Memory loss
  - Poor eye-hand coordination

FAS Diagnostic Criteria

- Functional disorders
  - Below average scores on standardized instrument or clinical impression of functional deficit in one of the following domains:

- General cognitive deficits
- Executive functions
- Motor functions
- Social skills
- Attention deficit/ hyperactivity
- Mental health problems
- Other

Developmental Concerns

Dysmaturity

Timelines:

Chronological age ——— 18
Expressive language ——— 23
Social maturity ——— 12
Math skills ——— 8
Reading decoding ——— 14
Reading comprehension ——— 9

We expect children at their chronological age to.....	But if the child is developmentally younger, they may.....
Chronological Age 5	Age 5 going on 2 developmentally
Go to school	Play at home, take naps
Follow three instructions	Follow one instruction, be shown
Sit still for 20 minutes	Be active, sit still 5–10 minutes
Play cooperatively, share	Engage in parallel play
Take turns	Always want their way
Chronological Age 10	Age 10 going on 6 developmentally
Listen and pay attention for an hour	Pay attention for about 10 minutes
Read and write fluently	Learn to write and read
Learn from worksheets	Learn by doing, experiencing
Structure their own recess	Need supervised and structured play
Get along and solve problems	Learn to problem solve
Have physical stamina, not tire easily	Become easily fatigued, overwhelmed
Chronological Age 18	Age 18 going on 10 developmentally
Be on the verge of independence	Need structure and guidance
Drive	Play with trucks
Graduate from high school	Still be dependent
Have a plan for their life	Be in the "now", may not plan ahead
Have relationships, safe sexual behavior	Be immature, curious, impulsive
Act responsibly	Act responsibly for a younger age level

Concerns in Infancy and Early Childhood

- Poor habituation
- Irritability in infancy
- Poor visual focus
- Sleep difficulties
- Mild developmental delays
- Distractibility and hyperactivity
- Difficulty adapting to change
- Difficulty following directions

Concerns in Middle Childhood

- Difficulty predicting and/or understanding consequences
- Appearance of capability without actual ability to perform
- Potential for emerging discrepancy between comprehension skills and expressive language
- Hyperactivity, memory deficits, impulsivity
- Poor comprehension of social rules/expectations

Concerns in Adolescence

- Poor adaptive functioning
- Confabulation—lying or stealing often without malice and arising from concrete thinking
- Faulty logic
- Low self-image and motivation
- Academic achievement lower than expected
- Inappropriate sexual behavior

Concerns in Adolescence

- May seem more able than they really are
- Impulsivity takes on possible dire consequences
- Lack of time awareness accentuated
- Relationship difficulties
- Unreliable/dangerous with money
- Mental health problems—depression, anxiety
- Possible trouble with law, substance abuse if unsupervised

Concerns in Adulthood

- Not as much known about this
- May seem more capable than they really are
- Development may continue to be uneven
- Secondary disabilities may predominate
- Natural support network may fall away
- Available services may be crisis oriented, not prevention or support based
- Employment failure likely

Concerns in Adulthood

- Vigilance needed for addictions
- Poor comprehension of social expectations
- Vulnerable to social, sexual, financial exploitation by others
- Need for supervised employment and housing
- Depression, anxiety

Summary of Behaviors and Outcomes

Behavior	Outcome
Poor judgment	Easily victimized
Attention deficits	Unfocused/distractible
Arithmetic disability	Difficulty handling money
Memory impairment	Difficultly learning from experience
Difficulty abstracting	Difficultly understanding consequences
Disoriented in time/space	Difficulty perceiving social cues
Impulsivity	Poor frustration tolerance

Potential Secondary Outcomes

- Mental health problems (over 90%)
- Trouble with the law (60%)
- Sexual misconduct (49%)
- Disrupted school experiences (60%)
- Problems with alcohol and/or drug use (35%)
- Confinement (50%)

FASD

- Screening
- Diagnosis
- Treatment

Factors Impacting Treatment

Primary Protective Factors

- Environmental
  - Living in a stable and nurturing home (particularly ages 8-12)
  - Being diagnosed before age 6
  - Not being a victim of violence
  - Not having frequent changes of household
  - Having received developmental disabilities services
- Intrinsic
  - Having a diagnosis of FAS (rather than other effects of alcohol exposure)
  - IQ score below 70

Secondary Protection Factors

- Diagnosis as intervention
- Protective factors as a guide
- Family education—convey message of hope and critical need for support
- Increased supervision throughout adolescence and early adulthood
- Proactive preparation for adulthood
- Plan for supported living and employment
- Proactive mental health services
- Community education

Family Stress: Child Issues

- **May "look good"**-others may not understand challenges and fail to support family
- **Difficulty learning from experience**-need to endure frustrating "re-learning"
- **Distractibility/impulsivity**-need for constant vigilance and supervision
- **Social difficulties**-may lead to isolation of the entire family
- **Sleep disturbances**-disrupted sleep for parent

Family Stress: Parent Issues

- **Alcohol use** and parenting child with FASD are a poor fit
- **Prior parenting strategies** may not work—leading to frustration and blame
- **Exhaustion** plays role in parental decision-making
- **Relationships** with spouse and other children may deteriorate

Family Stress: Community Issues

- Lack of knowledgeable medical providers and school personnel—may lead to delayed diagnosis and inappropriate interventions
- Lack of needed resources
  - Child care programs
  - Small classroom sizes
  - Appropriate after-school programs
  - Financial assistance
  - Supervised living and employment arrangements
- Lack of appropriate criminal justice options

Interventions

Behavioral Interventions

- Strategies traditionally gleaned from other disabilities and practical wisdom gained by parents and clinicians.
- In general, helpful interventions include:
  - Stable home environment
  - Working with educational staff or therapists and working with social services (e.g., foster care) to determine individualized treatment plans
- If developmental delay is suspected in a child under age three, refer to early intervention program.

Educational Interventions

- Special education placement
- 501 plans
- Individualized Education Plan (IEP)

Evidence-based Interventions for Children with FASDs

- **Project Bruin Buddies** – social skills training (www.cdc.gov/FASD)
- **Georgia Math Interactive Learning Experience** – math knowledge and skills training
- **ALERT program** – behavior regulation and executive functioning
- **Parent therapy program** – improve parent effectiveness and reduce behavior problems

Family Stress Intervention: Respite Care

- Short-term, temporary care of children with disabilities
- Provided in the home or in a variety of out of home settings
- Helps families avoid burnout, stress, etc.
- See resource list for National Respite Locator Service information
- If no program available, suggest creating an informal network of parents for respite care

Family Stress Intervention: Support Groups

- Provide a safe, non-judgmental and confidential outlet for sharing
- Help parents cope and develop positive attitudes about the future
- Allow members to help each other through sharing of knowledge and experience
- Offer resources and information not easily available outside the group

(Parent to Parent of Pennsylvania)

Family Stress Intervention: Psychotherapy

- Family therapy
  - Help modulate stress
  - Assist with relationship issues
- Behavior therapy
  - "Talk" therapy not appropriate
  - Assist family with providing structure and appropriate redirection and consequences
  - Assist family in planning environmental modifications
- Finding a therapist—utilize professional with developmental disability experience

Parental Strategies

- "Strength-based parenting"—search for, affirm, and build on child's strengths
- "Reframe" negative behaviors
- Use concrete language
- Use repetition and build routines
- Maintain high level of supervision, despite chronological age
- Educate all family members on FASD issues
- School and community advocacy

Family Education

- Advocacy education/resources
- Developmental progression and prevention of secondary conditions
  - Increased supervision
  - Sex education
- Planning for adulthood
  - Supervision & Financial
  - Employment & Housing

Alternative Treatments

- Biofeedback
- Recreational therapy
- Relaxation therapy
- Creative art therapy
- Yoga/exercise
- Vitamins/herbal treatment

Special Topics: Abuse/Neglect Issues

- Children with prenatal alcohol exposure may be at-risk for abuse and neglect due to child characteristics
- Child in birth-home may be in environment of continued alcohol abuse

Special Topics: Alcohol Addiction and Parenting

- FASD and parental addiction a dangerous mix
- Parent characteristics & alcohol use:
  - Impaired response time
  - Impaired judgment
  - Irritability
- Life stressors
  - Money worries
  - Job stress
  - Interpersonal stress

Special Topics: Adults with FASD as Parents

- Impulsivity and poor judgment—poor fit with care of child
- Vulnerable to model ineffective parenting practices
- High risk for child neglect
- Will need extensive support
  - Behavior management
  - Home management
- Multi-generational alcohol use during pregnancy may occur

Referral Process

Considerations for Initiating Referrals

- Confirmed heavy prenatal alcohol exposure
- In the following instances, with or without maternal alcohol exposure confirmation:
  - Any report of concern by a parent or caregiver
  - When all three facial features are present
  - When one or more facial features are present along with growth deficits in height and/or weight
- In the following instances, with or without maternal alcohol exposure confirmation:
  - When one or more facial features are present along with one or more CNS or neurobehavioral deficits
  - When one or more facial features are present along with growth deficits and one or more CNS or neurobehavioral deficits

Role of Health Providers

Primary Care Provider/Specialist

- Manage routine issues related to health care and FAS through pharmacotherapy
  - Attention problems
  - Depression and mood swings
  - Sleep
  - Aggression and impulse control
- Educate/refer parent to prevent recurrence

Role of Health Providers

Psychologist

- Neurodevelopmental testing

Family Therapist

- Maximize potential through early and persistent individual and family interventions
- Use of adaptive techniques to overcome disability

Client/Family Advocate

- Provide respite opportunities for family
- Ensure that proper referrals are made for family and child within the resources of their community
- Provide long-term foresight and planning
- Access to social services

Fetal Alcohol Spectrum Disorders

We see what we look for….

- and –

we look for what we know!

Fetal Alcohol Spectrum Disorders

- The best practices in the care of a child with an FASD are….

Early recognition and

Early intervention!

Juvenile Bipolar Disorder

Assessment of Juvenile Bipolar Disorder

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FEBRUARY 11, 2011

Objectives

During this videoconference, participants will…

- Review the prevalence of Bipolar Disorder (BPD) and, more specifically, Juvenile Bipolar Disorder (JBP)
- Explore the diagnostic criteria and assessments of the varying presentations of Bipolar Disorder (BPD) in children and adolescents
- Discuss differential diagnosis and most common comorbid disorders in children and adolescents
- Examine the controversies associated with a diagnosis of BPD in children and adolescents
- Review an alternative diagnosis of Temper Dysregulation Disorder with Dysphoria (TDD) proposed for inclusion in the DSM-V
- Discuss a case scenario and an assessment and diagnosis of an 8 year old girl

What is Bipolar Disorder (BPD)?

- BPD is a mood disorder
- Mood is “a conscious state of mind or predominant feeling”
- Abnormal mood changes reflect an inability to regulate emotions
- The highs and lows of mood are so extreme that a persons’ ability to judge reality and adequately adjust behaviors is compromised
- Affect is also used to describe mood

Mondimore (2006), p. 8

Ashley (8 years old)

Has rages, gets angry, breaks, and throws things

Talks non-stop

Does not care about punishments

Has pulled her pants down to let the dog lick her private parts

Once she turned over the kitchen table

Makes funny noises and acts silly

She thinks she is smarter than the other kids

It can take her 2 to 3 hours to go to sleep and often wakes up 2 to 3 hours early

Some days she is irritable, sad, and tired

Her "too happy moods" don't last for more than 2 days in a row.

She is overactive and energetic

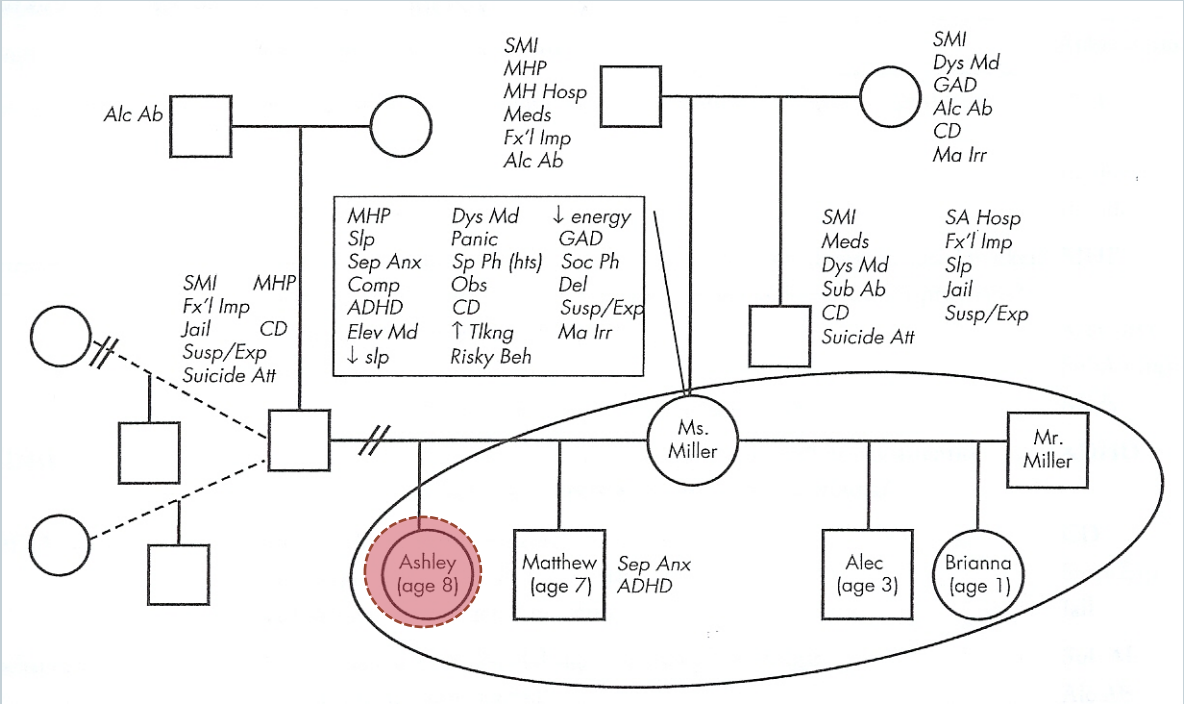
Tearful moods without explanation last for 20 minutes and sometimes a whole day

Low moods and rages started when she was two years old

Ashley also experienced racing thoughts and increase distractibility during her "high" mood states

Danner & Fristad (2009)

Family Genogram



Danner & Fristad (2009)

Prevalence

Prevalence of BPD in Adults

- Lifetime prevalence ranges from 0.4% to 1.6%
- Average age of onset is 20 for both males and females

DSM IV-TR

Prevalence of Juvenile Bipolar Disorder

- According to existing DSM criteria
  - General population in the U.S.
    - 1% of adolescents in United States have B.P.
    - Diagnosis for JBP increased from 0.025% in 1994 to 1.0% in 2003 in clinic sample (Parens & Johnston, 2010)
  - Psychiatric settings
    - 10% to 30% of pediatric clients in specialized psychiatric settings have BPD
    - 30% to 40% of children or adolescents in inpatients units have BPD
  - The prevalence varies depending on the type of practice (Kowatch et al., 2009)

Prevalence of Juvenile Bipolar Disorder

- Age of Onset
  - Very early — younger than 13 years — 28%
  - Early — ages 13 to 18 — 38%
  - Adults — older than 18 — 34%
- Studies of younger children with bipolar disorder have showed a mean age at onset of 7.3 (SD = 3) years
- The earlier the onset the more serious form of the disorder
- As many as 65% of adults with BP have an onset of their disorder in childhood and adolescence

Kowatch et al. (2009), Wozniak et al. (2010), and Soutullo et al. (2009)

Prognosis, Course, and Outcome

- Typically a progressive condition involving more frequent manic or hypomanic episodes as a person ages
- A person who experiences rapid cycling typically has a poorer prognosis
- 60% of those with BPD experience interpersonal and occupational difficulties between acute episodes
- 4-24% of those with Bipolar I and 1-5% with Bipolar II have first-degree biological relatives who have Bipolar I Disorder
- Those who have first-degree biological relatives with BPD are more likely to experience early onset of the disorder

DSM IV-TR (2000)

Diagnostic Criteria

DSM IV-TR

Purpose of an Accurate Diagnosis

- Patients with BD are generally not diagnosed until at least 10 years of full blown illness
- Untreated illness is associated with the highest suicide risk
- Mean average of delayed diagnosis is 1.5 years (Soutullo, 2009)
- Early intervention may prevent illness progression and reduce morbidity and mortality
  - Has not been proven that treating early in the course may be associated with less complicated treatment regime Duffy (2009)

Bipolar I

One episode of Mania for at least 1 week

Bipolar II

Least 1 Major Depression episode + Least 1 episode of Hypomania for 4 days (no episodes of mania)

Mania and Hypomania: Abnormally and persistently elevated, expansive, or irritable mood

- Inflated self esteem or grandiosity
- Decreased need for sleep
- More talkative than usual or pressure to keep talking
- Flight of ideas or subjective experience than thoughts are racing
- Distractibility
- Increase in goal-directed activity or psychomotor agitation,
- Excessive involvement in pleasurable activities that have a high potential for painful consequences

if mood is elevated and expansive need at least 3 symptoms

if mood is only irritable need at least 4 symptoms

Bipolar II

Least 1 Major Depression episode + Least 1 episode of Hypomania for 4 days (no episodes of mania)

Major Depression episode

Least 5 symptoms present for 2 consecutive weeks. At least one symptom is 1 or 2

every day (sad or empty, tearful) (irritable in children and adolescents)

2. Diminished interest in almost all activities
3. Significant weight loss or gain (5% a month)– decrease or increase appetite
4. Insomnia or hypersomnia
5. Psychomotor agitation or retardation
6. Fatigue or loss of energy
7. Feeling worthless and guilty
8. Inability to concentrate
9. Recurrent thoughts of death

Comparing Symptoms of Mania in BPD

Adults	Children
• Inflated self esteem or grandiosity • Decreased need for sleep • More talkative than usual or pressure to keep talking • Flight of ideas or subjective experience than thoughts are racing • Distractibility • Increase in goal-directed activity or psychomotor agitation	• Irritability • Acting out reckless behaviors • Inappropriate silliness • Uninhibited social interaction • Extended tantrums and rage • Intentional aggression • Suicidality • Hypersexuality • Rapid cycling

Common Assessment
Child Bipolar Questionnaire (CBQ)

- Some of the items that address mania/hypomania are:
  - Has periods of high, frenetic and motor activation
  - Has periods of excessive and rapid speech
  - Has exaggerated ideas about self or abilities
  - Tells tall tales; embellishes or exaggerates
  - Has elated or silly, goofy, giddy mood states
  - Displays precocious sexual curiosity
  - Has protracted, explosive temper tantrums
  - Has acknowledged experiencing hallucinations
  - Has many ideas at once
  - Displays abrupt, rapid mood swings

Papolos, Cockerham, & Hennon (2004)

Assessment for BPD

- General background information
  - Pregnancy and early development
  - Psychosocial stressors
  - Medical history
  - School history and current functioning
  - Current functioning with peer at home
- Family history of mental health problems
- Unique symptoms of BPD in children and adolescents
  - Characteristics of symptoms exceed developmentally appropriate levels

Family History of Mental Health Problems

- Research has shown an increased familial risk for BP-I disorder in relatives of children diagnosed with DSM-IV BP-I. Relatives of children with BP-I were also at increased risk for other psychiatric disorders frequently associated with pediatric BP-I.
  - Psychosis
  - Major Depression
  - Multiple anxiety disorders
  - ADHD
  - Oppositional defiant disorder
  - Conduct disorder
  - Substance (alcohol or drug) use (abuse or dependence)

Wozniak et al. (2009)

Unique Symptoms in Children

Symptoms of depression in children resemble those in adults

- Typical depressive symptoms include:
  - Sad
  - Irritable
  - Anxious
  - Argumentative
  - Aggressive and/or whiny to an excessive degree,
  - Unmotivated to play, showing little to no pleasure in play, and displaying lack of curiosity

Few children who present with mania display the symptoms listed in the current DSM criteria of Bipolar Disorder

- Typical manic symptoms include:
  - Severe irritability (*affective storms*) or intense and prolonged rages
  - Elevated or euphoric mood, unusually happy, silly, or giddy out of context to a problematic degree
  - Grandiose behaviors
  - Flight of ideas
  - Decreased need for sleep
  - Hypersexuality

DSM IV-TR

Differential Diagnosis

Differential Diagnosis

- *Persistent and intense irritable mood* is the main symptom of JBD distinguishing it from other disorders
- How is it different in JBP?
  - Usually called an *affective storm*
  - Aggressive temper outburst
  - Out of control behaviors
  - Prolonged period of dysregulation (could present for hours at the time)

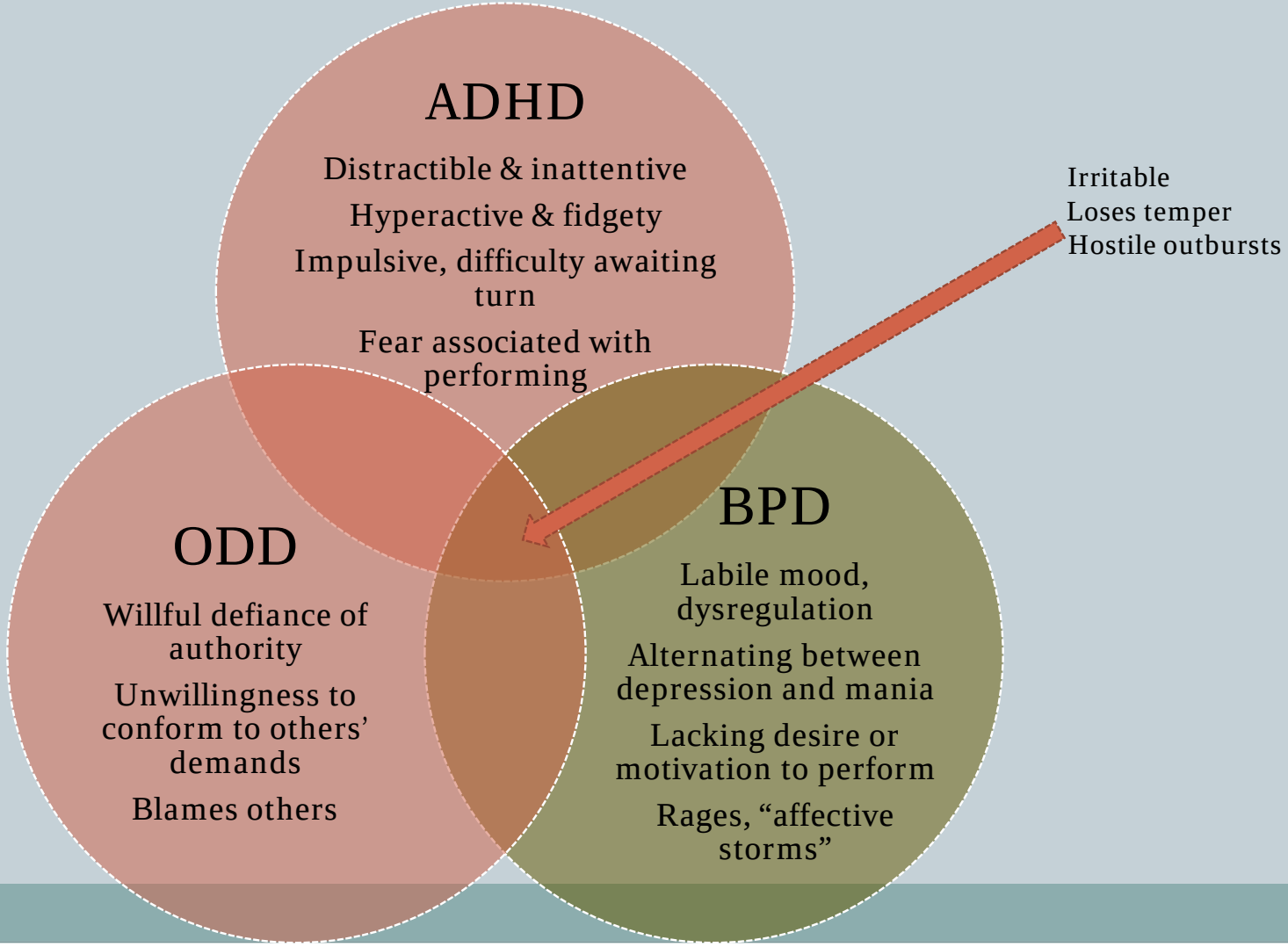
Grier et al. (2005)

Differential Diagnosis

- Other behaviors to look for are:
  - Acting out daredevil behaviors
  - Inappropriate silliness
  - Uninhibited social interaction
  - Extended tantrums and rage
  - Intentional aggression
  - Suicidality

Grier et al. (2005)

Overlapping Symptoms



Common Comorbid Disorders

Comorbid Disorders of JBD

- Children with bipolar disorder are more like to have higher rates of mental problems than children without bipolar disorder
  - More comorbid disorders
  - Impaired family and peer relationships
  - History of bipolar disorder in first and second order family members
  - Increased levels school failure and levels of substance abuse
  - More suicide attempts and completions

Kowatch et al. (2009)

Comorbid Disorders of JBD

COMORBID DISORDER	PREPUBERTAL (%)	ADOLESCENT (%)
ADHD	70-90	30-60
Anxiety disorders	20-30	30-40
Conduct disorders	30-40	30-60
ODD	60-90	20-30
Substance abuse	10	40-50
Learning disabilities	30-40	30-40

Kowatch et al. (2009)

Comorbid Disorders of JBD

- Children with Bipolar disorders are more like to have higher rates of mental problems than children without Bipolar disorder
  - More comorbid disorders
  - Impaired family and peer relationships
  - Increased levels school failure and levels of substance abuse
  - More suicide attempts and completions

Kowatch et al. (2009)

Controversies of BPD Diagnosis in Children and Adolescents

Concerns About the Current Diagnostic Description of BPD

- In recent years, the diagnosis of BPD in children in the U.S. has increased by 40%
- Possible reasons for the increase in diagnosis
  - Practitioners are more aware of the constellation of symptoms that point to BPD
  - OR
  - The criteria in the ICD-10* are less stringent than those in the DSM IV-TR (Parens and Johnson, 2009)
  - OR
  - The current diagnostic criteria lack appropriate descriptions of symptoms present in most children (esp. regarding the irritability and non-episodic nature of the condition)

*International Classification of Diseases – 10 (2010)

International Comparison

- Higher diagnostic rates in the US than many other nations
- A retrospective study in Spain supports the findings in the U.S.
- Research studies in Turkey and in other countries strongly suggest that pediatric BD may not be rare but that is may be difficult to diagnose (Emiruglu & Diler, 2009)
- A study in Canada had not found evidence of mania occurring prior to adolescence. It is hypothesized that U.S. may find manic episodes during childhood due to the clients exposure to antidepressants and/or stimulants (Duffy, 2009)

Temper Dysregulation Disorder with Dysphoria (TDD)

PROPOSED FOR INCLUSION IN THE *DISORDERS USUALLY FIRST DIAGNOSED IN INFANCY, CHILDHOOD, OR ADOLESCENCE* SECTION OF THE DSM-V

Proposed Criteria for TDD

DSM5.org (2011)

Rationale for Proposal

- Excludes a small percentage of children who fit the current criteria for BPD
- Reflect the unique features of a disorder exhibited by children
  - Non-episodic, rapid cycling
  - Characterized by severe irritability rather than euphoria
  - Angry outbursts
- Captures features of a syndrome called “severe mood dysregulation”
- Captures symptoms that do not overlap with ADHD, therefore, providing a distinct diagnosis for the constellation of criteria
- Those with TDD are not at risk for developing episodic BPD as compared with those with BPD

DSM5.org (2011)

Case Scenario

ASHLEY, 8 YEAR OLD GIRL

Danner & Fristad (2009)

Case Scenario

- Ashley is an 8 year old who lives with her biological mother, stepfather, full biological brother Matthew (age 7), and two maternal half-siblings (ages 3 and 1). Ashley has not seen her biological father since age 2.5 when he left the family
- Mother reports no drug use during pregnancy and normal birth
- Mother reported that Ashley was a fussy baby and cried most of the day
- There was one developmental delay– language

Danner & Fristad (2009)

Case Scenario

- Psychosocial stressors started when her father left the family and continued when grandmother took care of Ashley while mother worked (age 2). At age 4 they moved in with stepfather. During that year the police arrived at the house looking for Ashley's aunt who was using drugs and was later found unconscious in the street.
- Ashley had good physical health all of her life with no major illnesses, injuries, head traumas, or accidents.
- Ashley started kindergarten (age 5) and teachers made no complains to mother. During 1st grade Ashley was held back due to lack of satisfactory progress. She was moved to a different school but poor performance continued. Angry outbursts, stealing, and disruptive behavior started at this time in school.

Danner & Fristad (2009)

Case Scenario

- Ashley has had both grumpy moods and “rages” since she was 2 years old. Mother reports that now Ashley is mad two thirds of the day and she gets mean and aggressive. Ashley cannot be calmed for periods of 1 to 2 hours which occur 3 to 4 times per day. Ashley has had 4-5 nonconsecutive days in a period of 2 weeks where she was explosive or elated more often than not. Ashley experiences a decreased need for sleep not associated with fatigue and jittery feelings with psychomotor agitation.
- Ashley has sad moods with no energy and talks in slow motion for 20 minutes each day sometimes lasting an entire day.

Danner & Fristad (2009)

Resources

You might have a child with BP if...

- You spend more on meds than on food, shelter, or both combined!
- Your house resembles Martha Stewart's new address and not her old address.
- You have the psychiatrist on speed dial.
- The school has YOU on speed dial!
- You've had to change pdocs more often than your child changes clothes.
- Everyone at the school knows your child, and gives you "the look".
- All of your friends and family are ready, willing, and able to give YOU advice on what to do with your child(ren) when they're sure they have all the answers, but refuse to even babysit for you for one night.
- The neighborhood Wal-Mart greeter says "Oh, it's you again" instead of "Hi! Welcome to Wal-Mart!" when you and your child(ren) come in the store.
- Strangers feel the need to tell you how they could raise your child better.
- It takes a psychiatric consult to find out what med is safe to give your child for the common cold.
- Your neighbors children have soccer practice 2 days a week, your child has therapy appointments to learn relaxation techniques instead.
- You drive like you're 100 years old for fear of an object being hurled at your head.
- You have more doctors and hospitals programmed into your cell phone than you have friends.

Resources

- Organization websites
  - Child & Adolescent Bipolar Foundation www.bpkids.org
  - Georgia Childhood Bipolar Foundation www.gcbf.org
  - Juvenile Bipolar Research Foundation www.bpchildresearch.org
- National Institute of Mental Health (NIMH)
- Books
  - Raising a moody child: How to cope with depression and bipolar disorders (Fristad & Goldberg, 2004)
  - The bipolar child: The definitive and reassuring guide to childhood's most misunderstood disorder (3rd edition) (Papolos & Papolos, 2006)
  - What works for bipolar kids: Help and hope for parents (Pavuluri, 2008)

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TREATMENT OF JUVENILE BIPOLAR DISORDER

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MARCH 11, 2011

Objectives

During this videoconference, participants will…

- Review the factors associated with an effective assessment and diagnosis of juvenile bipolar disorder (JBD)
- Explore evidence-based treatments that address JBD
- Examine the role of monitoring to raise individual and family awareness and skills for improving treatment effectiveness
- Discuss a case scenario involving treatment implications for a 12 year old girl with JBD

Review of Assessment & Diagnosis of JBD

Negotiating the Tension of JBD Diagnosis

JBD Diagnosis Deferred

JBD Diagnosis Confirmed

- Prevent from labeling child
- Explore other diagnoses and associated treatments

- Improper treatments may exacerbate symptoms (i.e. use of stimulants with comorbid ADHD)
- Delayed treatment for mood-related symptoms may result in precipitous development of JBD

- Access appropriate pharmacological and psychotherapeutic treatments
- Moderate the course that can result in adult BPD

- Mood stabilizers typically have significant side effects

Bipolar Spectrum Disorder

- Referred to as a spectrum disorder due to common symptom overlap and comorbidity with other disorders
- Research typically involves adults in treatment in hospital settings
  - Results reflect treatments applied in extreme cases
  - National studies focused on presentation of JBD in children and adolescents have yet to be undertaken.
- Symptoms of mania in children and adolescents are thought to be different for those in adults

Differential diagnosis

- *Persistent and intense irritable mood* is the main symptom of JBD distinguishing it from other disorders
- How is mania different in JBD?
  - Usually called an *affective storm*
  - Aggressive temper outburst
  - Out of control behaviors
  - Prolonged period of dysregulation (could present for hours at the time)

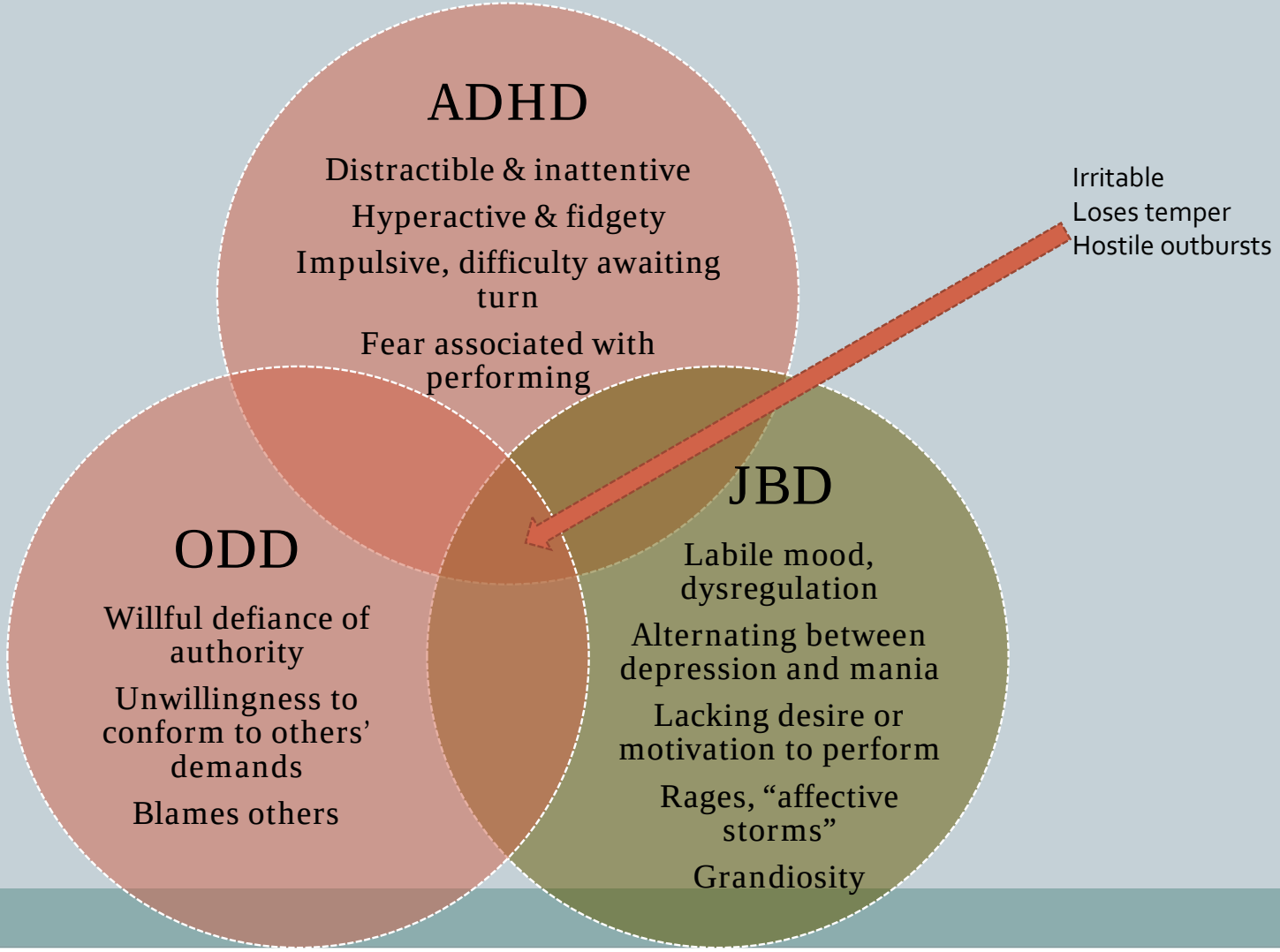
Grier et al. (2005)

Differential Diagnosis

- Other behaviors to look for
  - Acting out daredevil behaviors
  - Inappropriate silliness
  - Uninhibited social interaction
  - Extended tantrums and rage
  - Intentional aggression
  - Suicidality
  - Grandiosity

Grier et al. (2005)

Overlapping Symptoms



Comparing Children

Normal

- Stable mood
- Fantasize about their future while separating fantasy form reality
- Track thoughts
- Methodical speech
- Normal magical thinking as a basis for play

JBD

- Mood lability, unstable
- Convinced of the reality of their grandiose ideas
- Complain about thoughts moving too quickly
- Jump from topic to topic while speaking
- Act on magical thoughts by taking unnecessary risks

Mondimore, 2006

Comparing Children

ADHD

- Stable mood
- Disruptive in a classroom – clowning around, restless

JBD

- Mood lability, unstable mood swings
- Tell a teacher that the lessons are being taught incorrectly or try to take over

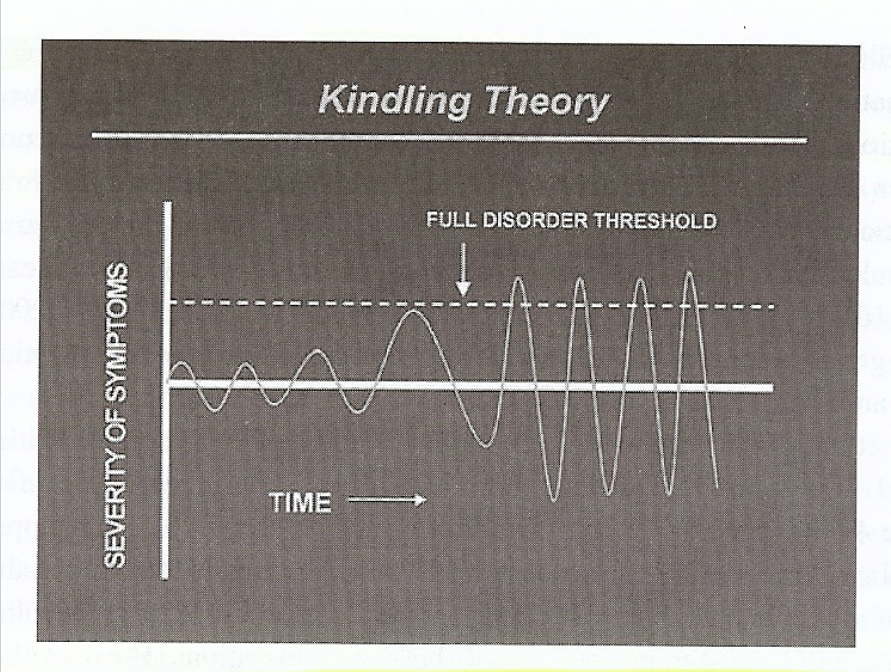
Mondimore, 2006

Making a Comprehensive Diagnosis

- Overlooking comorbidity of bipolar disorder
  - Stimulants and antidepressants addressing ADHD and depressive symptoms may trigger mania in those with undiagnosed bipolar disorder
- Overlooking comorbidity of ADHD
  - Focusing exclusively on and medicating for bipolar disorder may result in side effects and fail to improve symptoms related to ADHD

Parens & Johnston, 2010

Kindling Theory



- "The theory holds that with the combination of psychosocial stress and genetic vulnerability, greater destabilization occurs until a full mood episode occurs." (p. 316)
- "Development of affective disorder begins with subthreshold symptoms that over time combined with psychosocial stress eventually develop to a fully syndromal disorder; without intervention, the disorder naturally worsens in severity and course." (p. 317)

Chang, Gallelli, & Howe, 2007

Evidence-Based treatments for JBD

Types of Treatments

- *Pharmacotherapy*
  - Correct a neurochemical imbalance in the brain
- *Family Focused Treatment (FFT)*
  - A biopsychosocial model that targets adolescents (13-17 years old)
- *Psychoeducational Psychotherapy*
  - A biopsychosocial model that targets pre-teen (8 to 12 years old)

Pharmacotherapy

Categories of medications used to control mood cycling and other symptoms associated with JBD and comorbid conditions (i.e. ADHD)

- Mood stabilizers**
- Anticonvulsants – controls rapid cycling and mixed episodes in adults
- Antipsychotics**
- Selective seretonin reuptake inhibitors (SSRIs) – targets depressive symptoms
- Stimulants – used *only after* mood stabilization has occurred to address ADHD symptoms

Grier et al. (2005)

Pharmacotherapy

- If a child is formally diagnosed with JBD, how important do you consider medications?
- Would you consider recommending medication to a child if you think that he or she is likely to develop full blown JBD?
- What research has examined the effectiveness of medication in children with JBD?

Mood Stabilizers

- *Lithium Carbonate*
  - Research
    - Most studied mood stabilizer in children and adolescents
    - Only mood stabilizer approved by FDA for the treatment of “manic episodes” in children age 12 or older.
    - Studies suggested that 40% to 50% of manic children and adolescents with JBD will respond to the lithium monotherapy.
  - Targeted symptoms
    - Effective for the treatment of acute depression and mania in adolescents and children
    - Used for maintenance, pharmacotherapy prevents relapse in children and adolescents
- *Valproate*
  - *Research*
    - few studies involving limited numbers of children and adolescents that showed effectiveness
  - *Targeted symptoms*
    - *Showed to improve mania symptoms in children and adolescents*

Kowatch, 2009

Atypical Antipsychotics

- FDA approved the use of the following three antipsychotics in children and adolescents (age 10 to 17)
  - *Risperidone* – several studies showed the effectiveness in the treatment of irritability associated with JBD
  - *Aripiprazole (Abilify)* - two studies report that 70% of children and adolescents with bipolar responded to this drug
  - *Olanzapine (Zyprexa, Zydis)* –shown to be as effective as Risperidone in one study with preschoolers

Kowatch, 2009

Common Medication Side Effects by Class

- Mood stabilizers
  - Nausea
  - Sedation
  - Tremors
  - Involuntary movements (tardive dyskinesia)
  - Weight gain
  - Acne
  - Affect renal function (subsequent diabetes)
  - Development of hypothyroidism
  - Not be used during pregnancy
- Antipsychotics
  - Sleepy (somnolence)
  - Excessive or lack of movement (extrapyramidal disorder)
  - Fatigue

Medication Management

- Expect clients to be on medication for 12 to 18 months
- Reduction of medication may considered if child is euthymic or in remission
- Anticipation of possible relapse entails a decision between long-term treatment versus maintenance and cessation of medication

DISCUSSION QUESTION

- What consideration would you take if the family ask you to help them make a decision regarding maintenance or progressive cessation of medication?

Medication Management

- Monitor development of side effects
  - Movement disorder (tardive dyskinesia)
  - Weight gain
  - Pregnancy Insomnia
  - Sedation
  - Enuresis
  - Side effect of ADHD medication which may increase symptoms for BD

DISCUSSION QUESTIONS

- What is the role of the clinician in the management of side effects?
- What advice might you have for your client and family?

Break

Family Focus Treatment (FFT)

- A 21 session over 9 months treatment
- FFT's two main assumptions are
  - JBD symptoms affect the environment and vice versa.
  - Adolescents with JBD may also experience:
    - High rates of suicide
    - Hospitalizations
    - Drug and alcohol abuse
    - Conduct disorder
    - High potential for sexually transmitted diseases
    - Possibly falling back in school
    - Relational issues with peers
    - Difficulty with adherence to medication regimens
    - High level conflict families which correlate with recurrence of JBD symptoms

Miklowitz, 2005

FFT

- Goals:
  - Understand mood cycling and associated factors
  - Recognize vulnerabilities to the disease and plan to prevent or delay future symptoms
  - Accept the importance of medication
  - Develop adolescent's sense of identity in which illness is accepted along side one's strengths and abilities
  - Manage daily stressors that influence mood swings
  - Promote an environment conducive to long-term mood stability

Miklowitz, 2005

FFT

- Structure of program and intervention
  - Psychoeducation
    - Clarify individual goals
    - Review the symptoms
    - Develop individualized mood chart
    - Utilize the vulnerability/stress model
    - Increase awareness and management of risk and protective factors
    - Build a relapse prevention plan
  - Involve parents and other family members in monitoring and managing a stable environment
    - Communication enhancement
    - Problem-solving training

Miklowitz, 2005

Psychoeducational Psychotherapy

- Goals:
  - Take a “no-fault” approach to the illness.
  - Give space to the child with JBD to recuperate from the current episode.
  - Offer support, validation, and recognition to the family for the difficult experiences
  - Provide them with tools to help them cope with the illness.
- Research has shown that participants:
  - Learned about what to watch for
  - Increased knowledge about mood disorders
  - Feel much calmer
  - Talk to other parents in the same situation
  - Feel less alone and isolated
  - Recognize when moods are uncontrollable
  - Seek open exchange and look for good fit with providers
  - Accept the illness and focus on what it needs to be done

Fristad, 2003

Psychoeducational Psychotherapy

Multifamily group or single family treatment that lasts 8 weeks

Week	Parent group	Child group
1	Learn about Symptoms and disorders	Learn about symptoms and disorders
2	Learn about medications	Learn about medications
3	Learn about System of care (e.g. school)	Develop a “tool kit” to manage emotions
4	Learn about the negative family interaction patterns	Learn the Connection between thoughts, feelings, and actions (responsibility)
5	Improve Problem-solving coping skills	Improve problem-solving coping skills
6	Improve Communication coping skills	Improve nonverbal communication
7	Improve symptom management skills	Improve verbal communication skills
8	Review and graduate	Review and graduate

Fristad, 2006

Monitoring Treatment progress

Focus of Monitoring Activities

- Presence of symptoms
- Treatment management activities
- Reviewing progress
- Monitoring side effects

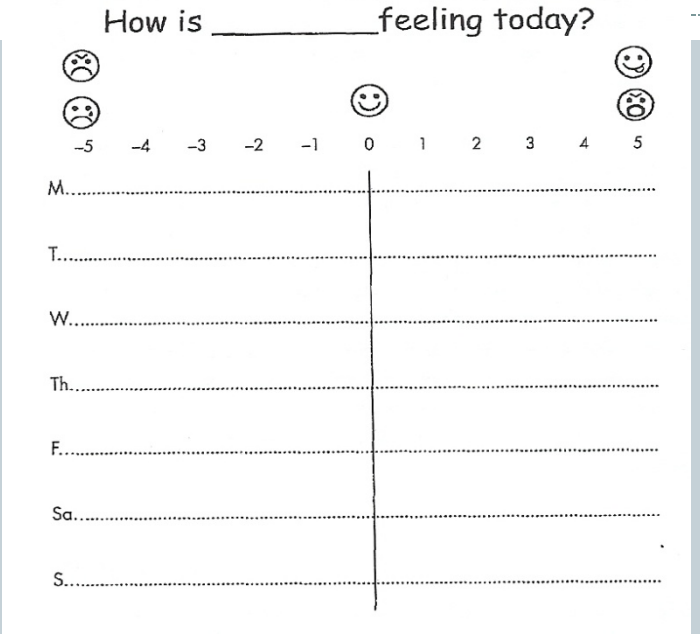
Monitoring Management of JBD

- How do you know when your client is getting better?
- Looking at the following list, discuss what would you be looking for in terms of improvement?
  - Medication
  - Individual Symptoms
  - Family environment
  - School environment

Monitoring Interventions

- Charting moods
- Actively listen to one another
- Paraphrasing
- Expressing negative feelings about specific behaviors
- Making positive requests for change
- Praising one another
- Naming the enemy
- Raising awareness of the connections among thoughts, feelings, and behaviors

Mood Chart Examples



Child's Name: _____ Treatment Provider/Program: _____

Medications (Type, Dose, Side Effects): _____

Month: _____

Date	Overall Rating (1=Great, 3=So-So, 5=Terrible)	Meds Taken?	Used Strategies (1=100%, 3=50%, 5=0%)	Weekly Comments (e.g., Life Event, Med Change, Med Side Effects, Sleep/Appetite Changes, Other)
1	1 2 3 4 5	Yes No	1 2 3 4 5	
2	1 2 3 4 5	Yes No	1 2 3 4 5	
3	1 2 3 4 5	Yes No	1 2 3 4 5	
4	1 2 3 4 5	Yes No	1 2 3 4 5	
5	1 2 3 4 5	Yes No	1 2 3 4 5	
6	1 2 3 4 5	Yes No	1 2 3 4 5	
7	1 2 3 4 5	Yes No	1 2 3 4 5	
8	1 2 3 4 5	Yes No	1 2 3 4 5	
9	1 2 3 4 5	Yes No	1 2 3 4 5	
10	1 2 3 4 5	Yes No	1 2 3 4 5	

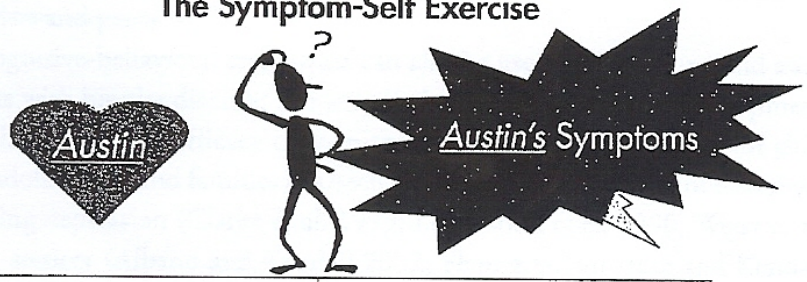
Young & Fristad, 2005

Mood Chart Examples

Name _____ Subject # _____

Session 2 Family Project - "Naming the Enemy"

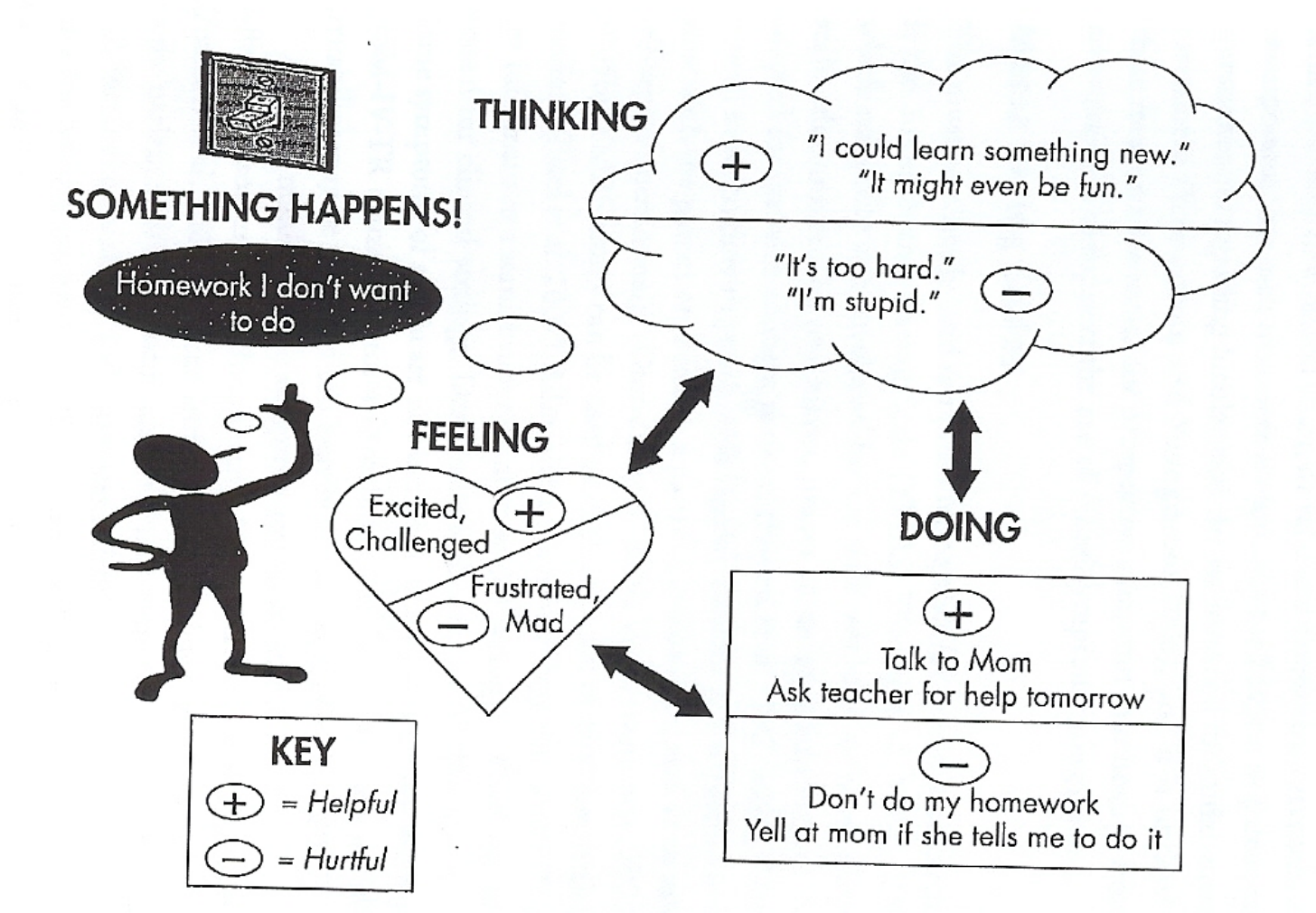
The Symptom-Self Exercise



Friendly	**Depression**
Likes to help with chores	• Grouchy, sad
Great at spelling	• Crying a lot
Creative	• Don't like myself
Kindhearted	• Not interested in playing with friends
Likes to draw	**Mania**
Animal lover	• "Super high" moods
Good at baseball	• Talks too fast
Helps younger sibling	• Needs less sleep
Great smile	• Risky/unsafe behavior
Curious	• Too much energy
Good with computers	• Acting silly
	ADHD
	• Attention problems
	• Hyperactive
	• Gets out of seat in class
	• Forgetful

Young & Fristad, 2005

Mood Chart Examples



Young & Fristad, 2005

School- Based Information and Interventions

- In a resent study it was found that:
  - 79% of children with JBD had behavioral problems at school.
  - 44% had low grades
  - 14% had learning disabilities
  - 11% were in remedial classes
  - 8% had repeated a grade
- Intervention strategies
  - Advocate for comprehensive psychological assessment
  - May request an Individual Education Plan (IEP) or “other health impaired” accommodation plan via Section 504
  - Request a Functional Behavior Assessment
  - Collaborate with school to establish a crisis intervention plan
  - Ask for an aide to be placed with child in the classroom

Grier et al., 2005

Case Study

Catherine, 12 year old girl

Mood cycles 5 to 10 times a day lasting an average of 30 min each

Wakes up in a silly and hyper mood

Alternates extreme anger an silliness after returning from school.

It takes her about two hours to go fall sleep and wakes up consistently after 6 hours of sleep

Has periods of time (3 to 4 days) of hyper and silly mood and (4 to 5 days) of irritable and sad mood.

Mother reports no clear patterns to changes between episodes (depression mania)

Last summer, Catherine had several days where she sleep 3 to 4 hours a day and was very hyper during the day. Mom had to call grandma to relieve her.

During school she gets in trouble for calling out in class and has a hard time completing her school work. She wants to stay home.

Father suffers from alcoholism and mood swings and mother had post partum depression

Her insight into her own mood swings is poor and her judgment impaired by her impulsivity

She is currently taking ADHD medication which seems to help at school.

Catherine's Case Study

- Using Catherine's case, discuss as a team (each site):
  - How would you start conceptualizing this case?
  - Who would you include in your treatment? Grandma?
  - Are you considering collaborating with other professionals? If so, with who?

Information on Catherine's environmental factors

As you listen to Catherine's environmental factors, start thinking on a possible restructuring of your treatment plan

Mom expressed that she feels pressured to keep the family together

Father feels shame which results from his alcohol abuse and thinking he is unable to provide for his family.

Grandmother is available, however she criticizes her son's in-law lack of involvement and drinking.

Mother feels she is not good a parenting her child and she takes things personally, blaming herself for her child's issues.

Catherine's younger brother (5 years old) started to misbehave.

Mother learned about the effects of Omega 3 and wants to replace Catherine's medication with a diet.

Teacher has reported that Catherine has conflicts with peers at school

Couple arguments are becoming more frequent.

Family and friends think that Catherine's problem reflect poor parenting.

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Reactive Attachment Disorder

REACTIVE ATTACHMENT DISORDER (PART 1) *ASSESSMENT AND DIAGNOSIS*

C.R. Macchi, PhD, LCMFT
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Kansas State University

March 9, 2012

Howard Steele (2003) states,

"The concept of attachment disorder, how it is assessed, and what diagnostic guidelines are most helpful/valid/reliable remains a matter of some debate, and is in urgent need of research. To date, there is no systematic evidence-based approach for treating children with attachment disorders, and the very concept of 'attachment disorders' remains controversial due to substantial questions about assessment and diagnosis."(p. 219)

Steele, H. (2003). Holding therapy is not attachment therapy: Editor's introduction to this invited Special Issue. *Attachment & human development, 5*(3), 219-220.

Objectives

During this videoconference, participants will…

- Discuss the importance of attachment to the healthy development of a child
- Review the prevalence of Reactive Attachment Disorder (RAD)
- Explore the current DSM IV-TR diagnostic criteria and assessment of RAD in children and adolescents
- Discuss the differential diagnosis of RAD in children and adolescents
- Review the proposed diagnostic changes in the upcoming version of the DSM V

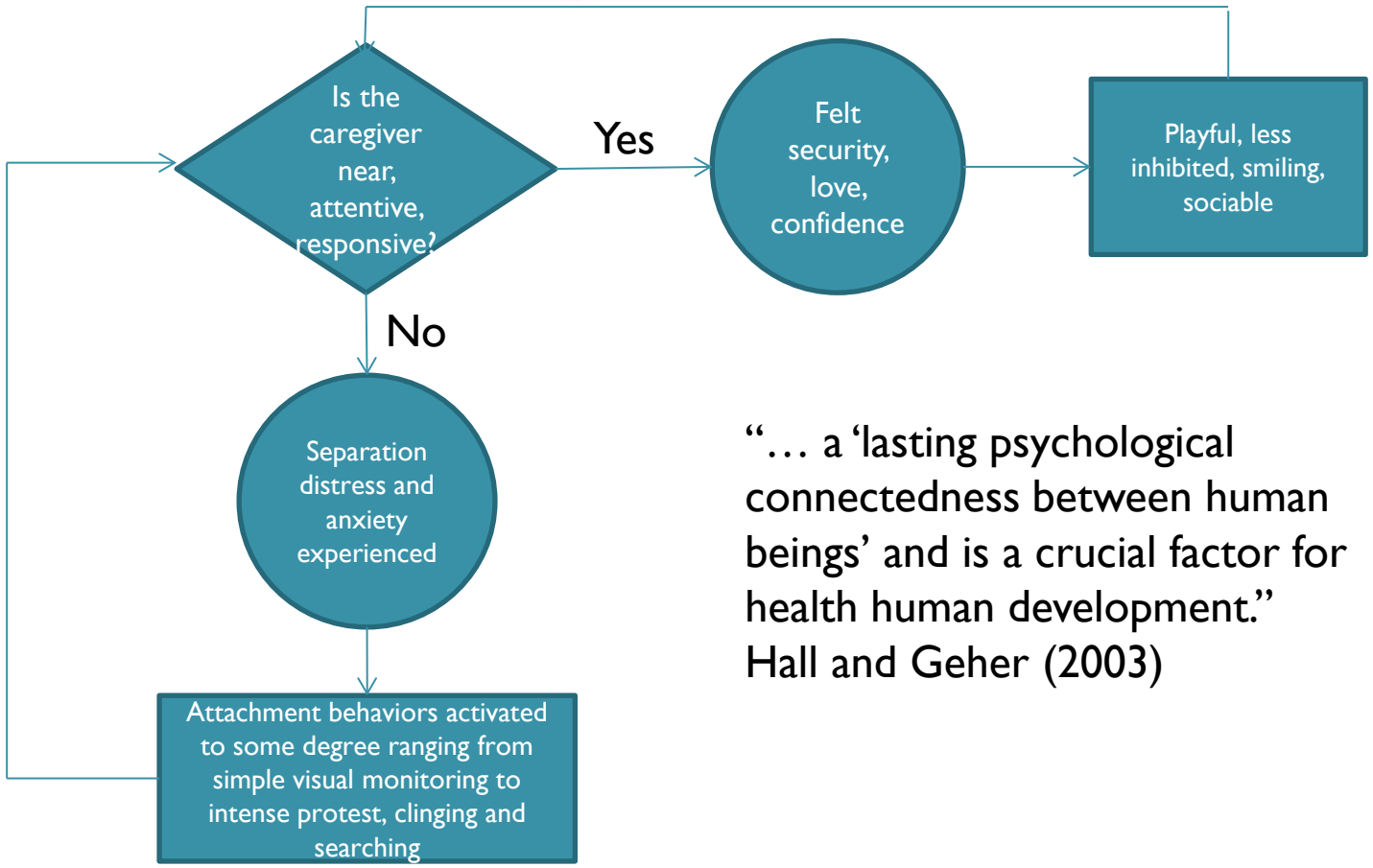
What is Attachment?

"The lasting psychological connectedness between human beings." (p. 2)

- Relatively stable throughout life
- Along a continuum extending from secure to insecure attachments
- Forms of insecure attachment
  - Avoidant attachment
  - Ambivalent attachment
  - Disorganized attachment

Swanson Cain, C. (2006). *Attachment disorders: Treatment strategies for traumatized children*. Lanham, MD: Rowman & Littlefield.

Determining a Child's Response to Attachment Figure



"… a 'lasting psychological connectedness between human beings' and is a crucial factor for health human development."
Hall and Geher (2003)

Adapted from Fraley, R., & Shaver, P. (2000). Adult romantic attachment: Theoretical developments, emerging controversies, and unanswered questions. *Review of General Psychology, 4*(2), 132-154.

Kay Hall, S., & Hall. (2003). Behavioral and personality characteristics of children with reactive attachment disorder. *The Journal of psychology, 137*(2), 145-162.

Why is Attachment So Important?

Seen as a crucial factor in a child's healthy development

- Attainment of full intellectual potential
- Ability to think logically
- Development of a conscience
- Ability to cope with stress and frustration
- Become self-reliant
- Development of emotionally safe, satisfying relationships
- Ability to handle fear, worry, and stresses
- Ability to handle any perceived threat to self

Prevalence of RAD

- Exceedingly rare – estimated 1% of all children
- The Mayo Clinic's website indicates "there are no accurate statistics on how many babies and children have the condition [RAD]".
- One of the first studies to examine RAD in maltreated children found 38-40% exhibited symptoms

Walter, M. R., & Petr, C. (2004). Reactive attachment disorder: Concepts, treatment, and research *Best practices in children's mental health: A series of reports summarizing the empirical research on selected topics* (pp. 26). Lawrence, Kansas: University of Kansas.

Zeanah, C., & Gleason, M. (2010). Reactive attachment disorder: A review for DSM-V. Arlington, Virginia: American Psychological Association.

CURRENT DIAGNOSTIC CRITERIA *DSM IV-TR*

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th, text revision ed.). Washington, D.C.: American Psychiatric Association.

Diagnostic Criteria *313.89*

A. Markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before age 5, as evidenced by either 1 or 2:
   1. Persistent failure to initiate or respond in a developmentally appropriate fashion to most social interactions, as manifest by excessively inhibited, hypervigilant, or highly ambivalent and contradictory responses (i.e. – child may respond to caregivers with a mixture of approach avoidance and resistance to comfort)
   2. Diffuse attachments as manifest by indiscriminate sociability with marked inability to exhibit appropriate selective attachments (i.e. – excessive familiarity with strangers)

B. The disturbance in Criterion A is not accounted for solely by developmental delay and does not meet criteria for a Pervasive developmental Disorder

Diagnostic Criteria *313.89*

C. Pathogenic care as evidenced by at least one of the following:
   1. Persistent disregard of the child's basic emotional needs for comfort, stimulation and affection
   2. Persistent disregard of the child's basic physical needs
   3. Repeat changes of primary caregiver that prevent formation of stable attachments (i.e. frequent changes in foster care)

D. There is a presumption that the care in Criterion C is responsible for the disturbed behavior in Criterion A

Subtypes

Inhibited Type

- If Criterion A1 predominates the clinical presentation
- Refers to a child who fails to initiate and respond to a social interaction in a developmentally appropriate way

Example: A child does not seek comfort from a caregiver in times of distress.

Disinhibited Type

- If Criterion A2 predominates the clinical presentation
- Refers to a child with an inability to select appropriate attachment figures

Example: A child displays excessive familiarity and affection to strangers.

Child Symptoms

- Avoids caregiver
- Avoids physical contact
- Difficult to comfort
- Does not make distinctions when socializing with strangers
- Resists social interaction
- Wants to be alone
- Abnormal speech patterns
- Destruction of property
- Hoarding of food
- Refusal to make eye contact
- Cruelty to animals
- Fire setting
- Poor impulsivity control
- Inappropriate sexual behavior

National Institutes of Health. (2012). Reactive attachment disorder of infancy or early childhood. *Child Mental Health*, from http://www.nlm.nih.gov/medlineplus/ency/article/001547.htm

Caregiver Symptoms

- Disregard for child's basic emotional needs for comfort, stimulation, and affection
- Disregard for child's basic physical needs like food, toileting, and play

National Institutes of Health. (2012). Reactive attachment disorder of infancy or early childhood. *Child Mental Health*, from http://www.nlm.nih.gov/medlineplus/ency/article/001547.htm

DIFFERENTIAL DIAGNOSIS *DSM IV-TR*

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th, text revision ed.). Washington, D.C.: American Psychiatric Association.

Mental Retardation

- Attachments are consistent with child's developmental level
- Severe mental retardation may lead to symptoms similar to RAD
- RAD should only be diagnosed if attachment symptoms are independent of MR

Pervasive Developmental Disorders

- Selective attachments fail to form in spite of positive psychosocial environment
- Also characterized by communication impairment and repetitive behaviors

Social Phobia

- Social inhibition is observable in social settings or anticipation of but not with familiar caregivers
- Socially deviant behavior in RAD, Inhibited Type is apparent in all social contexts

Attention Deficit/Hyperactivity Disorder

- General impulsivity as seen in children with ADHD should be distinguished from being overly familiar with or seeking comfort from unfamiliar adult caregivers

Follan, M., Anderson, S., Huline-Dickens, S., Lidstone, E., Young, D., Brown, G., & Minnis, H. (2011). Discrimination between attention deficit hyperactivity disorder and reactive attachment disorder in school aged children. *Research in developmental disabilities, 32*(2), 520-526.

Disruptive Behavior Disorders

- Antisocial behaviors associated with CD and ODD are not signs of RAD
- Those diagnosed with CD and/or ODD may have had pathogenic care
- But if marked disturbance in social relatedness is not present, RAD should not be diagnosed

- Instead, Child Neglect or Parent-Child Relational Problem may be noted in Axis IV

ASSESSMENT OF RAD

Multidimensional Assessment

- Systematic observations
- Child and family interviews
- School and family reports
- Individual and family assessments

O'Connor, T., & Zeanah, C. (2003). Attachment disorders: Assessment strategies and treatment approaches. *Attachment & Human Development, 5*(3), 223-244.

Issues with Assessment

- Problems with observation
- Children not referred for "attachment problems"
- Over-reporting
- Differential diagnoses are problematic
- Problems with questionnaires

O'Connor, T., & Zeanah, C. (2003). Attachment disorders: Assessment strategies and treatment approaches. *Attachment & Human Development, 5*(3), 223-244.

Attachment Figure

- Consistency
- Sensitivity
- Common focus of interest
- Influence of power and control
- Communication
- Perceptions

Swanson Cain, C. (2006). *Attachment disorders: Treatment strategies for traumatized children*. Lanham, MD: Rowman & Littlefield.

Characteristics of the Child

- Physiological state of the child
- Temperament
- Self-regulation
- Perceptions of self and others

Swanson Cain, C. (2006). *Attachment disorders: Treatment strategies for traumatized children*. Lanham, MD: Rowman & Littlefield.

Family Relationships

- Parental relationship
- Family relationships
- Sibling relationships
- Multigenerational relationships
- SES
- Community
- Social support
- Cultural influences

Swanson Cain, C. (2006). *Attachment disorders: Treatment strategies for traumatized children*. Lanham, MD: Rowman & Littlefield.

School Reports

- Peer relationships
- Academic performance
- Socialization
- Interactions with teachers and other authority figures

STANDARDIZED ASSESSMENTS

Individual and Family Assessments

- Randolph Attachment Disorder Questionnaire (RADQ)
- Child Behavior Checklist (CBCL)
- Observational Record of the Caregiving Environment
- Disturbances of Attachment Interview

Walter, M. R., & Petr, C. (2004). Reactive attachment disorder: Concepts, treatment, and research *Best practices in children's mental health: A series of reports summarizing the empirical research on selected topics* (pp. 26). Lawrence, Kansas: University of Kansas.

Randolph Attachment Disorder Questionnaire (RADQ)

- Attempts to determine causes and levels of severity between two subtypes
- Considered the most effective tool in the diagnosis of attachment disorders
- Parent-report, 30 items

Child Behavior Checklist (CBCL)

- Assesses behavioral problems and social competencies
- Several editions addressing varying age ranges
- Self-report, parent-report, teacher-report

Home Observation for Measurement of the Environment (HOME)

- Descriptive profile of environment in which a child is reared
- Multiple forms
  - Infant Toddler HOME: ages 0-3
  - Early Childhood HOME: ages 3-6
  - Middle Childhood HOME: ages 6-10
  - Early Adolescence HOME: ages 10-15
- Data obtained through observation and interview with primary caregiver

- Higher scores indicate more enriched home environment
- No cut off scores
- Scores in lowest 4th of score range indicate potential risk
- Scored as YES/NO
  - Infant Toddler HOME
    - 45 items
    - 6 domains
  - Early Childhood HOME
    - 55 items
    - 8 subscales

Disturbances of Attachment Interview (DAI)

- Asks about disturbances of attachment as well as secure base distortions (i.e. – self endangering, clinginess, hypervigilance)
- Semi-structured interview
- Administered by clinicians to caregivers
- 12 items related to diagnostic criteria
- 3-point Likert scale, scored 0, 1 or 2

Smyke, A., & Zeanah, C. (2011). Disturbances od attachment interview Retrieved 3/6/2012, from download.lww.com/...com/.../00004583-920020800-00014.doc

VARIABLES AND CONTROVERSIES OF ASSESSMENT AND DIAGNOSIS

Vulnerable Populations

- Adopted children
  - Tend to have more caregivers than children living with bio parents
  - More likely to have emotional, behavioral, educational problems
  - Rated lower on dimensions of social competence

Vulnerable Populations

- Child victims of abuse
  - Up to 80% of abused children display signs of RAD
  - Tend to display higher levels of aggression
  - Difficulty expressing their feelings
  - Difficulty appreciating the distress of others

High Risk Signs in Infants

- Tactile defensiveness
- Poor clinging and extreme resistance to cuddling
- Poor sucking response
- Poor eye contact, lack of tracking
- No reciprocal smile response
- Indifference to others
- Failure to respond with recognition to mother and father

Controversies with RAD Diagnosis

- Only reliable factor in determining a diagnosis is the history of pathological care
- The current DSM diagnosis includes both subtypes
  - The disinhibited type have more to do with problems with social interaction and less with the condition of the attachment relationship

DSM-V PROPOSED CRITERIA

Zeanah, C., & Gleason, M. (2010). Reactive attachment disorder: A review for DSM-V. from American Psychological Association
http://www.dsm5.org/Proposed%20Revision%20Attachments/APA%20DSM-5%20Reactive%20Attachment%20Disorder%20Review.pdf

DSM V

Proposed Revisions

Subtypes separated into two separate diagnoses

- Reactive Attachment Disorder of Infancy or Early Childhood
  - Includes lack of comfort seeking, lack of response to caregiver, persistent social/emotional disturbance thought to be caused by pathogenic care
- Disinhibited Social Engagement Disorder
  - Includes actively approaching and interacting with unfamiliar adults thought to be caused by pathogenic care during infancy and childhood
  - Behavior reflects inappropriate interpersonal interactions rather than problems with attachment to caregiver

COMMENTS

QUESTIONS?

REACTIVE ATTACHMENT DISORDER (PART II) *TREATMENT GOALS AND INTERVENTIONS*

C.R. Macchi, PhD, LCMFT
Jurdene Ingram
Kansas State University

April 20, 2012

Objectives

During this videoconference, participants will…

- Review the factors associated with an assessment and diagnosis of reactive attachment disorder (RAD)
- Explore existing models of treatment
- Learn family intervention strategies focused on addressing child and caregiver attachment relationship
- Discuss a case scenario involving treatment implications for a 12 year old girl with RAD

Why is Attachment So Important?

Seen as a crucial factor in a child's healthy development

- Attainment of full intellectual potential
- Ability to think logically
- Development of a conscience
- Ability to cope with stress and frustration
- Become self-reliant
- Development of emotionally safe, satisfying relationships
- Ability to handle fear, worry, and stresses
- Ability to handle any perceived threat to self

REVIEW OF ASSESSMENT & DIAGNOSIS OF RAD

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- Differential diagnoses are problematic
- Problems with questionnaires

O'Connor, T., & Zeanah, C. (2003). Attachment disorders: Assessment strategies and treatment approaches. *Attachment & Human Development, 5*(3), 223-244.

TREATMENT OF RAD

Despite a long history of the development of attachment-based theories and practices, there are no empirically-supported, effective treatments for working with RAD.

O'Connor, T., & Zeanah, C. (2003). Attachment disorders: Assessment strategies and treatment approaches. *Attachment & Human Development, 5*(3), 223-244.

General Treatment Recommendations

- Children's expressions of distress during therapy should be taken seriously
- State-of the-art, goal-directed, evidence-based approaches
- Based upon sound principles suggested by attachment theory
- Treatment should involve parents and caregivers

Chaffin, M., Hanson, R., Saunders, B., Nichols, T., Barnett, D., Zeanah, C., . . . Miller-Perrin, C. (2006). Report of the APSAC* Task Force on attachment therapy, reactive attachment disorder, and attachment problems. *Child Maltreatment, 11*(1), 76-89.

*American Professional Society on the Abuse of Children

General Treatment Restrictions

- Treatments should avoid physical coercion, physical restraint, provoked catharsis, humiliation or shaming
- Avoid making predictions about children's future behaviors based upon past childhood behavior
- Avoid portraying children in negative ways and approaches that advocate for use of aggressive techniques
- Intentionally provoking child's intense emotional distress should be avoided

Chaffin, M., Hanson, R., Saunders, B., Nichols, T., Barnett, D., Zeanah, C., . . . Miller-Perrin, C. (2006). Report of the APSAC* Task Force on attachment therapy, reactive attachment disorder, and attachment problems. *Child Maltreatment, 11*(1), 76-89.

*American Professional Society on the Abuse of Children

Factors Related to Attachment Disorder

- Treatment is recommended to address the attachment system at each of the following levels

1. Attachment level
2. Child's social cognition and belief system
3. Caregivers' knowledge, expectations, and understanding of the child and past trauma
4. Ecological factors affecting the child's day-to-day life

Minde, K. (2003). Attachment problems as a spectrum disorder: Implications for diagnosis and treatment. *Attachment & Human Development, 5*(3), 289-296.

ASSESSING EXISTING TREATMENTS

In a 2003 issue of the *Journal of Attachment and Human Development* various researchers and practitioners address

- The current state of the science on attachment assessment strategies and treatments approaches
- The controversies of existing practices
- Offer principles for working with children with RAD and their caregivers

Attachment & Human Development, Vol 5 No 3 (September 2003).

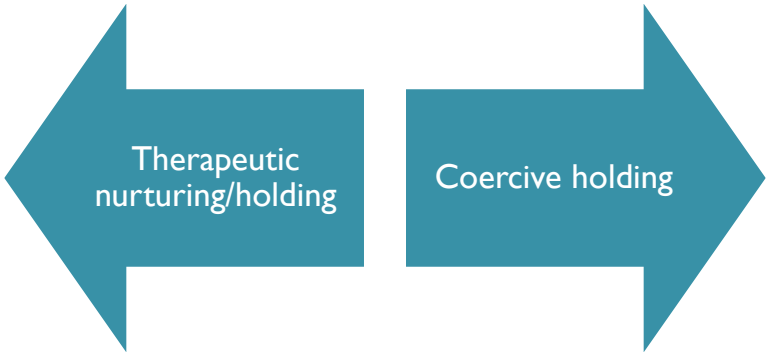
Issues Concerning Existing Practices

- Existing treatments have been studied by the developers with no independent, controlled trials
- Difficult to determine if treatment successes are due to the efficacy of the treatment or the enthusiasm of the practitioner who developed the approach
- Despite their popularity, holding therapies are contraindicated and potentially traumatizing to a child with a history of trauma or abuse

O'Connor, T., & Zeanah, C. (2003). Introduction to the special issue: Current perspectives on assessment of attachment disorders. *Attachment & Human Development, 5*(3), 221-222.

Holding Therapy

- Often referred to as *Attachment Therapy*
- Assumes that child dysregulation and lack of attachment must be controlled and expelled by the caregiver
- The types and extent of the use of parental or therapist physical holding appears to be intrusive and potentially threatening to the child and, therefore, remains controversial
- Unclear where therapeutic holding ends and coercive holding begins
- Often resembles treatments designed more for children with behavior disruptive disorders than attachment disorders



Dozier, M. (2003). Attachment-based treatment for vulnerable children. *Attachment & human development, 5*(3), 253-257.

Walter, M. R., & Petr, C. (2004). Reactive attachment disorder: Concepts, treatment, and research *Best practices in children's mental health: A series of reports summarizing the empirical research on selected topics* (pp. 26). Lawrence, Kansas: University of Kansas.

Dyadic Developmental Psychotherapy (DDP)

1. Addressing caregiver and therapist's own attachment strategies
2. Intersubjectivity
3. Use of Nonverbals
4. Therapist and caregiver maintain secure attachment
5. Misattunements are directly addressed
6. Recommended parental interventions are congruent with attachment theory
7. CBT strategies are utilized only after secure based is developed

Hughes, D.A. (2003). Psychological interventions for the spectrum of attachment disorders and intrafamilial trauma. *Attachment and Human Development*, 5, 271-277.

Parent Training and Family Support

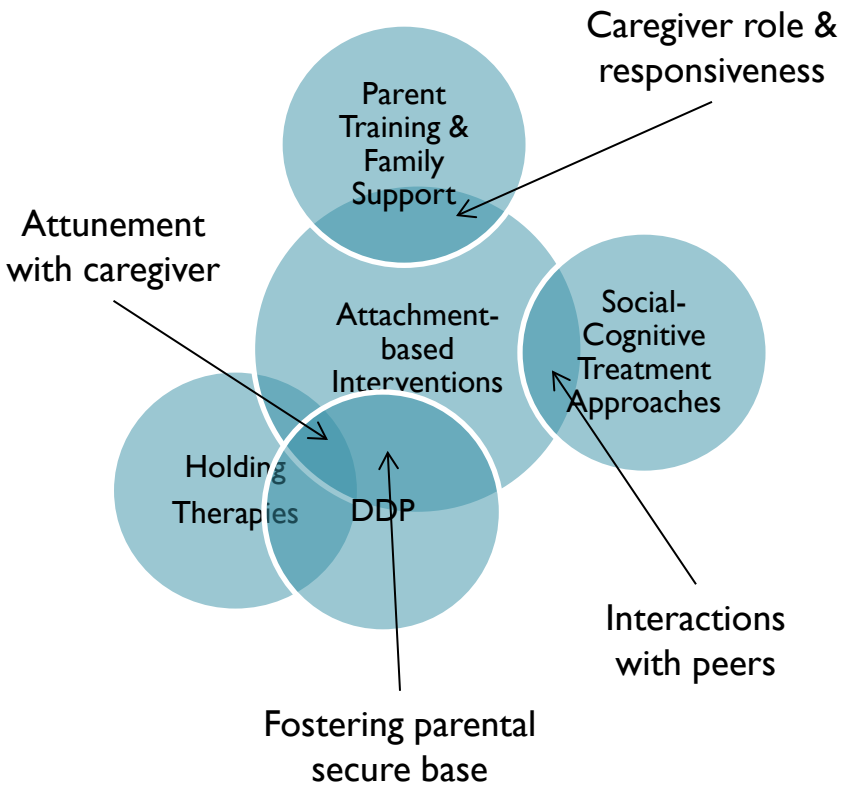
- Address parents' feelings of confusion and rejection
- Support parents through parent support groups and social networking
- Support parental monitoring and providing feedback for child who wanders off or inappropriately approaches strangers
  - Prohibitions and reinforcements
  - Vigilance
  - Constant reminders
- Provide respite care to support parent

Social-Cognitive Treatment Approaches

- Alternative to addressing the attachment issues per se
- Focus on addressing social and cognitive disturbances that accompany attachment disorder
- Address the range of child's social problems
  - Peer rejection
  - Difficulties forming friendships
  - Misattributing of others as aggressive or hostile
  - Difficulty understanding social situations and interactions

O'Connor, T., & Zeanah, C. (2003). Attachment disorders: Assessment strategies and treatment approaches. *Attachment & Human Development, 5*(3), 223-244.

Overlapping Principles with Attachment Theory



Each approach diverges from attachment theory despite several overlapping features

O'Connor, T., & Zeanah, C. (2003). Attachment disorders: Assessment strategies and treatment approaches. *Attachment & Human Development, 5*(3), 223-244.

Search for Evidence-based Approaches

- Research suggests "that adopted children often struggle to do as well as biological children in two-parent households, but that most eventually catch up rather well." (p. 262)

Barth, R. (2005). Beyond attachment theory and therapy: Towards sensitive and evidence-based interventions with foster and adoptive families in distress. *Child & family social work, 10*(4), 257-268.

Existing Attachment-Based Therapies

- Address therapist interest in providing opportunities for treatment to facilitate the establishment of a secure base
- Address parental concerns of child's distress and behaviors
  - Provides a detoured focus away from current caregiver and, instead, on past ones
  - Provides a way for caregivers to relinquish responsibility when using a child-focused approach
  - Therapy approaches differ for
    - A child and the caregiver to whom the child is selectively unattached
    - A child with a foster parent who have no relationship history or existing attachment

Barth, R. (2005). Beyond attachment theory and therapy: Towards sensitive and evidence-based interventions with foster and adoptive families in distress. *Child & family social work, 10*(4), 257-268.

TREATMENT PLANNING AND INTERVENTIONS

Hughes, D.A. (2003). Psychological interventions for the spectrum of attachment disorders and intrafamilial trauma. *Attachment and Human Development*, 5, 271-277.

Treatment Goals

- Increase child's trust of the current caregiver
- Increase the capacity of attunement through reciprocal interactions between child and caregiver
  - Acts of pleasing
  - Identifying with and having empathy for one another
  - Ability to resolve conflicts
- Improve caregiver's responsiveness to child's subjective experience to provide a secure base
- Improve child's ability to recognize, regulate, integrate, and appropriately express a wide range of affect
- Develop child's appropriate balanced behavioral skills, falling between impulsivity and inhibition, that serve the needs of self and other
- Develop child's cognitive abilities to
  - Reflect on inner life
  - Learn from new experiences
  - Redefine self as being worthwhile and capable

Special Considerations Working With Foster and Adoptive Parents

- Possible caregiver resistance to treatment focused on changing parental role if previously successful in raising securely attached children
- Potential to blame past or present caregivers for child attachment issues
- "Parental frustration and detachment may be mistaken as a source of child's disturbance rather than a result of it." (O'Conner & Zeanah, p. 239)

Barth, R. (2005). Beyond attachment theory and therapy: Towards sensitive and evidence-based interventions with foster and adoptive families in distress. *Child & family social work, 10*(4), 257-268.

O'Connor, T., & Zeanah, C. (2003). Attachment disorders: Assessment strategies and treatment approaches. *Attachment & Human Development, 5*(3), 223-244.

INTERVENTION STRATEGIES

Directive and Empathic

- Child misinterprets non-directive stance as permissiveness
- Enables manipulation of parent and therapist
- As directiveness increases so should engagement
- Communicate empathy for resistance and commitment to meeting deeper needs
- Uses mother-infant relationship as a guide
- Empathy offered in response to enjoyment, sadness, fear AND anger

Hughes, D. (1997). *Facilitating developmental attachment: The road to emotional recovery and behavioral change in foster and adopted children*. Lanham, MD: Rowman & Littlefield.

Relationship-Centered

- Focus is on child-therapist relationship and child-parent relationship
- Each are present during treatment
- Essential components of interactions
  - Eye contact is key
  - Physical contact
- Three qualities of relating:
  - Empathy
  - Curiosity and interest
  - Playfulness

Hughes, D. (1997). *Facilitating developmental attachment: The road to emotional recovery and behavioral change in foster and adopted children*. Lanham, MD: Rowman & Littlefield.

Emotional Richness

- Exposure to and acceptance of a of emotions
- Theraplay techniques fit here!
  - Structure
  - Challenge**
  - Intrude/Engage
  - Nurture

Hughes, D. (1997). *Facilitating developmental attachment: The road to emotional recovery and behavioral change in foster and adopted children*. Lanham, MD: Rowman & Littlefield.

Focused on Attachment Sequences

- Healthy sequence
  - Child feeling close to caregiver
  - Experience of a break in the relationship
  - Reestablishing the emotional connection
- Therapist helps child experience these phases in a healthy manner, over and over
- Expect frequent attempts at disengagement

Hughes, D. (1997). *Facilitating developmental attachment: The road to emotional recovery and behavioral change in foster and adopted children*. Lanham, MD: Rowman & Littlefield.

Play Therapy

- Traditional play therapy is often ineffective in developing secure attachment
- Non-directive techniques diminish attachment with the therapist and are counter to attachment therapy techniques
- Tends to exclude the parent or caregiver
- Used in conjunction with other techniques

Theraplay

- Theraplay replicates healthy parent-child relationships by
  - Creating positive interactions between child and caregiver,
  - Having the caregiver establish a confident take charge attitude
  - Meeting the child's needs by meeting them at their emotional age.
- Components of Theraplay approach
  - Structure
  - Challenge
  - Engagement
  - Nurture

Booth, P., & Jernberg, A. (2010). *Theraplay: Helping parents and child build better relationships through attachment-based play.* San Francisco, CA: John Wiley & Sons.

Use of Home Environment

Bring therapy into the home and the caregiver into therapy

- Caregiver will experience responding to child in home setting
- Facilitates transfer of skills from therapeutic to living space
- Child experiencing attachment sequence in the home has the potential of making the home a safe, secure space
- Transitioning therapist out of therapy may be easier

COMMENTS

QUESTIONS?

Using DSM-5 in HBFT

Using the DSM 5 in Home-Based Family Therapy

Una Henry, MA
Camille Lafleur, PhD, LCMFT

Adapted from "Revolutionizing Diagnosis & Treatment Using DSM 5" as presented by Jack Klott, MSSA, LISW, CSW and Susan Lewis, PhD, JD

Objectives

* Review the history of the DSM
* Learn about the new diagnostic process for the DSM 5
* Gain an understanding of how the changes to the DSM will impact home-based family therapy

Outline

* Expected Changes
* DSM 5 definition of Mental Illness
* History of the DSM
* Diagnostic Process

EXPECTED CHANGES IN THE DSM 5

Expected Changes

* Previous versions of the DSM focused on behaviors
  * There was symptom overlap
  * It ignored relationships
  * There was no treatment guidance given
* DSM 5 will be more easily used to conceptualize cases and develop treatment plans

MENTAL ILLNESS DEFINED PER THE DSM 5

Mental Illness

* Current definition
  * "a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual [which] is associated with present distress, disability… or with a significant impairment in important areas of functioning."

Mental Illness

* DSM 5 Proposed Definition
  * “a condition characterized by dysfunction in thought, mood or behaviors which cause distress. The condition should not be a result of social deviance or conflicts with society.

Mental Illness

* Additions to the definition
  * "Must draw concern from others in a relational, social, occupational, or vocational setting that requires a referral for treatment."
  * "Must incorporate respect for age, gender, and culture-specific factors and sensitivity to these factors when making a diagnosis."
  * "Diagnostics are guidelines for understanding human behaviors. Diagnostics are not to be considered legal definitions to be used by law enforcement and courts."

Mental Illness

* Important features:
  * These behaviors must NOT be an expected or culturally sanctioned response to a particular event
  * They may, or may NOT, be medical or biological illnesses
  * They are conditions that people HAVE and they do NOT define the person

Mental Illness

* They are disorders that quite often are early life coping (defense mechanisms that are now seen as dysfunctional and causing great distress in adult life.
* “We bring into adulthood early childhood defense mechanisms” –Harry Stack Sullivan, 1951

HISTORY OF THE DSM

DSM I (1952)

* Descriptions of 106 disorders, referred to as "reactions."
  * Reactions to social stress
  * Failure to adapt to social norms
* Clinically oriented book
* Subjective in nature
* Goal to create a common nomenclature
* Expected a biographical review of clients

DSM II (1968)

* Dramatic response to the subjectivity of the DSM I.
* Introduced the multi-axial system
* Eliminated the biographical review
* Sole focus on behaviors and diagnostic accuracy
  * Robert Spitzer and the "distinct disease" model
* Origin of the medicalization of psychiatry
  * Dehumanization of the DSM
* Increased the number of disorders to 182

DSM III (1980)

* Heavily based on scientific findings so its reliability was improved
  * Striving for epidemiological accuracy and diagnostic validity
* Radical medicalization of psychiatry
  * Treating conditions not people
* So popular that its revenues led to the formation of the American Psychiatric Press
  * Expanded to 494 pages
  * 265 diagnostic categories
* Became a guideline for insurance

DSM III-R (1987)

* Saw categories renamed, reorganized, and significant changes in criteria
* Response to ICD 9 codes
* Contained 297 diagnoses

DSM III-R (1987)

* The good –
  * A return to the spirit of the DSM I
  * The Multi-axial review
  * Comprehensive diagnostics
* The challenges –
  * Coding (ICD 9) begins – Managed Care
  * The Multi-axial review - Pathology

DSM IV (1994)

* Offered detailed information about each disorder, including;
  * Essential and associated features
  * Course of treatment
  * NOS category was introduced
* 365 Diagnoses and 886 pages

DSM IV (1994)

* The good –
  * Response to rapidly developing epidemiology
  * Suggesting treatment "outcomes"
  * Welcoming psychiatrists "back to the clinical arena"
* The bad –
  * The NOS categories
  * Overlapping diagnostic criteria

DSM IV-TR (2000)

* Disorders remained unchanged
* Correct any factual errors and make changes
* Perpetuated the medical model and the social stigma attached to mental disorders

DSM 5 (May 2013)

* Process began in 1999
* Many DSM IV participants not invited
* 50% from outside the USA
  * Experts in twin studies, genetics, neuroscience, and behavioral science
* First major overhaul since DSM III-R (1987)
* Current coding process has been changed to reflect ICD 10 process to be introduced in 2013

DSM 5 (2013)

* Goals
  * Improve diagnostic accuracy
    * Take time in diagnostics
  * Diagnoses dimensional in nature
  * Reduce use of NOS diagnosis
  * Decrease the massive dependence on the use of medication
  * Increase understanding of children
  * Increase awareness of risk behaviors
  * Reduce the stigma of some mental disorders

DIAGNOSTIC PROCESS AND THE ORGANIZATION OF DSM 5

Diagnostic Process

* Most disorder families in DSM IV included an NOS diagnosis that served as a catchall for patients
* DSM 5, NOS categories are replaced with CNEC for "conditions not elsewhere classified." CNEC categories will include a list of "specifier," each with a specific diagnostic code, that will convey clinical information.

Diagnostic Process

* CNEC – Conditions Not Elsewhere Classified
  * Designed to replaced NOS
  * To be used during diagnostic uncertainty:
    * Behaviors associated with a classification are seen but there is uncertainty regarding the diagnostic category
    * The client is unwilling to provide information; there is a brief period of time; the clinician is untrained in the classification
  * Can only be in place for 6 months

DSM 5 Organization

* Twenty Classifications
  * Neurodevelopmental Disorders
  * Schizophrenia Spectrum and Other Psychotic Disorders
  * Bipolar & Related Disorders
  * Depressive Disorders
  * Anxiety Disorders
  * Obsessive-Compulsive and Related Disorders
  * Trauma and Stressor Related Disorders

DSM 5 Organization

* Dissociative Disorders
* Somatic Symptom Disorders
* Feeding and Eating Disorders
* Elimination Disorders
* Sleeping Disorders
* Sexual Dysfunctions
* Gender Dysphoria*
  * May or may not be included in DSM 5

DSM 5 Organization

* Disruptive, Impulse Control, and Conduct Disorders
* Substance Use & Addiction Disorders
* Neurocognitive Disorders
* Personality Traits that Affect Treatment
  * Rather than Personality Disorders
* Paraphilic Disorders
* Other Disorders

SPECIAL FEATURES IN EACH DIAGNOSIS

Special Features in Each Diagnosis

* Insight Specifier
  * 1st Required Specifier
  * Syntonic vs. Dystonic Disorders
  * Each diagnostic definition will have a comment on "attitude considerations." It will comment on the client's eagerness and motivation for counseling/therapy based upon their insight toward the disorder. This is designed to enhance the distinction made between Axis I and Axis II formats in DSM III and DSM IV

Special Features in Each Diagnosis

* Insight Specifier
  1. Good/Fair Insight = Dystonic
  2. Poor Insight = Ambivalence
  3. Absent Insight = Syntonic

* Essential process as we formulate our case conceptualization and determine where we are going to begin our therapy.

Special Features in Each Diagnosis

* The Dystonic Conditions
  * The client is experiencing significant distress, disability, or impairment in functioning
  * The client has no capacity to cope with the condition or is using maladaptive coping
  * The client is motivated in therapy

Special Features in Each Diagnosis

* The client is heavily defended
  * They lack insight
  * They rationalize the behavior
* The client is resistant to therapy and often has to be mandated to enter therapy
* The client has no motivation to change behaviors

Special Features in Each Diagnosis

* Severity Index Across Time and Circumstances
  * 2nd Required Specifier
  * Dimensional in its approach
* Validates that behavior is a mental disorder by definition
* Is used across time and circumstances to validate effectiveness of interventions

Special Features in Each Diagnosis

* Severity Index
  * Assures that
    a) The individual does qualify for a mental disorder from definition
    b) That the clinician is continuing to assess treatment effectiveness
    c) Assures appropriate level of care

Special Features in Each Diagnosis

* Severity Index
* Applies the GAF
  * 0 – No impairment (GAF 71 to 100)
  * 1 – Mild impairment (GAF 61 to 70)
  * 2 – Moderate impairment (GAF 51 to 60)
  * 3 – Severe impairment (GAF 31 to 50)
  * 4 – Very Severe impairment (GAF 1 to 30)

Special Features in Each Diagnosis

* Respect for age, gender, and culture
  * 3rd Required Specifier
  * Will incorporate "developmental symptom manifestation" regarding the age of the client.
  * Each diagnosis will be on a life spectrum basis
  * Gender specific disorders and cultural sensitivity in regards to certain behaviors will also be addressed

Specifiers Not Always Required

* Correlated Disorders and Suicide Risk
  * Each diagnostic definition will comment on research based evidence of correlation among disorders (associated features)
  * Will be able to conduct a risk assessment for suicide using DSM 5

Specifiers Not Always Required

* Suicide Behavior Specifier
  * Added to any classification with a correlation or vulnerability to suicide
  * Assess for suicidal ideation by history (past)
  * Current suicidal ideation (current)
  * Chronic suicidal ideation (always)

Specifiers Not Always Required

* Suicide Behavior Specifier
  1. Suicide Ideation – a period of two months in duration where psychiatric, psychological, physical pain is so severe it defies individual's capacity to cope. The client views death as the only remedy.
  2. Chronic suicide ideation – over one year in duration.
  3. Suicide Attempts – lethal act with intent to die. The act is accidentally rescued, self-rescued, miscalculated in lethality

Specifiers Not Always Required

* The Five Pathogenic Care Realms:
  1. Persistent disregard for child's emotional needs
  2. Persistent disregard for child's physical needs
  3. Repeated changes in primary caregivers
  4. Raised in settings with limited opportunities for stable attachments
  5. Persistent harsh punishment or other types of grossly inept parenting

Specifiers Not Always Required

* The Five Pathogenic Care Realms
  * Diagnostics where the Five Pathogenic Care Realms can be applied or are required
    1. Reactive Attachment Disorder
    2. Disinhibited Social Engagement Disorder
    3. PTSD in children*
    4. Disruptive Mood Disregulation Disorder*
    5. Dissociative Disorders in Children
    6. Oppositional Defiant Disorder*
    7. Conduct Disorder
    8. Dissocial Personality (in lieu of Antisocial Personality)

Using the DSM 5 in Home Based Family Treatment
Part 2

Camille Lafleur, PhD, LCMFT

Una Henry, MA

Objectives

* Develop a better understanding of diagnosing children and adolescents
* Examine the DSM-5's expanded and comprehensive approach to disorders organized by categories
* Allow participants to engage in diagnosing according to the new format

Outline

* Review from Part 1
* Mental Disorder Classifications
* Review DSM – 5 Disorders
* Section 3 Information
* Case Study

Brief Review from Part 1

* Return to spirit of DSM 1
* Mental Illness Definition
* Specifiers
  - Insight
  - Severity
  - Life Spectrum
  - 5 Pathogenic Realms
  - Suicide Assessment

Classifications

* Neurodevelopmental Disorders
* Schizophrenia Spectrum & Other Psychotic Disorders
* Bipolar and Related Disorders
* Depressive Disorders
* Anxiety Disorders
* Obsessive-Compulsive and Related Disorders
* Trauma & Stress Related Disorders
* Dissociative Disorders
* Somatic Symptom Disorders

Classifications (cont.)

* Feeding & Eating Disorders
* Elimination Disorders
* Sleep-Wake Disorders
* Sexual Dysfunctions
* Gender Dysphoria
* Disruptive, Impulse Control, & Conduct Disorders
* Substance Use & Addiction Disorders
* Neurocognitive Disorders
* Personality Disorders
* Paraphilic Disorders
* Other Disorders

Neurodevelopmental Disorders A00-A22

* Intellectual Developmental Disorder
* Communication Disorders
* Autism Spectrum Disorder
* Attention Deficit/Hyperactivity Disorder
* Specific Learning Disorder
* Motor Disorder

Intellectual Developmental Disorders A00-A01

* Intellectual Developmental Disorder (IDD) is a disorder that includes both a current intellectual deficit and a deficit in adaptive with onset during the developmental period.
* Previously in Axis II, but with the change in multiaxial system, this is the main diagnosis.

Intellectual Developmental Disorders

* Characterized by deficits in general mental abilities such as reasoning, problem-solving, planning, abstract thinking, judgment
* "Culturally appropriate testing"
  * Taking into account current school system, current home environment, socioeconomic status, and issues of culture
* Requires assistance in vocational and/or occupational endeavors
* Severity Index is based on functioning and not on IQ

Communication Disorders A02-A08

* Language Disorders
* Speech Disorders
* Social Communication Disorders (for autism like communication problems who lack the repetitive behaviors often witnessed in autism) Previously diagnosed as Pervasive Developmental Disorder

Language Disorders

* Persistent difficulties in the acquisition and use of spoken language, written language
  * Symptoms may include the domains of vocabulary; grammar; narrative, expository & conversational discourse;
* Language abilities that are below age expectations in language
* Language disorders occur as a primary impairment or co-exist with other disorders

Autism Spectrum Disorder A09

* Persistent deficits in social communication and social interaction across context manifest by <u>all</u> 3 of the following:
  1. Deficits in social-emotional reciprocity
  2. Deficits in nonverbal communicative behaviors used for social interaction
  3. Deficits in developing and maintaining relationships

Autism Spectrum Disorder

* Restricted, repetitive patterns of behavior as;
  1. Stereotyped or repetitive speech or motoric movements
  2. Ritualized patterns of verbal or nonverbal behavior
  3. Highly restricted, fixated interests
  4. Hyper- or hypo-reactivity to sensory input
* Symptoms must be present in early childhood

Autism Spectrum Disorder

* Impairment in social interaction (two of the following): nonverbal behaviors, no peer relationships, lack of shared activities, lack of social reciprocity
* Repetitive activities of behavior (1 of the following;) pattern of activity, rituals, motor mannerisms, fixation on parts of objects

Autism Spectrum Disorder

* Merging selected diagnostic criteria from DSM IV-TR: Autism, Asperger's PDD NOS, CDD

1. No evidence to support distinction
2. Impact on relationships: Deficits in communication and social interaction
3. Found primarily in male gender
4. Tightening of criteria
5. Asperger's was viewed as "high functioning autism"

Attention Deficit/Hyperactivity Disorder A10-A11

AD/HD consists of a pattern of behavior that is present in giving rise to social, educational/work difficulties.

Inattention: Symptoms have persisted for at least 6 months:

* Fails to give close attention to details
* Difficulty sustaining attention, easily distracted
* Difficulty organizing & engaging in tasks

ADHD

Hyperactivity and impulsivity for at least 6 months

* Unable to play quietly, talks excessively
* Blurts out an answer, difficulty waiting his or her turn, interrupts or intrudes on others

Specify Based on Current Presentation

* Combined Presentation: Inattention/Hyperactivity-Impulsivity
* Predominantly Inattentive Presentation
* Predominantly Hyperactive/Impulsive Presentation

Trauma & Stress Related Disorders G00-G08

* Reactive Attachment Disorder
* Disinhibited Social Engagement Disorder
* PTSD in Preschool Children
* Acute Stress Disorder
* PTSD in Adults
* Adjustment Disorder
* Bereavement Disorder
* Non-suicidal Self-injurious Behavior

Reactive Attachment Disorder

* Behaviors, evident before 5 years of age
  * Rarely seeks comfort when distressed
  * Doesn’t really respond when comfort is offered
  * Limited positive affect
  * Unexplained irritability/sadness/fearfulness when interacting with adult caregivers for no apparent reason

Disinhibited Social Engagement Disorder

* Absent reticence approaching unfamiliar adults
* Ventures away from caregiver w/o checking back
* Behaviors are a consequence of inconsistent nurturing in the 5 pathogenic care realms
* Disinhibited modifier for RAD
* No boundaries in relationships
* Behavior is not better explained by ADHD
* Symptoms displayed before age 6; diagnosis after age 6

Posttraumatic Stress Disorder

* Re-experiencing the trauma, intrusion
* Avoidance and numbing
* Negative alterations in mood and cognition
* Arousal

Posttraumatic Stress Disorder in Preschool Children

* Essential feature of guilt and shame
  * The child, <6, has experienced, witness, or LEARNED about the following:
    * Death
    * Serious Injury
    * Sexual Violation
    * Violent Accident
  * NOT from TV, video, or electronic means; result of an interpersonal relationship

Posttraumatic Stress Disorder in Adults

* Results from lack of attention to effects of Acute Stress Disorder
* Experienced primarily in females with history of sexual assault
  * Elements:
    * Noted by intrusive memories or dreams
    * Dissociative reactions
    * Significant changes in relationships
    * Emotional constriction
    * Noted by self-devaluation, guilt, shame

Posttraumatic Stress Disorder in Adults

* Associated with Combat Veterans
  * In the adult it has a powerful correlation to drug use (cannabis and alcohol) for self-medicating goals. This diagnosis is the most powerful correlation to completed suicide with the following components:
    * Symptoms have been experienced for more than one year
    * The adult also experienced childhood trauma
    * There is a depression component – Complex
    * The client is self-medicating – Complex

Adjustment Disorder

* The development of emotional or behavioral symptoms in response to an identifiable stressor reduced when stressor is lessened
* Significant impairment in social, occupational functioning
* Within 3 months
* Symptoms specify with:
  * Depressed mood
  * Anxiety
  * Disturbance of Conduct

Adjustment Disorder (Pathological Bereavement)

* Following the death of a close family member or friend, the individual experiences on more days than not, for at least 12 months
  * Intense yearning for the deceased
  * Intense sorrow
  * Preoccupation with the deceased/their death
  * Intense anger over the loss
  * Difficulty planning for the future

Gender Dysphoria in Children

* A strong desire to be of the other gender
* In boys, preference for cross-dressing
* In girls, preference for wearing only typical masculine clothing
* Preference for cross-gender roles in fantasy play
* Preference for the toys, games, or activities typical of the other gender
* In boys, a rejection of masculine toys and games
* In girls, a rejection of feminine toys and games
* Strong dislike of one's sexual anatomy

Gender Dysphoria in Adolescents and Adults

* A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics
  * A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence
  * A strong desire for the primary and/or secondary sex characteristics of the other gender
  * A strong desire to be the other gender and treated like the other gender
  * A strong conviction that one has the typical feelings and reactions of the other gender
* The condition is associated with clinically significant distress or impairment…

Substance Use and Addictive Disorders

* Thirteen classes – alcohol, amphetamine, caffeine, cannabis, cocaine, hallucinogens, inhalants, nicotine, opioids, phencyclidines (PCP), sedatives/hypnotics, anxiolytics
* Five groups:
  * Substance Use Disorders
  * Substance-Induced Disorders
  * Intoxication
  * Withdrawal
  * CNEC

Substance Use and Addictive Disorders

* Criteria for Substance Use Disorder Severe with Physiological Dependence
  * Must have all of the symptoms below:
    * Tolerance
    * Withdrawal
    * Increased use to reach desired effects
    * Unsuccessful attempt to cut down use
    * Frantic attempts to access their substances
    * Impairment in functioning
    * Continued use despite effects
  * All symptoms must be met with a severity index of 2 to 4 across time and circumstances
  * No change in specifiers and modifiers

Gambling Disorder

* Moved to Non-Substance Use category
* Symptoms
  * Preoccupation with gambling
  * Repeated unsuccessful attempts to stop
  * Restless and irritable when not gambling
  * Multiple losses (inherent in the activity)
  * Behavior is not due to Bipolar Disorder (manic episodes)

Other Behavioral Addiction Disorders Considered

* Pornography – Sexual Disorders
* Sex – Sexual Disorders
* Exercise – Eating Disorders
* Technology (Internet) – Sect. 3
* Eating – Eating Disorders
* Self-mutilation - Other
* Pyromania – Sect. 3
* Kleptomania – Sect. 3

Schizophrenia Spectrum and Other Psychotic Disorders

* Schizotypal Personality Disorder
* Delusional Disorder
* Brief Psychotic Disorder
* Schizophreniform Disorder
* Schizoaffective Disorder
* Schizophrenia

Schizophrenia

* Subtypes Discontinued
* Two or more of the following:
  * Delusions
  * Hallucinations
  * Disorganized Speech
  * Negative symptoms, e.g., diminished emotional expression
  * Catatonia
  * Age of onset Male (17-24), Female (26-32)
  * Symptoms for a month

Schizophrenia

* Pre-morbid functioning
* Cultural differences
* Gender differences
* Correlates to suicide and self-mutilation
* The stigma of schizophrenia
* Schizophrenia Differential Diagnosis
  * Substance-induced Psychosis
  * Schizophrenia with Depression (depression is secondary)
  * Depression with psychotic feature

Anxiety Disorders

* Separation Anxiety Disorder
* Panic Disorder
* Agoraphobia
* Specific Phobia
* Social Anxiety Disorder
* Generalized Anxiety Disorder

Separation Anxiety Disorder

* Age inappropriate and excessive fear or anxiety at:
  * Separation from major attachment figures
  * Refusal to go away from home e.g. school
  * Reluctance about being alone
  * Refusal to sleep away from home
  * Somatic complaints

Panic Disorder

* A panic attack is an episode of intense fear that someitme comes out of the blue (for no apparent reason). The symptoms of a panic attack include:
  * Racing heart
  * Shortness of breath
  * Dizziness
  * Sweating
  * Fear of losing control or
  * Dying

Agoraphobia

* Marked fear or anxiety for situations where escape may be difficult, Ex. Being in shops, cinemas, transportation by car or bus, etc.
  * Panic Disorder with or without Agoraphobia eliminated

Generalized Anxiety Disorder

* Symptoms in children: (0-11 yrs)
  * Severity index of 3 or 4 possibly culturally understandable or learned PTSD
* Symptoms in adolescents: (12-19 yrs)
  * Performance anxiety in athletics and/or academics
  * Highly correlated to suicide
* Symptoms in adults (20+ yrs)
  * 6 months of persistent worry and fretting
  * Develop management styles
  * Powerful vulnerability to cannabis
  * Major risk factor to suicide

Bipolar and Related Disorders

* Bipolar I
* Bipolar II
* Cyclothymic Disorder
* Substance-Induced Bipolar Disorder

Bipolar I Disorder

* Presence of one or more Manic Episodes (lasting one week)
  * Grandiosity/Psychosis
  * Decreased need for sleep
  * Thoughts are racing
  * Distractibility
  * Hyperactivity (e.g., unrestrained buying sprees, foolish business investments)
  * Presence of at least one depressive episode

Bipolar Symptoms in Children

* Mania
  * Hyperactivity, irritability, grandiosity with psychosis, elated mood, rapid speech/racing thoughts, refuses sleep
* Depression
  * Personality change, drop in grades, morbid, pessimistic, suicide ideation, somatic complaints (chronic)

Bipolar II Disorder

* Presence (or history) of one or more Major Depressive Episodes
* Presence (or history) of at least one Hypomanic episode
* There has never been a Manic Episode

Cyclothymic Disorder

* Two years of hypomanic episodes and depressive symptoms that do not meet diagnostic criteria
* No correlation to suicide
* Often seen as having “mood swings”
* Underdiagnosed

Depressive Disorders

* Disruptive Mood Dysregulation Disorder
* Major Depressive Disorder, Single Episode Major Depressive Disorder, Recurrent
* Dysthmic Disorder
* Premenstrual Dysphoric Disorder

Disruptive Mood Dysregulation Disorder

* Children who meet this diagnosis will also meet Opposition Defiant Disorder
* Onset before 10 years old
* Temper outbursts (verbal or behavioral) that are grossly out of proportion to events
* Occur more than three times a week
* Overall negative mood
* Not due to psychosis or PTSD
* Present for 12 months or more

Premenstrual Dysphoric Disorder

* Affects estimated 2% of female population
* At least 5 months out of 12
* One week prior to cycle
* Depression, hopelessness, self-critical
* Severity index of 3 or 4 required for diagnosis

Non-Suicidal Self Injury (Self Harm Syndromes)

* Individual has on 5 or more occasions engaged in intentional self-inflicted damage
* Intentional injury is associated with 2 of the following:
  * Interpersonal difficulties or negative feelings occurring immediately prior to the self-injurious act
  * Urge and Preoccupation
  * Activity is engaged in with the expectation of relief

Non-Suicidal Self Injury (Self Harm Syndromes)

* The behavior is the consequence of significant stressors:
  * Emotional Regulation Deficits
  * Dissociative Experiences
  * Body Dysmorphic Issues
  * Anxiety/Depression Regulation
  * Isolation and Social Cohesion Needs (cutting to get attention)

Non-Suicidal Self Injury (Self Harm Syndromes)

* The intentional injury is goal oriented and not a behavior occurring during psychosis, delirium, or intoxication
* It is not a socially or culturally sanctioned behavior (tattooing, body piercing, culturally sanctioned rituals) and has NO correlation to suicide intention
* There is NO correlation to behaviors due to the Autism Spectrum Disorder

Suicidal Behavior Disorder (V Code)

* Individual has initiated a behavior that is intended to lead to the individual's own death within the last 24 months
* Does not meet criteria for non-suicidal self injury
* Can apply to individuals who survived due to an interruption by 3rd party
* Act during intoxication does not preclude diagnosis

Suicidal Behavior Specifier

* Suicide ideation
  * Period of two months in duration where psychiatric, psychological, physical pain is so severe it defies individual's capacity to cope. The client views death as the only remedy.
* Chronic suicide ideation
  * Over one year in duration
* Suicide Attempts
  * Lethal act with intent to die. The act is accidentally rescued, self-rescued, miscalculated in lethality.

Obsessive-Compulsive and Related Disorders

* Obsessive-Compulsive Disorder
* Body Dysmophic Disorder
* Hoarding Disorder
* Hair-Pulling Disorder (Trichotillomania)
* Skin Picking Disorder

Obsessive-Compulsive Disorder

* Recurrent, persistent, intrusive thoughts which are suppressed or managed by compulsive acts (hand washing, safety checks, etc.)
* Thoughts are not psychotic, may be bizarre or unreasonable
* Awareness is key

Hoarding Disorder

* Persistent difficulty discarding or parting with possessions regardless of value
* Symptoms result in the accumulation of large number of possessions that fill up and clutter living space
* Must cause clinically significant distress or impairment in social, relational, or vocational functioning for the diagnosis
* People are usually unable to discard items due to
  * Indecision
  * Emotional attachment
  * Inability to organize

Dissociative Disorders

* Depersonalization/Derealization Disorder
* Dissociative Amnesia
* Dissociative Identity Disorder

Depersonalization/Derealization Disorder

* Depersonalization: Experiences of unreality, detachment, or being an outside observer with respect to one's thoughts, feelings, sensations, body, or actions. Often associated with self-injury
* Derealization: Experiences of unreality or detachment with respect to surroundings (e.g., individuals or objects are experienced as unreal, dreamlike)

Dissociative Amnesia

* An inability to recall important autobiographical information, inconsistent with ordinary forgetting (Specify if with Dissociative Fugue)
* Purposeful travel or bewildered wandering sudden, unexpected, with inability to recall some or all of one's past
* The travels associated with the condition can last for a few hours or as long as months
* Victims may suddenly realize that they do not belong where they find themselves

Dissociative Identity Disorder

* Victims of significant child physical and sexual abuse
* Childhood defense mechanism brought into adulthood
* Protective personality
* Validity remains in question – kappa .2
* Overwhelming false positives
* No risk for suicide

Feeding and Eating Disorders

* Pica
* Rumination Disorder
* Avoidant/Restrictive Food Intake Disorder
* Anorexia Nervosa
* Bulimia Nervosa
* Binge Eating Disorder

Rumination Disorder

* Eating copious amounts of food and regurgitating it (over and over)
* Process not an event
* Correlation with throat cancer

Avoidant/Restrictive Food Intake Disorder

* Eating disturbance (not limited to lack of interest in eating/food; avoidance because of the sensory characteristics of food)
* Weight loss/Nutritional deficiency; Need for enteral feeding/nutritional supplements
* Subtypes
  * Individuals who do not eat enough/ little interest in feeding;
  * Individuals who accept a limited diet in relation to senses
  * Individuals whose food refusal is related to aversive experience

Binge Eating Disorder

* Recurrent episodes of the following:
  * Eating, in a discrete period of time more food than a person would ordinarily eat
  * A sense of lack of control over eating
* The binge eating episodes are associated with 3 (or more) of the following:
  * Eating rapidly
  * Eating until feeling physically uncomfortably full
  * Eating large amounts of food when not feeling physically hungry
  * Eating alone because of feeling embarrassment
* The binge eating occurs, on average, at least once a week for 3 months

Disruptive, Impulse Control, and Conduct Disorders

* Oppositional Defiant Disorder
* Intermittent Explosive Disorder
* Conduct Disorder
  * Callous and Unemotional Specifier for Conduct Disorder (No more Anti-Social Personality Disorder)
* Dyssocial Personality

Callous and Unemotional Specifier for Conduct Disorder

* Meets full criteria for Conduct Disorder
* Callous Unemotional Traits
  * Lack of remorse/guilt
  * Callous lack of empathy
  * Unconcerned about performance e.g. school
  * Shallow or deficient affect, manipulative

Somatic Symptom Disorders (Previously Somatoform Disorders)

* Somatic Symptom Disorder
* Illness Anxiety Disorder
* Conversion Disorder (Functional Neurological Symptom Disorder)
* Psychological Factor Affecting Medical Condition

Somatic Symptom Disorder

* Somatic symptoms:
* Excessive thoughts, feelings, and behaviors related to these somatic symptoms or associated health concerns: At least one of the following must be present.
  1) Disproportionate and persistent thoughts about the seriousness of one's symptoms
  2) Persistently high level of anxiety about health or symptoms
  3) Excessive time and energy devoted to these symptoms
* Chronicity: Typically > 6 months

Illness Anxiety Disorder

* No diagnosed physical condition
* Preoccupation with having or acquiring a serious illness
* High level of anxiety about health
* Repeatedly checking one's body for signs of illness yet avoiding doctors' appointments and hospitals
* Symptoms present for at least 6 months

Specifiers

Care-seeking: care-seeking individuals have elevated rates of medical utilization

Care-avoidant: rarely seek medical care because seeing a physician and undergoing tests and diagnostic procedures heighten their anxiety to intolerable levels

Psychological Factors Affecting Medical Condition

* Serious medical condition is present and diagnosed
* Behaviors adversely affect the medical condition:
  * Refusal to respond to medical directives
  * Factors may be defined as sub-intentional suicide intent in those with terminal or chronic conditions

Assessment of Personality Pathology

A standard approach to the assessment of personality pathology using the DSM-5 model could be the following:

1. Is impairment in personality functioning (self and interpersonal) present or not?
2. If so, rate the level of impairment in self (identity or self-direction) and interpersonal (empathy or intimacy) functioning on the levels of Personality Functioning Scale.
3. Is one of the 6 defined types present?
4. Record the type and severity of impairment.

Assessment of Personality Pathology (cont.)

5. If not, is PDTS-Trait Specified present?
6. If so, record PDTS, identify and list the trait domain(s) that are applicable, and record the severity of impairment.
7. If a PD is present and a detailed personality profile is desired and in the case conceptualization evaluated the trait facets.
8. If neither a specific PD type or PDTS is present, evaluate the trait domains, if these are relevant and helpful in the case conceptualization.

Personality Traits: 5 Domains

1. Negative Affectivity: Frequently experiences negative emotions
2. Disinhibition: Impulsive
3. Antagonism: Difficult to get along with
4. Detachment: Withdrawal from others
5. Psychoticism: Unusual or bizarre experiences

A Sample Diagnostic from the DSM 5

* Major Depressive Disorder, Recurrent
  1. Good insight
  4. Very severe impairment

  Chronic suicide ideation

  Suicide attempt history with accidental rescue
* Gambling Disorder
  3. Absent insight
  4. Severe impairment

  Suicide specifier addressed

QUESTIONS?
COMMENTS?

Autism Spectrum Disorder

DIAGNOSIS AND ASSESSMENT OF AUTISM SPECTRUM DISORDER

CAMILLE LAFLEUR, PH.D., LCMFT

VALUES INHERENT IN THE DSM

- THE MERE ACT OF SPECIFYING WHAT TO OBSERVE ASKS PRACTITIONERS TO BE BOTH "OBJECTIVE" AND TO MAKE JUDGMENTS ABOUT WHAT IS NORMAL VERSUS ABNORMAL BEHAVIOR; VALUES WILL ALWAYS BE CENTRAL TO MAKING SUCH IMPORTANT DECISIONS.
- THE DSM AS A DIAGNOSTIC SYSTEM SEEKS TO MIMIC THE MEDICAL APPROACH, AND SO LEAVES MANY ASSUMING THAT THERE IS A PALPABLE DISEASE UNDERLYING EACH DIAGNOSIS

"A DOZEN GENERAL TIPS FOR ACCURATE AND SAFE DIAGNOSIS"

- 1. HIPPOCRATES SAID THAT KNOWING THE PATIENT IS JUST AS IMPORTANT AS KNOWING THE DISEASE. KNOW CONTEXT: TIME, PLACE, AND PERSON.
- 2. TAKE THE TIME AND MAKE THE EFFORT. ADEQUATE TIME. MULTIPLE INTERVIEWS.
- 3. IF YOU HEAR HOOF BEATS ON BROADWAY, THINK HORSES, NOT ZEBRAS! WHEN IN DOUBT… GO WITH THE ODDS. STICK WITH THE MORE COMMON DIAGNOSES.
- 4. GET ALL THE INFORMATION YOU CAN. NO ONE SOURCE IS EVER COMPLETE. TRIANGULATION OF DATA.

A DOZEN TIPS CONTINUED…

- 5. CONSIDER PREVIOUS DIAGNOSES, BUT DON'T BLINDLY BELIEVE THEM. INCORRECT DIAGNOSES TEND TO HAVE A LONG HALF-LIFE AND UNFORTUNATELY STAYING POWER.
- 6. CONSTANTLY REVISIT THE DIAGNOSIS. DON'T BE BLIND. BE OPEN TO CONTRADICTORY DATA.
- 7. CHILDREN AND TEENAGERS ARE ESPECIALLY HARD TO DIAGNOSE. THEY HAVE A SHORT TRACK RECORD, MATURE AT VARYING RATES, MAY BE USING DRUGS OR ALCOHOL, AND ARE REACTIVE TO FAMILY AND ENVIRONMENTAL STRESSES. THE INITIAL DIAGNOSIS IS LIKELY TO CHANGE.
- 8. THE ELDERLY ARE HARD TO DIAGNOSE. THEIR PSYCHIATRIC SYMPTOMS MAY BE CAUSED BY NEUROLOGICAL OR OTHER MEDICAL ILLNESS, AND THEY ARE PRONE TO DRUG SIDE EFFECTS, INTERACTIONS, AND OVERDOSES.

A DOZEN TIPS CONTINUED…

- 9. THE LESS SEVERE THE PRESENTATION, THE MORE DIFFICULT IT IS TO DIAGNOSE. THERE IS NO BRIGHT LINE DEMARCATING THE VERY HEAVILY POPULATED BOUNDARY BETWEEN MENTAL DISORDER AND NORMALITY. MILDER PROBLEMS OFTEN RESOLVE SPONTANEOUSLY WITH TIME AND WITHOUT NEED FOR DIAGNOSIS AND TREATMENT.
- 10. WHEN YOU ARE IN DOUBT, IT IS SAFER AND MORE ACCURATE TO UNDERDIAGNOSE. IT IS EASIER TO STEP UP TO A MORE SEVERE DIAGNOSIS THAN TO STEP DOWN FROM IT.
- 11. ACCURATE DIAGNOSIS CAN BRING GREAT BENEFITS; INACCURATE DIAGNOSIS CAN BRING DISASTER.
- 12. ALWAYS REMEMBER THE OTHER ENDURING DICTUM FROM HIPPOCRATES: "FIRST, DO NO HARM."

Francis, A. 2013. Essential of Psychiatric Diagnosis: Responding to the Challenges of DSM-5.

ELEMENTS OF A FULL DIAGNOSIS

- INTERVIEW WITH THE PERSON
- OBSERVATION OF THE PERSON
- INTERVIEW WITH AN INFORMANT ABOUT THE PERSON'S DIFFICULTIES IN DAILY LIFE.

DSM 5 CHANGES

- AUTISM: NEW NAME REFLECTS SCIENTIFIC CONSENSUS THAT THE 4 SEPARATE DISORDERS WERE ACTUALLY A SINGLE CONDITION WITH DIFFERENT LEVEL OF SEVERITY IN 2 CORE DOMAINS. ASD = AUTISM, ASPERGER'S, CHILDHOOD DISINTEGRATIVE, AND PDD, NOS.
- OVERALL DIAGNOSTIC CRITERIA REMAIN THE SAME
- CONCERNS ABOUT AUTISM NOT BEING "HOMOGENOUS"

DSM 5 CHANGES

- DSM-IV-TR – ASD INDICATED IMPAIRMENT IN THREE AREAS:
  - SOCIAL INTERACTION
  - SOCIAL COMMUNICATION
  - SOCIAL IMAGINATION
    - DECREASED CAPACITY TO THINK ABOUT AND PREDICT THE CONSEQUENCES OF ONE'S OWN ACTIONS AND THOSE OF OTHER PEOPLE
- DSM 5 – INDICATES IMPAIRMENT ONLY IN SOCIAL INTERACTION AND SOCIAL COMMUNICATION

Wing, L., Gould, J., & Gillberg, C. (2011). Autism spectrum disorders in the DSM-V: Better or worse than the DSM-IV? Research in Developmental Disabilities, 32, pg. 768-773. DOI: 10.1016/j.ridd.2010.11.003.

DIAGNOSTIC CRITERIA

A. PERSISTENT DEFICITS IN SOCIAL COMMUNICATION AND SOCIAL INTERACTION ACROSS CONTEXTS, AS MANIFESTED BY THE FOLLOWING, CURRENTLY OR BY HISTORY:

1. DEFICITS IN SOCIAL-EMOTIONAL RECIPROCITY, RANGING, FOR EXAMPLE, FROM ABNORMAL SOCIAL APPROACH AND FAILURE OF NORMAL BACK-AND-FORTH CONVERSATION; TO REDUCED SHARING OF INTERESTS, EMOTIONS, OR AFFECT; TO FAILURE TO INITIATE OR RESPOND TO SOCIAL INTERACTIONS
2. DEFICITS IN NONVERBAL COMMUNICATIVE BEHAVIORS USED FOR SOCIAL INTERACTION, RANGING, FOR EXAMPLE, FROM POORLY INTEGRATED VERBAL AND NONVERBAL COMMUNICATION; TO ABNORMALITIES IN EYE CONTACT AND BODY LANGUAGE OR DEFICITS IN UNDERSTANDING AND USE OF GESTURES; TO A TOTAL LACK OF FACIAL EXPRESSIONS AND NONVERBAL COMMUNICATION.
3. DEFICITS IN DEVELOPING, MAINTAINING, AND UNDERSTANDING RELATIONSHIPS, RANGING, FOR EXAMPLE, FROM DIFFICULTIES ADJUSTING BEHAVIOR TO SUIT VARIOUS SOCIAL CONTEXTS; TO DIFFICULTIES IN SHARING IMAGINATIVE PLAY OR IN MAKING FRIENDS; TO ABSENCE OF INTEREST IN PEERS.

DIAGNOSTIC CRITERIA

B. RESTRICTED, REPETITIVE PATTERNS OF BEHAVIOR, INTERESTS, OR ACTIVITIES, AS MANIFESTED BY AT LEAST TWO OF THE FOLLOWING, CURRENTLY OR BY HISTORY:

1. STEREOTYPED OR REPETITIVE MOTOR MOVEMENTS, USE OF OBJECTS, OR SPEECH
2. INSISTENCE ON SAMENESS, INFLEXIBLE ADHERENCE TO ROUTINES,, OR RITUALIZED PATTERNS OF VERBAL OR NONVERBAL BEHAVIOR
3. HIGHLY RESTRICTED, FIXATED INTERESTS THAT ARE ABNORMAL IN INTENSITY OR FOCUS
4. HYPER- OR HYPOREACTIVITY TO SENSORY INPUT OR UNUSUAL INTEREST IN SENSORY ASPECTS OF THE ENVIRONMENT

C. SYMPTOMS MUST BE PRESENT IN THE EARLY DEVELOPMENTAL PERIOD

D. SYMPTOMS CAUSE CLINICALLY SIGNIFICANT IMPAIRMENT IN SOCIAL, OCCUPATIONAL, OR OTHER IMPORTANT AREAS OF CURRENT FUNCTIONING

E. THESE DISTURBANCES ARE NOT BETTER EXPLAINED BY INTELLECTUAL DISABILITY OR GLOBAL DEVELOPMENTAL DELAY. INTELLECTUAL DISABILITY AND AUTISM SPECTRUM DISORDER FREQUENTLY CO-OCCUR; TO MAKE COMORBID DIAGNOSES OF AUTISM SPECTRUM DISORDER AND INTELLECTUAL DISABILITY, SOCIAL COMMUNICATION SHOULD BE BELOW THAT EXPECTED FOR GENERAL DEVELOPMENTAL LEVEL

SEVERITY LEVELS FOR AUTISM SPECTRUM DISORDER

Severity level	Social communication	Restricted, repetitive behaviors
Level 3 **"Requiring very substantial support"**	Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social overtures from others.	Inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changing focus or action.
Level 2 **"Requiring substantial support"**	Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others.	Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.
Level 1 **"Requiring support"**	Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions, and clear examples of atypical or unsuccessful responses to social overtures of others. May appear to have decreased interest in social interactions.	Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.

WILL THE CHANGES AFFECT DIAGNOSES?

- GIVEN THE SIMILARITIES IN DIAGNOSTIC CRITERIA, DIAGNOSES BETWEEN DSM 5 CRITERIA AND DSM IV-TR CRITERIA REMAIN ACCURATE
- HUERTA ET AL. FOUND THAT THE MAJORITY OF CHILDREN WITH CLINICAL DIAGNOSES OF PDDS MET THE DSM-5 ASD CRITERIA

CONCERNS ABOUT CHANGE AFFECTING SERVICES

- INDIVIDUALS ON THE SPECTRUM NOT MEETING THE MORE STRINGENT CRITERIA OF ASD
- CONCERNS WITH SOCIAL IMAGINATION, DIAGNOSIS IN INFANCY AND ADULTHOOD, THE REMOVAL OF SUBGROUPS, AND THE UNRECOGNIZED OR MISDIAGNOSIS OF GIRLS AND WOMEN WITH AUTISM
- OBJECTION TO THE AUTISM LABEL

Lai, M. C., Lombardo, M., Chakrabarti, B., & Baron-Cohen, S. (2013). Subgrouping the autism "spectrum": Reflections on DSM-5. PLOS Biology, Vol 11(4), pg. 1-7.
Wing, L., Gould, J., & Gillberg, C. (2011). Autism spectrum disorders in the DSM-V: Better or worse than the DSM-IV? *Research in Developmental Disabilities,* 32, pg. 768-773. DOI: 10.1016/j.ridd.2010.11.003.

AUTISM SERVICES IN YOUR AREA

- HOW IS AUTISM HANDLED IN YOUR AGENCY?
- DO YOU SEE THE DIAGNOSTIC CHANGES IMPACTING SERVICES? BILLING?
- DO YOU BELIEVE YOUR AGENCY CAN EFFECTIVELY TREAT INDIVIDUALS ON THE AUTISM SPECTRUM?
- IS THERE A CUTOFF PER SEVERITY LEVELS?

THREE-PART DIAGNOSIS

- INTERVIEW WITH THE CAREGIVER
- OBSERVATION OF THE INDIVIDUAL
  - REAL LIFE OBSERVATION
  - PART OF A PSYCHIATRIC EVALUATION CENTER
- PSYCHOLOGICAL EVALUATION OF THE INDIVIDUAL'S COGNITIVE LEVEL

Lauritsen, M. B. (2013). Autism spectrum disorders. European Child and Adolescent Psychiatry, 22(1), pg. 37-42. DOI: 10.1007/s00787-012-0359-5.

COMORBIDITY

- REPORTED UNDERDIAGNOSES OF ASD AMONG CHILDREN WITH DOWN SYNDROME (DS)
- DISORDERED SLEEP AND FOOD SELECTIVITY ARE WELL-RECOGNIZED CO-MORBID ISSUES
- 70% OF INDIVIDUALS WITH ASD MEET THE CRITERIA FOR AT LEAST ONE OTHER DISORDER

Yates, K., & Couteur, A. L. (2012). Diagnosing autism. Pediatrics and Child Health, 23(1), pg. 5-10.

PROBLEMS THAT MAY ACCOMPANY ASD

- SENSORY PROBLEMS
- MENTAL RETARDATION
- SEIZURES
  - 1 IN 4 CHILDREN DEVELOP SEIZURES, OFTEN STARTING IN EARLY CHILDHOOD OR ADOLESCENCE.
- FRAGILE X SYNDROME
  - MOST COMMON INHERITED FORM OF MENTAL RETARDATION
  - AFFECTS ABOUT 2 TO 5 PERCENT OF PEOPLE WITH ASD
  - 10 TO 15 PERCENT OF THOSE WITH FRAGILE X SHOW AUTISTIC TRAITS
- TUBEROUS SCLEROSIS
  - RARE GENETIC DISORDER THAT CAUSES BENIGN TUMORS TO GROW IN THE BRAIN AS WELL AS IN OTHER VITAL ORGANS
  - 1 TO 4 PERCENT OF PEOPLE WITH ASD ALSO HAVE TUBEROUS SCLEROSIS

Judd, S. J. (2007). Autism and pervasive developmental disorders sourcebook: basic consumer health information about autism spectrum and pervasive developmental disorders, such as classical autism, asperger syndrome, rett syndrome, and childhood disintegrative disorder, including information about related genetic disorders and medical problems and facts about causes, screening methods, diagnostic criteria, treatments and interventions, and family and education issues. Omnigraphics Inc.

COMMUNICATING AN ASD DIAGNOSIS

- HAVING WRITTEN INFORMATION HELPS PARENTS TO UNDERSTAND THE DIAGNOSIS
- HAVING A STRUCTURED AND FOCUSED SESSION TO CONVEY THE DIAGNOSIS AND INFORMATION IS HELPFUL TO PARENTS
- PARENTS VALUE CLINICIANS WHO ARE HOLISTIC AND HOPEFUL IN THEIR APPROACH

Abbott, M., Bernard, P., & Forge, J. (2013). Communicating a diagnosis of autism spectrum disorder – A qualitative study of parents' experiences. Clinical Child Psychology and Psychiatry, 18, pg. 370. DOI: 10.1177/135914512455813.

ASSESSMENT

- INFORMAL ASSESSMENT
  - OFTEN DONE BY PARENTS, CAREGIVERS, RELATIVES, TEACHERS, THOSE ENGAGED IN CHILD'S LIFE
- FORMAL ASSESSMENT
  - STANDARDIZED, NORM-REFERENCED OR CRITERION-REFERENCED ASSESSMENT TOOLS

ASSESSMENT

- TWO TYPES OF SCREENING FOR ASD
  - POPULATION METHOD
    - COHORTS ARE SCREENED FOR THE NEED FOR FURTHER ASSESSMENT
  - SPECIFIC SCREENING OF AN INDIVIDUAL

ASSESSMENT

- AREAS OF ASSESSMENT
  - PRACTICAL SKILLS AND MOTOR FUNCTIONING
  - SOCIAL INTERACTION SKILLS AND COMMUNICATION
  - EMOTIONAL UNDERSTANDING
  - SELF-REGULATION
  - IMPULSE CONTROL
  - INTERESTS
  - SEXUAL INTERESTS AND DESIRES
  - INSIGHT
  - MOTIVATION

ASSESSMENT TOOLS

- CHILDHOOD AUTISM TEST (CHAT)
  - SCREENING TOOL DEVELOPED FOR PEDIATRICIANS TO USE AT THE EIGHTEEN-MONTH CHECKUP FOR CHILDREN. CLINICIANS COMPLETE FIVE ITEMS BASED ON OBSERVATION AND ASK PARENTS TO ANSWER YES/NO TO AN ADDITIONAL NINE ITEMS. EACH SECTION TAKES AN AVERAGE OF FIVE MINUTES TO COMPLETE.

ASSESSMENT TOOLS

- CHILDHOOD AUTISM RATING SCALE (CARS) BY SCHOPLER, REICHLER, DEVELLIS, & DALY, 1980 AND REVISED IN 1986 BY SCHOPLER, REICHLER, & RENNER.
- EASY TO ADMINISTER WITHOUT SUBSTANTIAL TRAINING OR EXPERIENCE
- ITEMS: RELATING TO PEOPLE; IMITATION; EMOTIONAL RESPONSE; BODY USE; OBJECT USE; ADAPTATION TO CHANGE; VISUAL RESPONSE; LISTENING RESPONSE; TASTE, SMELL, AND TOUCH RESPONSE AND USE; FEAR OR NERVOUSNESS; VERBAL COMMUNICATION; NONVERBAL COMMUNICATION; ACTIVITY LEVEL; CONSISTENCY OF INTELLECTUAL RESPONSE; GENERAL IMPRESSIONS
- EACH ITEM IS RATED ON A SCALE OF 1-4 SO THE TOTAL SCORE RANGE IS FROM 15 – 60.
- CUTOFF SCORES: NONAUTISTIC: 15-29, MILDLY TO MODERATELY AUTISTIC: 30-36.5, SEVERELY AUTISTIC: 37-60.

Van Bourgondien, M.E. & Mesibov, G.B. (1989). Diagnosis and treatment of adolescents and adults with autism. In Autism: Nature, Diagnosis, and Treatment. (Ed.) Dawson, G. Guilford Press: New York.

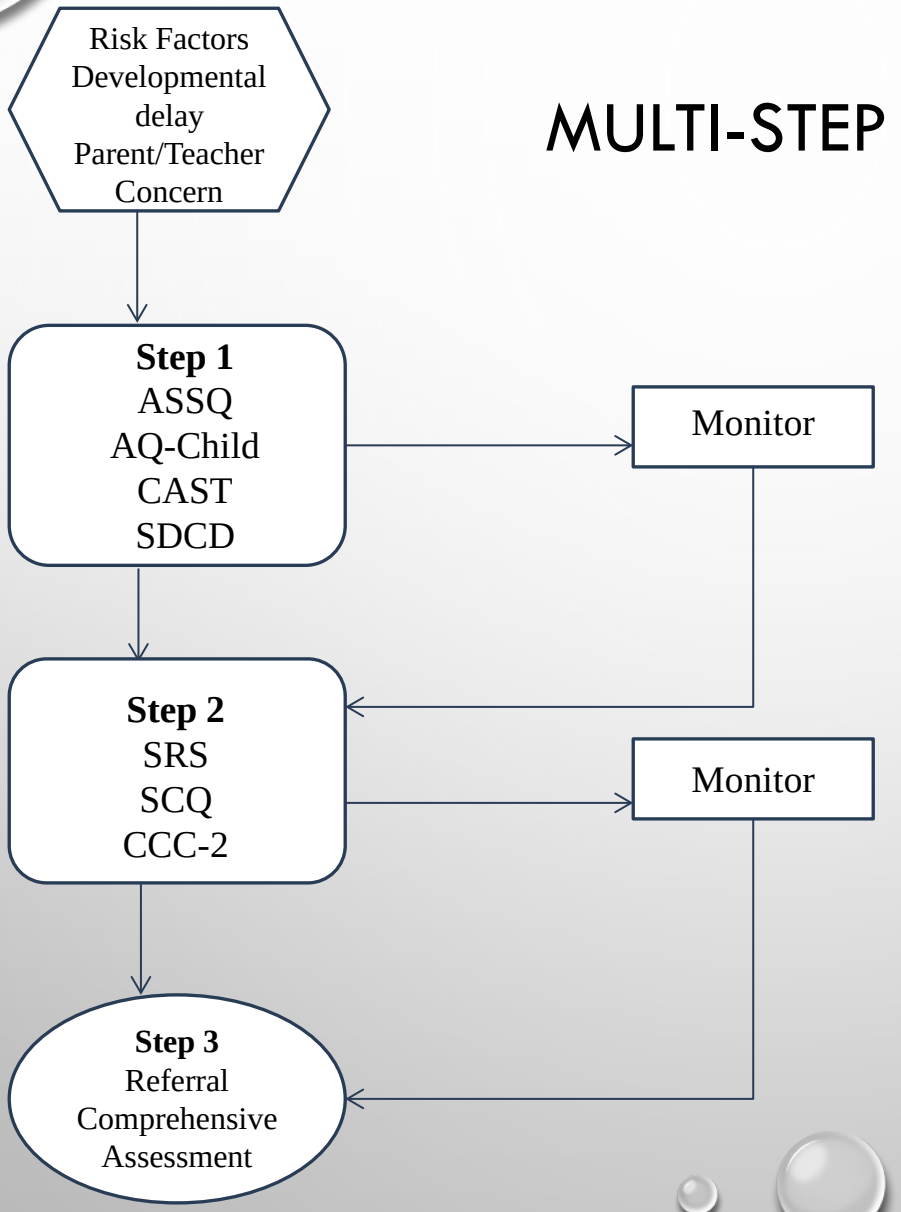
PARENT COMPLETION ASSESSMENTS

- ASSQ = AUTISM SPECTRUM SCREENING QUESTIONNAIRE
- AQ-CHILD = AUTISM SPECTRUM QUOTIENT: CHILDREN'S VERSION
- CAST = CHILDHOOD AUTISM SPECTRUM TEST
- CCC = CHILDREN'S COMMUNICATION CHECKLIST
- SCDC = SOCIAL COMMUNICATION DISORDERS CHECKLIST
- SCQ = SOCIAL COMMUNICATION QUESTIONNAIRE
- SRS = SOCIAL RESPONSIVENESS SCALE

PARENT COMPLETION ASSESSMENTS

Measure	Age range	Format (no. of items)	Sensitivity	Specificity	Time to Complete
ASSQ	6-17	Parent/Teacher (27)	.91	.86	10 minutes
AQ-Child	4-11	Parent (50)	.95	.95	10 minutes
CAST	4-11	Parent (37)	1.0	.97	10 minutes
CCC-2	4-16	Parent or Professional (70)	.89	.97	10-15 minutes
SCDC	4-16	Parent (12)	.88	.91	10 minutes
SCQ	4-Adult	Parent (40)	.85	.75	10 minutes
SRS	4-18	Parent/Teacher (65)	.85	.75	10-20 minutes

MULTI-STEP SCREENING PROCESS



BEST PRACTICE IN ASSESSMENT

1. CHILDREN WHO SCREEN POSITIVE FOR ASD SHOULD BE REFERRED FOR A COMPREHENSIVE ASSESSMENT.
2. ASSESSMENT SHOULD INVOLVE CAREFUL ATTENTION TO THE SIGNS AND SYMPTOMS CONSISTENT WITH ASD AS WELL AS OTHER COEXISTING CHILDHOOD DISORDERS.
3. WHEN A STUDENT IS SUSPECTED OF HAVING AN ASD, A REVIEW OF HIS OR HER DEVELOPMENTAL HISTORY IN AREAS SUCH AS SPEECH, COMMUNICATION, SOCIAL AND PLAY SKILLS IS AN IMPORTANT FIRST STEP IN THE ASSESSMENT PROCESS.

BEST PRACTICE IN ASSESSMENT

4. A FAMILY MEDICAL HISTORY AND REVIEW OF PSYCHOSOCIAL FACTORS THAT MAY PLAY A ROLE IN THE CHILD'S DEVELOPMENT IS A SIGNIFICANT COMPONENT OF THE ASSESSMENT PROCESS.
5. THE INTEGRATION OF INFORMATION FROM MULTIPLE SOURCES WILL STRENGTHEN THE RELIABILITY OF THE ASSESSMENT RESULTS.
6. EVALUATION OF ACADEMIC ACHIEVEMENT SHOULD BE INCLUDED IN ASSESSMENT AND INTERVENTION PLANNING TO ADDRESS LEARNING AND BEHAVIORAL CONCERNS IN THE CHILD'S OVERALL SCHOOL FUNCTIONING.

BEST PRACTICE IN ASSESSMENT

7. ASSESSMENT PROCEDURES SHOULD BE DESIGNED TO ASSIST IN THE DEVELOPMENT OF INSTRUCTIONAL OBJECTIVES AND INTERVENTION STRATEGIES BASED ON THE STUDENT'S UNIQUE PATTERN OF STRENGTHS AND WEAKNESSES.
8. BECAUSE IMPAIRMENT IN COMMUNICATION AND SOCIAL RECIPROCITY ARE CORE FEATURES OF ASD, A COMPREHENSIVE DEVELOPMENTAL ASSESSMENT SHOULD INCLUDE BOTH DOMAINS.

Wilkinson, L. (2010). A best practice guide to assessment and intervention for autism and Asperger syndrome in schools. Jessica Kingsley Publishers.

ROLE OF THE FAMILY IN ASSESSMENT

- PARENTS NEED HELP AND HAVE MORE QUESTIONS THAN ANSWERS FROM THE MOMENT THAT A DIAGNOSIS OF ASD IS MENTIONED TO THEM.
- SUPPORT NEEDED WILL VARY FROM PARENT TO PARENT.
- PARENTS OF CHILDREN DIAGNOSED WITH DEVELOPMENTAL DISABILITIES EXPERIENCE A GRIEF PROCESS – GRIEVING THE LOSS OF THE TYPICAL CHILD THEY THOUGHT THEY HAD

Casey, L. B., & Elswick, S. E. (2011). The social worker's role in the assessment of autism spectrum

MULTIDISCIPLINARY ASSESSMENT

- FOR A COMPLETE AND ACCURATE ASSESSMENT A MULTIDISCIPLINARY TEAM IS NECESSARY
- WHAT BARRIERS EXIST WHEN TRYING TO FORM A MULTIDISCIPLINARY TEAM?
- WHAT CAN BE DONE TO DEVELOP MULTIDISCIPLINARY TEAMS IN YOUR AREA?

GOAL OF TREATMENT

- OPTIMIZE THE FUNCTIONAL INDEPENDENCE OF THE INDIVIDUAL WITH ASD BY MINIMIZING THE CORE ASD FEATURES
- INTERVENTION OR TREATMENT FOR THOSE WITH ASD NEEDS TO INCLUDE EDUCATION AND SUPPORT FOR THE FAMILIES

Lauritsen, M. B. (2013). Autism spectrum disorders. European Child and Adolescent Psychiatry, 22(1), pg. 37-42. DOI: 10.1007/s00787-012-0359-5.

CULTURAL TIPS TO CONSIDER FOR ASSESSMENT AND DIAGNOSIS

- MORE MALES THAN FEMALES ARE AFFECTED WITH ASD
- AWARENESS OF MASS MEDIA CAMPAIGNS
- OBSERVATION OF BEHAVIORS MAY RESEMBLE CULTURAL NORMS
- ASSESSMENT TOOLS MAY NOT BE UNDERSTANDABLE DUE TO DIFFERENT LEVELS OF FLUENCY FOR ESL POPULATION
- COMMUNICATING RESULTS MAY BE CONSIDERED AS STIGMATIZING
- HAVE A SYSTEM IN PLACE FOR COORDINATING REFERRAL APPOINTMENTS

Pasco, G. (2011). The diagnosis and epidemiology of autism. Tizard Learning Disability Review, Vol 16(4), pg. 5-19. DOI: 10.1108/13595471111172813.
Wing, L., Gould, J., & Gillberg, C. (2011). Autism spectrum disorders in the DSM-V: Better or worse than the DSM-IV? *Research in Developmental Disabilities*, 32, pg. 768-773. DOI: 10.1016/j.ridd.2010.11.003.

QUESTIONS?

COMMENTS?

PART 2 – APRIL 11
9AM – 12PM

- PART 2 WILL COVER TREATMENT OF ASD WITH INDIVIDUALS, FAMILIES, AND USING IN-HOME TREATMENT
- ADDITIONAL RESOURCES AVAILABLE IN KANSAS WILL ALSO BE OUTLINED

REGISTER TODAY!

WWW.TRAININGTEAMS.ORG

TREATMENT OF AUTISM SPECTRUM DISORDER

CAMILLE LAFLEUR, PHD, LCMFT

UNA HENRY, MS

DSM 5 DIAGNOSTIC CRITERIA

A. PERSISTENT DEFICITS IN SOCIAL COMMUNICATION AND SOCIAL INTERACTION ACROSS CONTEXTS, AS MANIFESTED BY THE FOLLOWING, CURRENTLY OR BY HISTORY:
   1. DEFICITS IN SOCIAL-EMOTIONAL RECIPROCITY, RANGING, FOR EXAMPLE, FROM ABNORMAL SOCIAL APPROACH AND FAILURE OF NORMAL BACK-AND-FORTH CONVERSATION; TO REDUCED SHARING OF INTERESTS, EMOTIONS, OR AFFECT; TO FAILURE TO INITIATE OR RESPOND TO SOCIAL INTERACTIONS
   2. DEFICITS IN NONVERBAL COMMUNICATIVE BEHAVIORS USED FOR SOCIAL INTERACTION, RANGING, FOR EXAMPLE, FROM POORLY INTEGRATED VERBAL AND NONVERBAL COMMUNICATION; TO ABNORMALITIES IN EYE CONTACT AND BODY LANGUAGE OR DEFICITS IN UNDERSTANDING AND USE OF GESTURES; TO A TOTAL LACK OF FACIAL EXPRESSIONS AND NONVERBAL COMMUNICATION.
   3. DEFICITS IN DEVELOPING, MAINTAINING, AND UNDERSTANDING RELATIONSHIPS, RANGING, FOR EXAMPLE, FROM DIFFICULTIES ADJUSTING BEHAVIOR TO SUIT VARIOUS SOCIAL CONTEXTS; TO DIFFICULTIES IN SHARING IMAGINATIVE PLAY OR IN MAKING FRIENDS; TO ABSENCE OF INTEREST IN PEERS.

DSM 5
DIAGNOSTIC CRITERIA (CONT.)

B. RESTRICTED, REPETITIVE PATTERNS OF BEHAVIOR, INTERESTS, OR ACTIVITIES, AS MANIFESTED BY AT LEAST TWO OF THE FOLLOWING, CURRENTLY OR BY HISTORY:
   1. STEREOTYPED OR REPETITIVE MOTOR MOVEMENTS, USE OF OBJECTS, OR SPEECH
   2. INSISTENCE ON SAMENESS, INFLEXIBLE ADHERENCE TO ROUTINES,, OR RITUALIZED PATTERNS OF VERBAL OR NONVERBAL BEHAVIOR
   3. HIGHLY RESTRICTED, FIXATED INTERESTS THAT ARE ABNORMAL IN INTENSITY OR FOCUS
   4. HYPER- OR HYPO-REACTIVITY TO SENSORY INPUT OR UNUSUAL INTEREST IN SENSORY ASPECTS OF THE ENVIRONMENT

C. SYMPTOMS MUST BE PRESENT IN THE EARLY DEVELOPMENTAL PERIOD

D. SYMPTOMS CAUSE CLINICALLY SIGNIFICANT IMPAIRMENT IN SOCIAL, OCCUPATIONAL, OR OTHER IMPORTANT AREAS OF CURRENT FUNCTIONING

E. THESE DISTURBANCES ARE NOT BETTER EXPLAINED BY INTELLECTUAL DISABILITY OR GLOBAL DEVELOPMENTAL DELAY. INTELLECTUAL DISABILITY AND AUTISM SPECTRUM DISORDER FREQUENTLY CO-OCCUR; TO MAKE COMORBID DIAGNOSES OF AUTISM SPECTRUM DISORDER AND INTELLECTUAL DISABILITY, SOCIAL COMMUNICATION SHOULD BE BELOW THAT EXPECTED FOR GENERAL DEVELOPMENTAL LEVEL

SEVERITY LEVELS FOR AUTISM SPECTRUM DISORDER

Severity level	Social communication	Restricted, repetitive behaviors
Level 3 "Requiring very substantial support"	Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social overtures from others.	Inflexibility of behavior, extreme difficulty coping with change, or other restricted/repetitive behaviors markedly interfere with functioning in all spheres. Great distress/difficulty changing focus or action.
Level 2 "Requiring substantial support"	Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others.	Inflexibility of behavior, difficulty coping with change, or other restricted/repetitive behaviors appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.
Level 1 "Requiring support"	Without supports in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions, and clear examples of atypical or unsuccessful responses to social overtures of others. May appear to have decreased interest in social interactions.	Inflexibility of behavior causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organization and planning hamper independence.

THREE-PART DIAGNOSIS

- INTERVIEW WITH THE CAREGIVER
- OBSERVATION OF THE INDIVIDUAL
  - REAL LIFE OBSERVATION (SCHOOL AND/OR HOME)
  - PART OF A PSYCHIATRIC EVALUATION CENTER
- PSYCHOLOGICAL EVALUATION OF THE INDIVIDUAL'S COGNITIVE LEVEL
- SOME RESEARCH INCLUDED A DEVELOPMENTAL HISTORY AND REVIEW OF RECORDS AS PART OF THE ASSESSMENT/DIAGNOSING PHASE (AKSHOOMOFF, CORSELLO, & SCHMIDT, 2006)
- OTHER RESEARCH SUGGESTS USING A MULTIAGENCY TEAM TO HELP ASSES ASD IN INDIVIDUALS ESPECIALLY YOUNG CHILDREN UNDER THE AGE OF THREE.

Lauritsen, M. B. (2013). Autism spectrum disorders. European Child and Adolescent Psychiatry, 22(1), pg. 37-42. DOI: 10.1007/s00787-012-0359-5.

ASD SECONDARY DIAGNOSES

- SOCIAL ANXIETY DISORDER
- ATTENTION DEFICIT/HYPERACTIVITY DISORDER
- OPPOSITIONAL DEFIANT DISORDER
- DEPRESSION DISORDER
- BIPOLAR DISORDER

COMMUNICATING AN ASD DIAGNOSIS

- HAVING WRITTEN INFORMATION HELPS PARENTS TO UNDERSTAND THE DIAGNOSIS
- HAVING A STRUCTURED AND FOCUSED SESSION TO CONVEY THE DIAGNOSIS AND INFORMATION IS HELPFUL TO PARENTS
- PARENTS VALUE CLINICIANS WHO ARE HOLISTIC AND HOPEFUL IN THEIR APPROACH

Abbott, M., Bernard, P., & Forge, J. (2013). Communicating a diagnosis of autism spectrum disorder – A qualitative study of parents' experiences. Clinical Child Psychology and Psychiatry, 18, pg. 370. DOI: 10.1177/1359104512455813.

THE PHASES OF THERAPY

PHASES ADDRESSING *FAMILIES MANAGING ASD*

How will you know when the family is adequately adjusted to the ongoing demands of living with ASD? — Termination

What will it take to equip and empower the family members with the skills needed for meeting the long-term demands of ASD management? — Interventions

What is the immediate need of the family? Does the family recognize their collaborative role in the process of therapy? — Contracting with Family — *Treatment Goal-Setting*

How are family members responding to the tasks needed to manage the ASD? — Assessing Family — *Diagnosis*

What is your understanding of the members' multiple perspectives and experiences of living with ASD? — Joining with Family — *Rapport*

ASSUMPTIONS INFORMING THE PHASES OF THERAPY

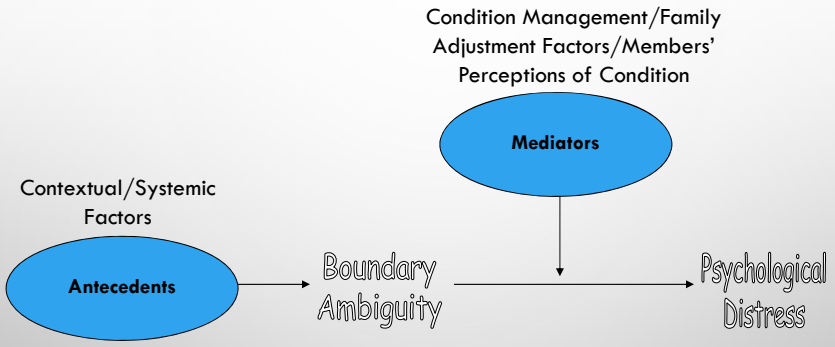
- ESTABLISH GOALS AND EXPECTATIONS OF THERAPY
- ADDRESS THE MULTIPLE NEEDS OF THE FAMILY
- USE OF INTERVENTIONS THROUGHOUT THE COURSE OF THERAPY
- DEFINING THE COMPLIMENTARY ROLES IN THERAPY
  - CLIENT'S ROLE
  - THERAPIST'S ROLE
- DETERMINE AND MAKE PROGRESS TOWARD ACCOMPLISHING THERAPEUTIC OUTCOMES

JOINING WITH THE WHOLE FAMILY

JOINING WITH THE FAMILY IN THEIR HOME

- HOME AS A NATURAL SETTING
- FAMILIARITY, STABILITY, PREDICTABILITY
- FOUNDATION OF FAMILIARITY

EFFECTS OF BOUNDARY AMBIGUITY ON PSYCHOLOGICAL DISTRESS



Berge, J., & Holm, K. (2007). Boundary ambiguity in parents with chronically ill children: Integrating theory and research. *Family Relations, 56*(2), 123-134.

QUESTIONS EXPLORING ROLE AMBIGUITY

- TO WHAT EXTENT DO YOU FEEL LIKE A MEDICAL ASSISTANT RATHER THAN A PARENT TO YOUR CHILD?
- TO WHAT EXTENT DO YOU FEEL LIKE HAVING A CHILD WITH SPECIAL NEEDS INTERFERES WITH YOUR ABILITY TO…
  - …ESTABLISH AND MAINTAIN FRIENDSHIPS?
  - …LEAVE HOME?
  - …TAKE TIME FOR YOURSELF?
  - …ATTEND TO YOUR OWN NEEDS?
- TO WHAT EXTENT DO YOU HAVE DISAGREEMENTS WITH YOUR SPOUSE/PARTNER ABOUT YOUR INVOLVEMENT WITH YOUR CHILD?
- HOW UNCERTAIN ARE YOU ABOUT HOW TO DISCIPLINE YOUR CHILD?
- TO WHAT EXTENT ARE YOU CONFUSED ABOUT YOUR EXPECTATIONS FOR YOUR CHILD AND HOW MUCH YOU SHOULD BE DOING FOR HER/HIM?

Adapted from Berge, J., & Holm, K. (2007). Boundary ambiguity in parents with chronically ill children: Integrating theory and research. *Family Relations, 56*(2), 123-134.

EXAMPLES OF PARENTAL AMBIVALENCE

- "MOTHER OF A 5-YEAR OLD BOY WITH AD:

  '[MY FEELINGS] KIND OF GO BACK AND FORTH DEPENDING ON THE SITUATION. I MEAN, SOMETIMES I'M VERY FRUSTRATED WHEN HE'S NOT DOING WHAT HE'S SUPPOSED TO DO. SOMETIMES I FEEL SAD BECAUSE HE DOESN'T HAVE THE SOCIAL SKILLS THAT OTHER KIDS HIS AGE HAVE. AND SOMETIMES [I FEEL] JUST THRILLED BECAUSE HE'S MADE WONDERFUL PROGRESS IN THE LAST YEAR.'"
- "MOTHER OF AN 8-YEAR OLD CHILD WITH AS:

  'I'VE GOT REAL MIXED FEELINGS. PART OF ME MAY BE EXPECTING TOO MUCH OF HIM, BUT THEN THERE'S PART OF ME THAT SAYS HE'S VERY, VERY BRIGHT AND HE SHOULD BE EXPECTED TO DO WHAT IS EXPECTED OF HIS AGE. I DON'T WANT HIM THINKING HE CAN GET BY IN HIS LIFE WITH LESS, BUT IF THIS IS ALL THAT WE CAN EXPECT FROM HIM, THEN MAYBE I AM EXPECTING TOO MUCH.'"

O'Brien, M. (2007). Ambiguous loss in families of children with autism spectrum disorders. *Family Relations, 56*(2), 135-146.

EXPLORING MEMBERS' BELIEFS ABOUT THE CONDITION AND ITS IMPACT ON THE FAMILY

- HOW HAS THE DIAGNOSIS OF THE ASD ALTERED THE NARRATIVE OF THE FAMILY?
- WHAT HAS THE FAMILY HAD TO GIVE UP IN ORDER TO RESPOND TO LIVING WITH AN ASD?
- IN WHAT WAYS HAS THE FAMILY ADJUSTED ROLES AND RULES? WHAT EXAMPLES OF MEMBERS' BEHAVIORS APPEAR TO DEMONSTRATE RIGID EXPECTATIONS ABOUT MAINTAINING PREVIOUS VIEWS OF FAMILY LIFE?
- TO WHAT EXTENT DO MEMBERS FEEL IN CONTROL OF THE CHANGING CIRCUMSTANCES WITHIN THE FAMILY?
- HOW HAS THE SPOUSAL RELATIONSHIP CHANGED IN THE CONTEXT OF ADJUSTING TO NEW DEMANDS?
- TO WHAT EXTENT ARE EACH OF THE CHILDREN RECEIVING DEVELOPMENTALLY APPROPRIATE AND BALANCED ATTENTION FROM THE PARENTS? HOW DO THEY ENJOY EACH OTHER DIFFERENTLY?
- TO WHAT EXTENT DO FAMILY MEMBERS FACE DEMANDS WITH INCREASED STRESS AND CONFLICT?
- WHAT IS THE NATURE OF THE FAMILY'S FUTURE STORY? TO WHAT EXTENT DO THE MEMBERS HAVE HOPES AND EXPECTATIONS OF SUPPORTING EACH OTHER AND THRIVING AS A FAMILY?

CONTRACTING WITH THE FAMILY

ESTABLISH GOALS AND EXPECTATIONS FOR THERAPY

- DEFINE FAMILY THERAPIST'S DISTINCT AND COMPLIMENTARY ROLE ON THE TREATMENT TEAM
- ESTABLISH FAMILY COLLABORATIONS WITH OTHER MEMBERS OF THE TREATMENT TEAM
- DETERMINE SHORT-TERM CLARITY OF FAMILY MEMBERS' ROLES
- REDEFINE ADAPTABLE FAMILY ROLES AND ROUTINES THAT MEET CHANGING DEMANDS OF LIVING WITH ASDS
- IMPROVE COMMUNICATION ABOUT ROLE AND BOUNDARY AMBIGUITIES ASSOCIATED WITH LIVING WITH ASDS
- ASSIST THE FAMILY IN LIVING WITH ENDURING AMBIGUITIES TO IMPROVE DECISION-MAKING SKILLS

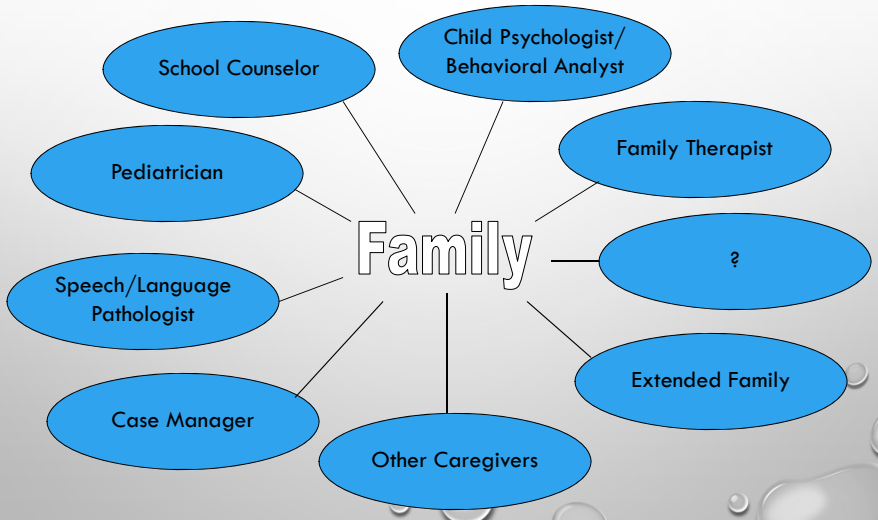
O'Brien, M. (2007). Ambiguous loss in families of children with autism spectrum disorders. *Family Relations, 56*(2), 135-146.

GOAL OF TREATMENT

- OPTIMIZE THE FUNCTIONAL INDEPENDENCE OF THE INDIVIDUAL WITH ASD BY MINIMIZING THE CORE ASD FEATURES
- INTERVENTION OR TREATMENT FOR THOSE WITH ASD NEEDS TO INCLUDE EDUCATION AND SUPPORT FOR THE FAMILIES

Lauritsen, M. B. (2013). Autism spectrum disorders. European Child and Adolescent Psychiatry, 22(1), pg. 37-42. DOI: 10.1007/s00787-012-0359-5.

COLLABORATIVE TREATMENT TEAMS



INDIVIDUAL AND SYSTEMIC INTERVENTIONS

MOVING FROM TRADITIONAL APPROACHES OF CARE

- TRADITIONAL APPROACHES OF CARE HAVE EMPHASIZED "KNOWLEDGE ACQUISITION"
- "MORE CURRENT THEORETICAL AND EMPIRICAL RESEARCH HAS SHIFTED FOCUS FROM PATIENTS' KNOWLEDGE OF [THE CONDITION] AND ITS TREATMENT TO THEIR *CONFIDENCE* AND *SKILLS* IN MANAGING THEIR CONDITION."
- THE FOCUS OF TREATMENT SHOULD EQUIP PARENTS AND CHILDREN TO PARTICIPATE THROUGHOUT THE PHASES OF THERAPY.
- INTERVENTIONS ADDRESSING THE TREATMENT FOCUS SHOULD…
  - …REINFORCE INDIVIDUAL AND FAMILY ROLES
  - …SET LIMITED GOALS
  - …IDENTIFY BARRIERS
  - …ESTABLISH A PLAN TO OVERCOME BARRIERS

Wagner, E., Austin, B., Davis, C., Hindmarsh, M., Schaefer, J., & Bonomi, A. (2001). Improving chronic illness care: Translating evidence into action. *Health Affairs, 20*(6), 64-78.

FAMILY-FOCUSED TREATMENT

- CLIENT WITH ASD
- COUPLE INTERACTIONS
- PARENTAL RELATIONSHIP
- PARENTING STYLES
- SIBLINGS OF THE CLIENT

ADJUSTING COUPLE INTERACTIONS

- ESTABLISH CONNECTIONS BETWEEN SPOUSES THROUGH…
  - EMOTIONAL RESPONSIVENESS TO VARYING DEGREES OF ROLE AND BOUNDARY AMBIGUITY
  - INSTRUMENTAL RESPONSIVENESS
  - COMMUNICATION
- DETERMINE WAYS TO SHARE RESPONSIBILITIES AND ADAPT TO CHANGING EVENTS AND CIRCUMSTANCES
- ESTABLISH COPING MECHANISMS THAT REDUCE EFFECTS OF ROLE STRAIN TO IMPROVE DEPRESSION AND/OR STRESS
  - MONITORING AND ADJUSTING LEVELS OF CONFLICT

ADJUSTING PARENTAL ROLES

- DEVELOP COLLABORATIVE DECISION-MAKING SKILLS
- INCREASE AWARENESS AND USE OF SKILLS NEEDED
- ESTABLISH FAMILY STRUCTURE
- MUTUAL DEVELOPMENT AND SUPPORT FOR ALL HOUSEHOLD RULES AND ROUTINES

Seligman, M., & Darling, R. (2007). *Ordinary families, special children: A systems approach to childhood disability* (3rd ed.). New York: Guilford.

ADJUSTING PARENT-CHILD INTERACTIONS

- ADDRESS PERCEIVED NEEDS AND ADAPTIVE PARENTAL RELATIONSHIP WITH EACH CHILD
- ADJUST A CHILD'S ROLE THAT EXCEEDS HIS/HER DEVELOPMENTAL CAPACITY
- IDENTIFY SPECIFIC WAYS THAT PARENT(S) CAN NURTURE A UNIQUE AND VITAL RELATIONSHIP WITH EACH CHILD

Seligman, M., & Darling, R. (2007). *Ordinary families, special children: A systems approach to childhood disability* (3rd ed.). New York: Guilford.

ADJUSTING SIBLING RELATIONSHIPS

- EDUCATE SIBLINGS ABOUT THEIR BROTHER/ SISTER'S SPECIAL NEEDS
- GUIDE SIBLINGS MOVE FROM COMPETITIVE TOWARD MORE SPECIALIZED, COMPLIMENTARY ROLES
- EXPLORE CHILDREN'S FEELINGS

Seligman, M., & Darling, R. (2007). *Ordinary families, special children: A systems approach to childhood disability* (3rd ed.). New York: Guilford.

TREATMENT APPROACHES

- FAMILY THERAPY – CREATING POSITIVE CYCLES
  - COGNITIVE BEHAVIORAL THERAPY
    - MINDFULNESS COGNITIVE BEHAVIORAL THERAPY (MCBT)
      - WHAT IS MINDFULNESS?
  - DIALECTICAL BEHAVIORAL THERAPY
  - ACCEPTANCE AND COMMITMENT THERAPY
  - OTHER APPROACHES USED?

PHASES OF THERAPY: BRIDGE TO HOME-BASED WORK

BRIDGING THERAPY TO THE HOME

- DESPITE THE FAMILIARITY OF THE HOME FOR THE FAMILY, THE ENVIRONMENT IS UNFAMILIAR TO THE THERAPIST
- THE THERAPIST IS THE "GUEST" IN THE HOME. THIS CAN PROVIDE AN OPPORTUNITY TO OVERTLY EXPRESS THE FAMILY'S ACTIVE ROLE IN THERAPY AS THE "HOST".
- WHILE GUIDING THE COURSE OF THERAPY, THE THERAPIST FINDS WAYS TO USE THE OBSERVATIONS AND INTERRUPTIONS OCCURRING IN THE HOME AS OPPORTUNITIES FOR FURTHER INTERVENTIONS
- OPERATING IN ANOTHER'S ENVIRONMENT CAN INCREASE THE THERAPIST'S LEVEL OF ANXIETY
- EXPOSURE TO ANOTHER'S AMBIGUITY MAY RESULT IN A THERAPIST EXPERIENCING INCREASED ANXIETY AND DECREASED CLINICAL CONFIDENCE

AVAILABLE RESOURCES FOR THERAPISTS AND FAMILIES

AVAILABLE RESOURCES ADDRESSING ASD

PLEASE SHARE INFORMATION WITH US THAT YOU HAVE DISCOVERED THROUGH YOUR CLINICAL PRACTICE AND EXPERIENCES:

- VIDEOS
- BOOKS
- WEBSITES
- ASSOCIATIONS AND SUPPORT GROUPS

THE HBFT PARTNERSHIP

WWW.HBFTPARTNERSHIP.COM

LEARNING MODULES

ACCESS TO RESOURCES

INTERACTIONS WITH COLLEAGUES THROUGHOUT KANSAS

WORKSHOPS/TELECONFERENCES

CONSULTATIONS

PLEASE LET US KNOW HOW WE CAN SUPPORT YOUR IMPORTANT WORK.

QUESTIONS?

Ethics Topics

Self-Care

Confidentiality

Collaboration

Domestic Violence

Social Networking

Child Sexual Abuse

Assessment and Diagnosis

Self-Care

Ethical Implications of Home-Based Family Therapist Self-Care

Nancy O'Conner, LCMFT
C.R. Macchi, PhD, LCMFT
The Family Center
Kansas State University

Objectives

Participants will…

- Explore the personal and professional risks associated with neglecting self-care
- Review the correlation between self-care and provider impairment
- Learn to monitor personal and professional boundaries
- Develop strategies for improving self-care and experience overall well-being

Underlying Virtues of Professional Codes of Ethics

- **Beneficence**: duty to do good and help others
- **Nonmalfeasance**: obligation to minimize harm in all actions we take as professionals
- **Fidelity**: need to carry out and fulfill our professional obligations to those we provide services
- **Autonomy**: goal of promoting the independence of those we serve and not taking any actions that would increase their dependence on us
- **Justice**: obligation to afford all individuals the opportunity for equal access to the same high-quality treatment
- **Self-Care**: obligation to adequately attend to our own healthy functioning

Therapist Stress

- Stress can come from several sources for the professional therapist
  - Extending the therapeutic role into non work aspects of one's life
  - Susceptibility to physical and emotional exhaustion
  - Condition of constantly giving without reciprocity
  - Work conditions external to therapy activities
  - Slow, erratic nature of therapeutic progress
  - Personal issues raised for the therapist as a result of his/her work
- Intense and long term stress can lead to burnout and compassion fatigue

Continuum of Therapist Self-Care

Each therapist experiences varying degrees of personal and professional stresses. Therapist responses to stress vary along a continuum illustrating the type of management used to address the stress ranging from preventative to remedial with a increasing degree of reactivity to stress spanning between them.

Consider your current stresses and determine where you are on the continuum of self-care based upon your own responses to those stresses.

Ongoing Activities of Self-Care

This presentation will examine the ongoing activities a therapist needs for effective self-care:

- ***Awareness*** – engagement in activities designed to help a therapist identify personal and professional stressors and the types of approaches he/she currently uses to address them
- ***Knowledge*** – learn about the impact of varying types of stressors on professional responsibilities
- ***Skills*** – develop the tools necessary for successful navigation along the continuum toward preventative and proactive management of stress

Burnout

- Emotional exhaustion and depersonalization
- Lack of self-efficacy
- Burn-out will normally occur slowly, over a long period of time. It may express itself
  - Physically
  - Socially
  - Mentally
  - Emotionally
  - Spiritually

Compassion Fatigue

- "Set of symptoms experienced by caregivers who become so overwhelmed by the exposure to the feelings and experiences of their clients that they themselves experience feelings of fear, pain and suffering." (Panos, A. (2007). Understanding and preventing compassion fatigue. www.giftfromwithin.org)
- Rapid onset of symptoms and more pervasive than burnout
  - Sense of helplessness, shock and confusion
  - Sense of isolation
  - Symptoms seem disconnected to the real causes
- Experience of fear and anxiety

Major Contributors to Therapist Burnout and Compassion Fatigue

- Therapist competence
  - Knowledge, training, and experience
  - Theoretical orientation
  - Therapist personal characteristics
- Emotional exhaustion and fatigue
- Anxiety and depression
- Interpersonal relationships
- Disillusionment about the profession
- Other?

Compassion Satisfaction

- Sense of reward, efficacy, and competence one feels in one's role as a helping professional

Killian, K.D. (2007). What we know (so far) about therapist self-care: Myths of individual coping, realities of organizational policy. *Family Therapy Magazine*, March/April, 28-30.

- What about your work contributes to compassion satisfaction?

Journal Questions

- Have you ever lost sleep over a particular case?
- Have you had intrusive thoughts about an awful experience that a client disclosed to you?
- Have you had difficulty concentrating, or had a panic attack, due to your workload or stress associated with some of your cases?

Killian, K.D. (2007). What we know (so far) about therapist self-care: Myths of individual coping, realities of organizational policy. *Family Therapy Magazine*, March/April, 28-30.

What Constitutes Therapist Wellness

- According to Spencer Faunce wellness involves being well integrated
  - Physically
  - Mentally
  - Emotionally
  - Spiritually
  - Being congruent

The therapist "in the state of wellness has…"

- High self-esteem
- Feeling of personal power
- Sense of self as a unique individual

Faunce, P.S. (1990). Self-Care and Wellness of Feminist Therapists. *Feminist Ethics in Psychotherapy*, 123-130.

What is Therapist Self-Care?

According to Carroll, Gilroy, and Murra (1999) a clinician's personal and professional self-care includes, but is not limited to, the following efforts:

- Intrapersonal work—clarifying your view of yourself as an adult and a clinician.
- Interpersonal support—seeking and receiving help and support from others, especially friends and family
- Professional development and support—attending continuing education workshops and conferences, and receiving support from colleagues and supervisors
- Physical and recreational activities—spending time engaged in hobbies and activities that refresh, rejuvenate and invigorate the mind and body

Carroll, L., Gilroy, P., & Murra, J. (1999). The moral imperative: Self-care for women psychotherapists. *Women & Therapy, 22(2), 133-143.*

Making the Connection between Therapist Self-Care and Ethical Responsibility

How ethical codes address self-care

- AAMFT
- ACA
- APA
- Feminist Therapy
- NASW

	SELF-CARE		IMPAIRMENT
Codes of Ethics	Preventative	Reactive	Remedial
AAMFT (2001)		"…seek appropriate professional assistance for their personal problems or conflicts that may impair performance or clinical judgment." (Section 3.3)	
ACA (2005)	"…engage self-care activities to maintain and promote their emotional, physical, mental, and spiritual well-being to best meet their professional responsibilities." (Section C – *Professional Responsibility, Introduction*)	"…continually monitor their effectiveness as professionals and take steps to improve when necessary." (Section C, Part 2.d. – *Monitor Effectiveness*)	"…alert to signs of impairment from their own physical, mental, or emotional problems… assist colleagues or supervisors in recognizing their own professional impairment and provide consultation and assistance when warranted with colleagues or supervisors showing signs of impairment and intervene as appropriate to prevent imminent harm to clients." (Section C, Part 2.g. – *Impairment*)
APA (2002)		"…refrain from initiating an activity they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner." (Section 2 – *Competence*, Part 2.06 – *Personal Problems and Conflicts*)	

	SELF-CARE		IMPAIRMENT
Codes of Ethics	Preventative	Reactive	Remedial
Feminist Therapy (1999)	"…recognizes her personal and professional needs and utilizes ongoing self-evaluation, peer support, consultation, supervision, continuing education, and/or personal therapy. She evaluates, maintains, and seeks to improve her competencies, as well as her emotional, physical, mental, and spiritual well-being." (Part IV – *Therapist Accountability*, Section C) "…engages in self-care activities in an ongoing manner outside the work setting." (Section IV – *Therapist Accountability*, Part E)	"When the feminist therapist has experienced a similar stressful or damaging event as her client, she seeks consultation." (Section IV – *Therapist Accountability*, Part C)	

	SELF-CARE		IMPAIRMENT
Codes of Ethics	Preventative	Reactive	Remedial
NASW (1999)		"…should be aware of any conflicts between personal and professional values and deal with them responsibly." (*Purpose of NASW Code of Ethics*) "…should not permit their private conduct to interfere with their ability to fulfill their professional responsibilities." (Section 4 – *SWs' Ethical Responsibilities as Professionals*, Part 4.03 – *Private Conduct*)	"…should not allow personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties to interfere with their professional judgment and performance or to jeopardize the best interests of people for whom they have professional responsibility… should immediately seek consultation and take appropriate remedial action by seeking professional help, making adjustments in workload, terminating practice, or taking any other steps necessary to protect clients and others." (Section 4 – *SWs' Ethical Responsibilities as Professionals*, Part 4.05 – *Impairment*)

What is Impairment?

- Definition – A deficiency of a therapist's competence in at least one of three areas:
  1. Knowledge, training, experience
  2. Theoretical orientation
  3. Therapist personal characteristics
- Prevalence
  - Difficult to determine since an impaired therapist can operate indefinitely if he/she has not been charged with an ethical violation
- Impacts of therapist impairment
  - Adverse effects on client well-being
  - Impedes therapy outcomes
  - Jeopardizes therapist's professional role

Journal Questions

- Is self-care an ethical issue?
  - Whose right is it to tell someone he/she needs to care for self?
- Gatekeeping:
  - What is the professional's responsibility?
- Are you aware of a colleague whose personal problems are interfering with his/her work performance?
- Have you ever offered to help and/or referred an "impaired" colleague to a regulatory agency?

Impact of Awareness and Commitment on Therapist Self-Care

		Does the therapist have a personal commitment to self-care?	
Is the therapist aware of his/her level of distress and impairment?		Yes	No
	Yes	• Recognizes therapist self-care serves to enhance that of the client • Regularly practices self-care • PROACTIVE	• Disregards the value of or need for self-care • Perceives therapy as evidence of personal failure • Perceives personal uncertainty, self-doubt, and confusion as marks of inadequacy or even failure • Work in the grey zone between ethical and unethical conduct • REACTIVE
	No	A clinician cannot commit to something for which he/she is unaware	• Oblivious to their own mental health issues and impairment • REMEDIAL

Carroll, L., Gilroy, P., & Murra, J. (1999). The moral imperative: Self-care for women psychotherapists. *Women & Therapy, 22(2), 133-143.*

Risks Associated with Neglecting Self-Care

Risk Categories

- Personal
  - Substance abuse
  - Emotional problems/mental health issues
  - Sexual misconduct
- Professional
  - Legal
    - Ethical violation
  - Supervisory
    - Gatekeeping

BSRB Data

- Nature of violations
  - Child Custody
  - Professional Concerns
    - Complaints filed by BSRB
    - Self-report by a licensee
    - Reports by a third party
      - Confidentiality
      - Dual relationships
      - Practicing with an expired license
      - Irregularities in application or renewals

Collegial and Supervisory Responsibilities

- Codes of Ethics describe the responsibility of each clinician to the profession and to the client
  - What is the colleague's responsibility regarding self-care?
  - What is the supervisor's responsibility regarding self-care?

Effects of Impairment on Therapy Effectiveness

What could this look like

- How often have you worked when too distressed to be effective?
  - Ability to process new information
  - Ability to respond appropriately to information
  - Decrease in problem solving abilities
  - Decreased interest in clients
  - Decreased empathy toward clients
- Consider therapeutic goals and expectations
  - Imposed by self, client, supervisor, agency
- Ability to accept occasional “failures”
- When under distress, can you accurately assess the quality of care provided to clients?

Monitoring Personal and Professional Boundaries

Boundaries

- Similar to Minuchin's description of interpersonal boundaries, a therapist that has clear boundaries with clients is…
  - Present to others
  - Emotionally connected
  - Responsive to the others' needs
  - Creative problem-solving
  - Use of humor
  - Feeling interested and hopeful in clients' success
- When a therapist experiences accumulated compassion fatigue or burnout, the therapist may develop boundaries that are…
  - Too rigid
    - In the effort to insulate one's self from additional stress, the therapist may fortify a rigid boundary between him/her and the client
  - Too diffuse
    - In an effort to be responsive to the client, the therapist may compromise one's own well-being and the health of his/her personal relationships

Strategies for Improving Self-Care

Self-Care Strategies

- Strategies that result in the most effective self-care must occur at several levels:
  - Personal self-care
  - Collegially-supported self-care
  - Supervisory
  - Agency-supported self-care
- The self-care strategies that we are emphasizing will be mainly focused on the first two types

Self-Care Strategies

- Awareness
  - Establish a baseline measuring your personal quality of life using ProQOL to determine levels of…
    - Compassion satisfaction
    - Burnout
    - Compassion fatigue/secondary trauma
  - Share the ProQOL with colleagues and share your results with each other
- Knowledge
  - Read articles and books that address ways to further your own self-care
  - Discuss themes from your readings with your colleagues while sharing self-care strategies that have worked

Self-Care Strategies

- Skills
  - Take regularly scheduled breaks
  - Take regular vacations without work responsibilities
  - Nurture friendships
  - Engage in hobbies and other personal interests
  - Limit work hours and caseload
  - Participate in peer support and supervision
  - Engage in personal therapy as needed
  - Journaling
  - Attend to religious or spiritual needs
  - Participate in relaxing activities such as reading, prayer, meditation, listening to music

Barnett, J., Johnston, L., & Hillard, D. (2005). Psychotherapist wellness as an ethical imperative. In L. VandeCreek & J. Allen (Eds.), *Innovations in clinical practice: Focus on health and wellness (pp. 257-271). Sarasota, FL: Professional Resource Press.*

Comments!!!
Questions???

Confidentiality

Ethics of Confidentiality in HBFT

Nancy O'Conner, MS, LCMFT
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The Family Center
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Learning Objectives

Participants will…

- Understand the ethical dilemmas unique to home-based work
- Learn ways to proactively address ethical issues with families
- Learn ways to collaboratively work with families to determine how to minimize the impact of ethical dilemmas on therapy progress and client well-being

Journal

Define confidentiality as you understand the term

Underlying Virtues of Professional Codes of Ethics

- **Beneficence**: duty to do good and help others
- **Nonmalfeasance**: obligation to minimize harm in all actions we take as professionals
- **Fidelity**: need to carry out and fulfill our professional obligations to those we provide services
- **Autonomy**: goal of promoting the independence of those we serve and not taking any actions that would increase their dependence on us
- **Justice**: obligation to afford all individuals the opportunity for equal access to the same high-quality treatment
- **Self-Care**: obligation to adequately attend to our own healthy functioning

Protection of Client Information

- Privacy: “A Right”
- Privilege: “A Legal Right”
- Confidentiality: “A Condition”
- Security: “A Safeguard”

Journal

Identify two situations where confidentiality was challenged.

Informed Consent

- Describe reasonable expectations during therapy
  - Expected from client system
  - Expected from therapist
  - Expected from the therapy process
- Information to inform client choices
  - Procedures, goals, and possible side effects of therapy
  - Qualifications, policies, and practices of the therapist
  - Availability of additional sources of help
  - Fees and length of therapy

Huber, C. (1994). *Ethical, legal, and professional issues in the practice of marriage and family therapy (2nd ed.). Upper Saddle River, NJ: Prentice-Hall.*

Hare-Mustin, R., Maracek, J., Kaplan, A., Liss-Levenson, N. (1979). Rights of clients, responsibilities, of therapists. *American Psychologist, 34*, 2-16.

Health Insurance Portability and Accountability Act (HIPAA)*

Privacy practices *reasonable safeguards* to protect patient privacy:

- Patient notification of privacy practices
- Patient authorization required to disclose patient health information
- Written patient acknowledgement of receipt of notice
- Post and distribute notice of privacy practice
- Ongoing training for all entities on HIPAA privacy practices
- Monitor compliance with HIPAA policies
  - Disclosing, storing, and destroying patient records

* Department of Health and Human Services (Updated May, 2003)

HIPAA*

- *Reasonable safeguards*
  - "Covered entities should analyze their own needs and circumstances, such as the nature of the protected health information it holds, and assess the potential risks to patients' privacy. Covered entities should also take into account the potential effects on patient care and may consider other issues, such as the financial and administrative burden of implementing particular safeguards." (p. 1-2)
- *Minimum necessary standard*
  - "Policies and procedures that limit how much protected health information is used, disclosed, and requested for certain purposes." (p. 2)

* Department of Health and Human Services (2003). OCR HIPAA Privacy: Incidental uses and disclosures.

BSRB Statistics
*Confidentiality Violation Reports**

- 191 violations since 1982
- 15.4% of all ethical violations reported in Kansas since 1982
  - 7.9% specifically related to confidentiality
  - 5.5% failing to properly inform or provide information
  - 0.4% performing services inconsistent with training
  - 1.6% Dual relationship non-sexual

* Kansas Behavioral Sciences Regulatory Board (Updated June 30, 2008)

Standards of Ethical Practice Related to Confidentiality

Standards of Ethical Practice *Confidentiality*

- Relationship with the client
  - Engendering client trust
  - Respecting client privacy
  - Identifying cultural meanings of confidentiality (ACA, 2005)
    - "Respecting differing views toward disclosure" (B.1.a.)
  - Discussing confidentiality with clients
  - Seeking consent about extents and limits of confidentiality
  - Informing and involving clients when disclosure is necessary
- Protection of client identity and information
  - Storing, transmitting, and disposal of client information
  - Limiting disclosure of client information
  - Consulting with other professional/professions
  - Ensuring appropriate settings for consultations
  - Developing policies that guide the practices of subordinates

Complexities of Confidentiality

Working in Rural Areas

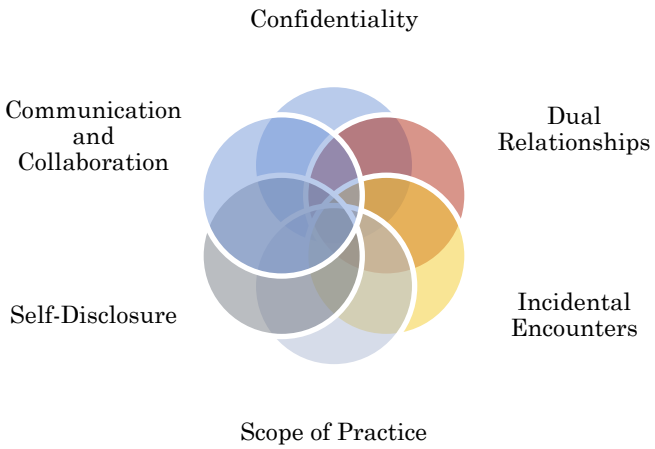
- Small size communities
- Low density of population
- Limited resources
- Familiarity
- Interconnectedness
- Dual relationships

Working in Urban Areas

- Large size communities
- High density of population
- Resources are plentiful
- Anonymity
- Community members may be less familiar

Standards of Ethical Practice Related to Confidentiality

- Dual relationships
- Incidental encounters
- Scope of practice
- Self-disclosure
- Communication and collaboration



Standards of Ethical Practice: *Dual Relationships*

- Non-sexual dual relationships are inevitable and not always unavoidable
- Embedded in the social structure
  - Normal and healthy part of communal living
  - Can increase trust
  - In selecting a therapist, rural communities tend to rely on word of mouth and first hand information
  - In selecting a therapist within an urban community, therapist may be more of an unknown
  - Bartering

Standards of Ethical Practice: *Incidental Encounters*

- Random, unexpected or unplanned meetings
  - Inevitable especially in rural communities
  - Flexible boundaries
  - Managing client's sense of privacy and autonomy
  - Enhance or detract from therapeutic relationship

Standards of Ethical Practice: *Scope of Practice*

- Codes of ethics refer to what is "reasonable" or "appropriate"
  - Prevailing professional judgment of clinicians engaged in similar activities in similar circumstances
    - Difference between what is reasonable in rural and urban settings
- Rural communities require the therapist to attend to very broad range of mental health issues
  - Overlapping roles: therapist and case manager
  - Lack of resources
- Urban communities have specialists available
  - Abundance of resources

Standards of Ethical Practice: *Self-Disclosure*

- Deliberate self-disclosure
  - Self-revealing
  - Self-involving
- Unavoidable self-disclosure
- Accidental self-disclosure
  - Incidental encounters
  - Therapists' spontaneous verbal or nonverbal reactions
- Client seeks information about the therapist

Standards of Ethical Practice: *Communication and Collaboration*

- Measures taken to ensure that the *process by which information is shared* protects confidentiality
  - Tone of voice
  - Language used to describe the family, family issues, and clinical hypotheses and impressions
- References and descriptions of the family *demonstrate respect* and *protect their dignity*
- Explicitly differentiate known information from clinical impressions and hypotheses

Confidentiality specific to HBFT

Common Scenarios in HBFT

- Visitors stop by the home during a session
- Community visibility of a home-based visit (therapist's car is parked outside the home with the agency name on the door)
- Working on parental/marital issues effecting the child when billing requires the child be present during a session
- Attempting to use a collaborative approach when the family is required to attend therapy
- Separating case management from therapeutic work
- Choosing to use a home-based approach for therapeutic reasons and not for an increased reimbursement rate
- Determining the therapeutic reasons for addressing issues about cleanliness and not because of personal preferences
- Addressing core therapeutic issues without becoming distracted by personal preferences – cleanliness, family styles, family values revealed by the home environment
- Becoming aware of the custody arrangements when sharing information with another parent not in therapy

Framework for determining a challenge to confidentiality

Choose one scenario from the previous page.

- In that scenario, which of the following issues are relevant? If so, describe the issue's relevance.
  - Privacy?
  - Privilege?
  - Confidentiality?
  - Security?
- What are the challenges to the protection of the relationship with the client?

Framework for determining a challenge to confidentiality

- What are the challenges to the protection of the client identity or information related to the client?
- How might the issue of confidentiality overlap with one or more of the following:
  - Dual relationships?
  - Incidental encounters?
  - Scope of practice?
  - Self-disclosure?
  - Communication and collaboration?

Proactive Strategies for Protecting Client Confidentiality

- Professional preparation
  - Ongoing training to reinforce policies of confidentiality
  - Supervision
- Involving the family
  - Proactive planning
    - Informed consent
  - Overtly address challenges with family

Process of Ethical Decision-Making

1. Identify the issue
2. Identify the relevant moral, ethical, clinical, legal, professional and other issues and conflicts involved
3. Develop a series of alternative courses of action
4. Conduct a risk/benefit analysis of each course of action or inaction
5. Weigh the risks against the benefits within each option then compare them and choose a course of action
6. Implementing the course of action
7. Developing ways to assess the success or effectiveness of the plan and respond to the results

Zur, O. (2006) Therapeutic boundaries and dual relationships in rural practice: Ethical, clinical and standard of care considerations. *Journal of Rural Community Psychology*, E9(1), 1-41.

Framework for Securing Confidentiality

Use the ethical decision-making model to develop an action plan securing confidentiality with the same scenario.

Kitchener's Model for Ethical Decision-Making

- Intuition
- Ethical rules (Professional rules)
- Ethical principles
  - Autonomy
  - Nonmaleficence
  - Beneficence
  - Fidelity
  - Justice
- Ethical Theory
  - Universality: The "Golden Rule"
  - Balancing

Questions?????

Comments!!!!!

Collaboration

Ethical Implications of Collaboration in HBFT

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The Family Center
Kansas State University

Objectives

Participants will…

- Explore the types and intentions of collaboration
- Review guidelines for collaboration provided by professional codes of ethics and Kansas laws
- Explore the potential risks of collaborations
- Identify factors associated with effective collaborations and ethical practice
- Review and apply an ethical approach to improving collaborative relationships

Underlying Virtues of Professional Codes of Ethics

- **Beneficence**: duty to do good and help others
- **Nonmalfeasance**: obligation to minimize harm in all actions we take as professionals
- **Fidelity**: need to carry out and fulfill our professional obligations to those we provide services
- **Autonomy**: goal of promoting the independence of those we serve and not taking any actions that would increase their dependence on us
- **Justice**: obligation to afford all individuals the opportunity for equal access to the same high-quality treatment
- **Self-Care**: obligation to adequately attend to our own healthy functioning

What is meant when we refer to *collaboration*?

- Primarily focused on empowering and equipping the client family with the skills needed to promote
  - Agency – "active involvement in and commitment to one's own care" (p. 9)
  - Communion – "emotional bonds that are often frayed by illness, disability, and contact with the healthcare system" (p. 9)
- Connecting client family with available resources
- Equip client family to generalize learning from therapeutic work to natural settings and circumstances

McDaniel, S., Hepworth, J., & Doherty, W. (1992). *Medical family therapy: A biopsychosocial approach to families with health problems.* New York: BasicBooks.

Purpose of Collaboration

- Overall goal of treatment is to improve the person's quality of life
- Collaboration requires the client and team find areas of agreement
- Collaboration requires that the points of view of everyone involved be considered
- Collaboration requires acknowledgement of the legitimate role of both client and each team members

"Why bother to integrate care?"

- Clients come with undifferentiated problems
  - "Over half of the high [medical care] utilizers were significantly psychologically distressed" (p. 7)
- Collaborators share expertise and perspectives on client issues and experiences
- Better client outcomes
  - Effects of collaboration on patient depression compared with non-collaborative control group
    - Greater medication adherence
    - Greater satisfaction of quality of care
    - More attributed to medication as helping
    - Significant symptom reduction

Blount, A. (Ed.). (1998). *Integrated primary care: The future of medical and mental health collaboration.* New York: Norton.

Collaborations Specific to HBFT

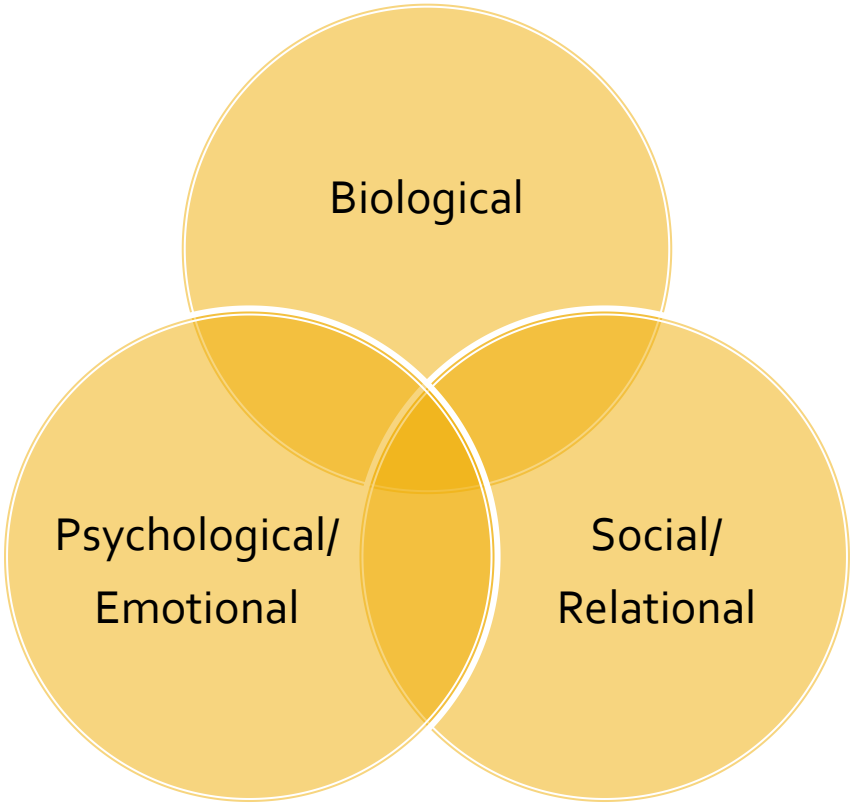
- Source of solutions
- Relationship
- Orientation
- Assessment
- Expectations
- Planning
- Access to services
- Outcomes

Osher, D. (2002). Creating comprehensive and collaborative systems. *Journal of Child and Family Studies, 11*(1), 91-99.
Osher, T., & Osher, D. (2002). The paradigm shift to true collaboration with families. *Journal of Child and Family Studies, 11*(1), 47-60.

Biopsychosocial Therapeutic Factors

Medical and mental health collaborations address client issues involving aspects of the

- whole person
- multiple dimensions of experience



Diagnostic Rule Outs

"The symptoms are not due to the direct physiological effects of a substance or general medical condition."

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders (4th, text revision ed.).* Washington, D.C.: American Psychiatric Association.

Influences of Broader Systems

- Social Ecological Theory helps to explain the broader systems exerting multiple influences on children and families as they attempt to address issues and adjust to development
  - Microsystem – client and family
  - Mesosystem – connections among microsystems
  - Exosystem – environmental and contextual partners
  - Macrosystem – broader social and cultural milieu and public policies effecting the client family

Steele, R., & Aylward, B. (2009). An overview of systems in pediatric psychology research and practice. In M. Roberts & R. Steele (Eds.), *Handbook of pediatric psychology (4th ed.).* New York: Guilford.
Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design.* Cambridge, MA: Harvard University Press.

Collaborative Partners

- Individual level
  - Families
  - Therapists
  - Physicians and nurses
  - School counselors and teachers
  - Case managers
- Systems level
  - Communities
  - Mental health
  - Healthcare
  - Schools
  - Social Services

The Days of Innocence are Over

"The days of innocence are over. We now know that human life is a seamless cloth spun from biological, psychological, social, and cultural threads; that patients and families come with bodies as well as minds, feelings, interaction patterns, and belief systems; that there are no biological problems without psychosocial implications, and no psychosocial problems without biological implications. Like it or not, therapists are dealing with biological problems, and physicians are dealing with psychosocial problems. The only choice is whether to do integrated treatment well or to do it poorly."

McDaniel, S., Hepworth, J., & Doherty, W. (1992). *Medical family therapy: A biopsychosocial approach to families with health problems.* New York: BasicBooks.

The Collaborative Family Healthcare Approach

"The collaborative family healthcare model envisions seamless collaboration between psychosocial, biomedical, nursing, and other healthcare providers, and views patient, family, community, and provider systems as equal participants in the healthcare process.

"This approach is a radical departure from conventional "diagnose and refer" models and is distinctly different from the usual managed care approaches. It recognizes that clinical events always occur at biological, psychological and social levels, and that patient, family, and community levels represent integrated elements of a single ecosystem.

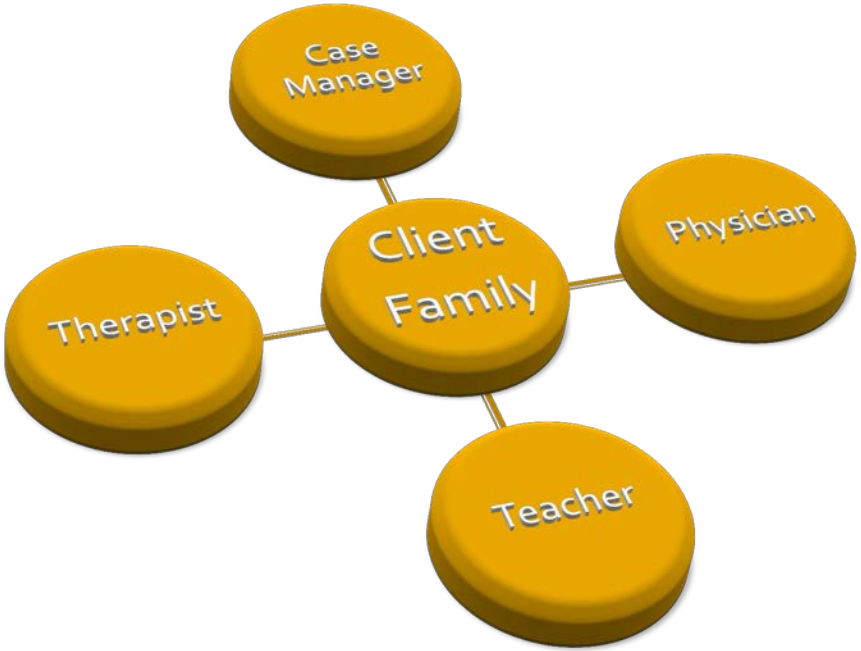
"By adding the essential ingredients of psychological and family care at the front end, and continuously throughout the healthcare process, and by coordinating and integrating the expertise of these and other healthcare professions, wasteful and repeated diagnostic procedures are minimized, as are costly sub-specialty referrals.

"It is a profoundly ethical approach that conserves resources for all participants: patients and their families, clinical providers, administrative and financial entities."

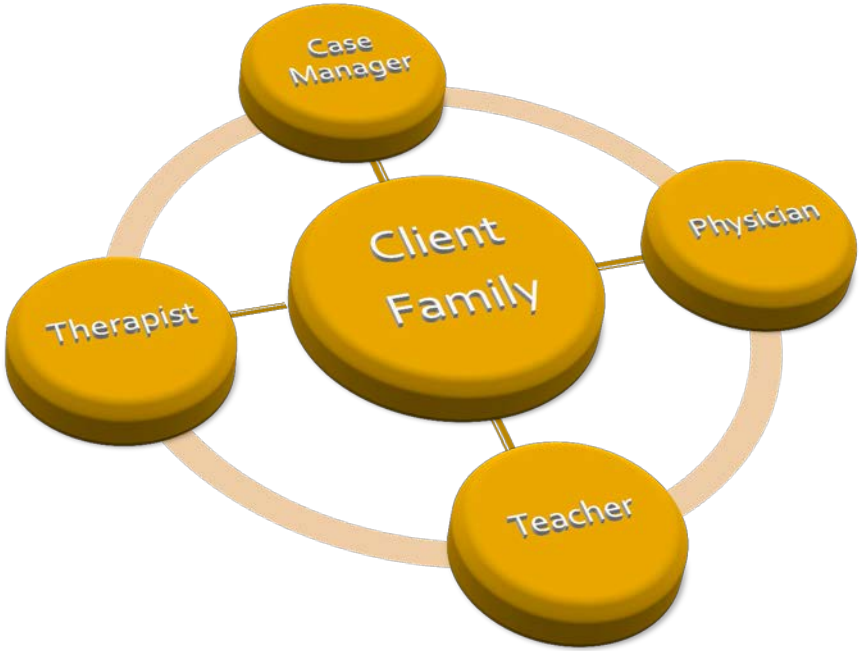
http://www.cfha.net/pages/CFHA-Approach/

Two Types of Collaboration

COORDINATED WORK



INTEGRATED WORK



Professional Ethical Codes Addressing Collaboration

Several codes generally describe the following requirements:

- the purpose of consultations are designed to better serve the client needs and insure an ethical standard of practice
- the need for obtaining a release of information
- limiting the amount of information disclosed which is necessary for consultation
- seeking consultation when the demands of the case reach beyond the therapist's scope of practice, training, experience

Kansas Law

- Kansas Regulations
  - Physician collaboration or obtain a signed waiver

Office of Civil Rights. (2002). OCR privacy brief: Summary of the HIPAA privacy rule. In Office of Civil Rights (Ed.): U.S. Department of Health and Human Services. Retrieved October 13, 2009. http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/privacysummary.pdf

MFT

- **102-5-13. Licensee consult with physician when determining symptoms of mental disorders.**
- (a) "Consult," as used in K.S.A. 65-6404 and amendments thereto, shall be defined as contact made by the licensee with the appropriate medical professional for the purpose of promoting a collaborative approach to the client's care and informing the medical professional of the client's symptoms. This contact shall not be intended to accomplish confirmation of diagnosis. The timing of any such action by the licensee shall be managed in a way that enhances the progress of assessment, diagnosis, and treatment. This consult may or may not be completed in the initial session of service delivery.

ACA

- **102-3-14. Licensee consult with physician when determining symptoms of mental disorders.**
- (a) "Consult," as used in K.S.A. 65-5804 and amendments thereto, shall be defined as contact made by the licensee with the appropriate medical professional for the purpose of promoting a collaborative approach to the client's care and informing the medical professional of the client's symptoms. This contact shall not be intended to accomplish confirmation of diagnosis. The timing of any such action by the licensee shall be managed in a way that enhances the progress of assessment, diagnosis, and treatment. This consult may or may not be completed in the initial session of service delivery.

APA

- **102-1-17. Licensee consult with physician when determining symptoms of mental disorders.**

(a) "Consult", as used in K.S.A. 74-5302 and amendments thereto, shall be defined as contact made by the licensee with the appropriate medical professional indicated in subsection (b), for the purpose of promoting a collaborative approach to the client's care. This contact may or may not be intended to accomplish confirmation of diagnosis. The timing of this action by the licensee shall be managed in a way that enhances the progress of assessment, diagnosis, and treatment. This consult may or may not be completed in the initial session of service delivery.

NASW

- **102-2-13. Licensee consult with physician when determining symptoms of mental disorders.**
- (a) Each licensed specialist clinical social worker or licensed master social worker who has a client with symptoms of a mental disorder shall, upon the signed consent of the client, consult with the client's physician or psychiatrist, except when a client requests in writing that consultation with a physician be waived.

HIPAA

- Health Insurance Portability and Accountability Act of 1996 (HIPAA)

  "The HIPAA Privacy Rule is not intended to impede these customary and essential communications and practices and, thus, does not require that all risk of incidental use or disclosure be eliminated to satisfy its standards. Rather, the Privacy Rule permits certain incidental uses and disclosures of protected health information to occur when the covered entity has in place reasonable safeguards and minimum necessary policies and procedures to protect an individual's privacy."

  - *Reasonable safeguards*
  - *Minimum necessary standard*

Office of Civil Rights. (2002). OCR privacy brief: Summary of the HIPAA privacy rule. In Office of Civil Rights (Ed.): U.S. Department of Health and Human Services. Retrieved October 13, 2009. http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/privacysummary.pdf

Journal Questions

- What are some collaborations that you routinely incorporate into your work to provide a base standard of care?
- What client family issues and crises prompt you to routine initiate specific collaborations?

Challenges Associated with Collaborating

Family Challenges to Collaboration

- Accessing the system
  - Awareness of community resources
  - Financial means
  - Accessibility to appointments – timing and location
- Navigating the system
  - Skills to navigate unfamiliar system
  - Case management skills for coordinating care among multiple providers
- The clinical encounter
  - Treatment alliance
  - Social, cultural, ethnic differences from treatment provider
  - Family-clinician communication of care options
- Implementing the care plan
  - Diagnostic vs. family perceptions of health issues

Seid, M., Opipari-Arrigan, L., & Sobo, E. (2009). Families' interactions with the health care system: Implications for pediatric psychology. In M. Roberts & R. Steele (Eds.), *Handbook of pediatric psychology (4th ed.).* New York: Guilford.

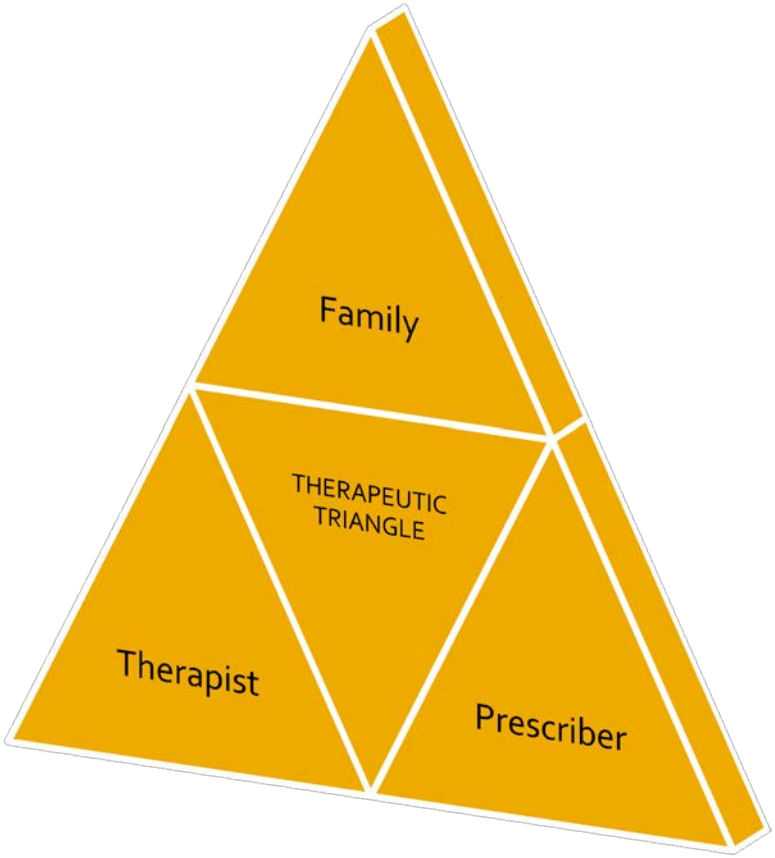
Clinician Challenges to Collaboration

- Confidentiality
  - HIPAA requirements
- Economic
  - Billable hours
  - Reimbursement issues
    - Coding and billing
    - Access to insurance panels
- Medical, psychological, and systemic approaches to common family issues
  - Theoretical and conceptual underpinnings
  - Language
  - Intervention strategies

Stancin, T., Perrin, E., & Ramirez, L. (2009). Pediatric psychology and primary care. In M. Roberts & R. Steele (Eds.), *Handbook of pediatric psychology (4th ed., pp. 630-646).* New York: Guilford.

The Therapeutic Triangle

- Who is in the lead (top) position?
- What are the implications for the roles in each position?
- Who is responsible for what?



Diamond, R., & Scheifler, P. (2007). The therapist-prescriber-client relationship. In *Treatment collaboration: Improving therapist, provider, client relationship (pp. 45-84).* New York: Norton.

The Therapeutic Triangle

Prescriber-Therapist-Client Responsibility

1. Who is responsible for what?
2. How do differences in power influence relationships in mental health?
3. What is an expert and what are the limits of this expertise?
4. How do personal values affect decision making?
5. What is the difference between compliance, adherence, and the effective use of medication?
6. How can collaboration between therapists, clients, and prescribers best be fostered?

Diamond, R., & Scheifler, P. (2007). The therapist-prescriber-client relationship. In *Treatment collaboration: Improving therapist, provider, client relationship (pp. 45-84).* New York: Norton.

Factors Involved with Effective Collaborations

Forming a Multidisciplinary Team

- Meaning of multidisciplinary team is related to the setting and population
- The team should include representatives from all potential service area providers
  - What are the client's biopsychosocial - spiritual needs (individual and family)?
  - Who is best suited to address those needs?
  - What are the natural supports for the family?
- Multidisciplinary teams rely on taking the time to understand EVERYTHING about the family
  - Comprehensive case conceptualization is the nuts and bolts of good treatment planning

Therapeutic Relationship

Studies demonstrate that the *client and provider therapeutic relationship* serves a primary role in facilitating positive treatment outcomes

Blow, A., & Sprenkle, D. (2001). Common factors across theories of marriage and family therapy: A modified delphi study. *Journal of Marital and Family Therapy, 27*(3), 385-401.
Hubble, M., Duncan, B., & Miller, S. (1999). *The heart & soul of change: What works in therapy.* Washington, D.C.: American Psychological Association.

Client Family Empowerment

- Family is consulted throughout assessment and evaluation of treatment
- Family experiences collaboration as a team member
- Family members are active participants
- Family experiences and perceptions are vital resources
- Family owns the process of change
- Family makes decisions from several options

Isomorphic Effects of Collaborations

- Providers acknowledging the leadership of clients in their own change process reinforces client empowerment
- Providers acknowledging the expertise and contributions of other collaborating providers reinforces the priority of client involvement and contributions to that process

McDaniel, S., Hepworth, J., & Doherty, W. (1992). *Medical family therapy: A biopsychosocial approach to families with health problems.* New York: BasicBooks.

Small Group Question

- What are some strategies that you have found helpful in your work with differing professions?

Benefits of Effective Collaborations

- Reduced medical costs
- Higher rates of patient satisfaction
- Lower provider turnover
- Increased productivity

Stancin, T., Perrin, E., & Rameriez, L. (2009). Pediatric psychology and primary care. In M. Roberts & R. Steele (Eds.), *Handbook of pediatric psychology (4th ed., pp. 630-646).* New York: Guilford.

Strategies for Improving Collaborations

An Ethical Practice Approach

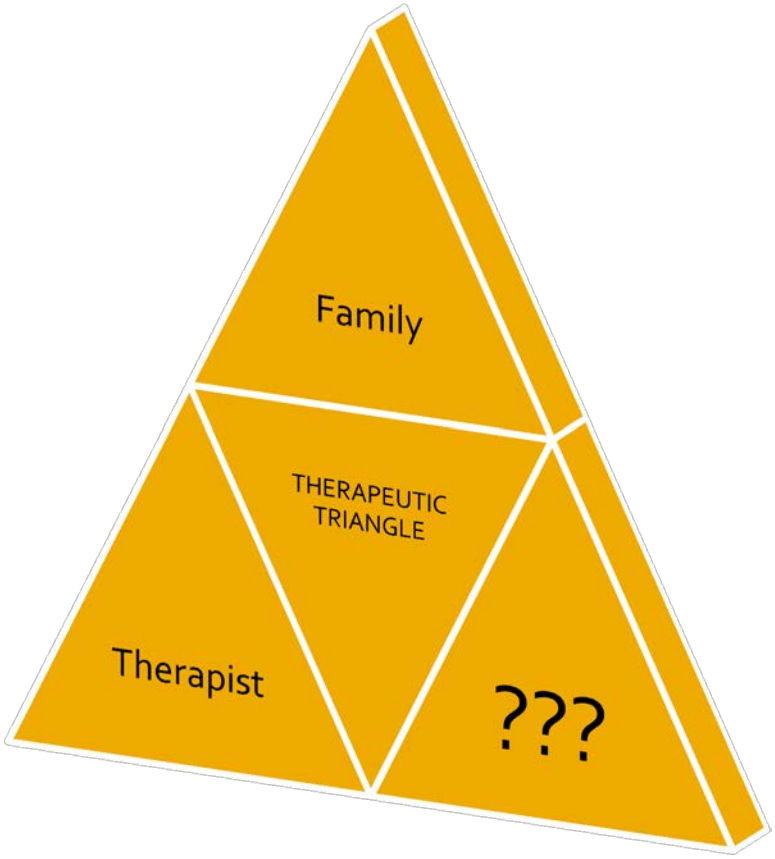
Employing Principles of Motivational Interviewing

- Collaboration
  - Honoring client expertise and perspectives
  - Clinician provides atmosphere that is conducive to change
- Evocation
  - Priority is placed on intrinsic client motivations
- Autonomy
  - Clinician affirms the client's right and capacity for self-direction and informed choice

Miller, W., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change.* New York: Guilford, p. 35.

The Therapeutic Triangle

- Who is in the lead (top) position?
- What are the implications for the roles in each position?
- Who is responsible for what?



Diamond, R., & Scheifler, P. (2007). The therapist-prescriber-client relationship. In *Treatment collaboration: Improving therapist, provider, client relationship (pp. 45-84).* New York: Norton.

Strategies Specific to HBFT

- Conducting ecologically valid assessments in the family's natural environment
  - Home-based therapist often has the broader picture of the client needs through work in the natural environment
  - Connections to both professional and natural support resources
  - Linking the family to services that will empower the family long after formal services have ended
- Therapist often has primary responsibility for the case plan
  - Responsibility for integrating the information from various potential service providers

Comments!!!
Questions???

Domestic Violence

ETHICAL CONTROVERSIES IN DOMESTIC VIOLENCE

C.R. Macchi, PhD, LCMFT
Marcos Mendez, MS, LMFT

Kansas State University

October 29, 2010

REACTIONS TO DOMESTIC VIOLENCE

- Think about your most recent case in which domestic violence (DV) was an issue.
- What are some of the challenges that you encountered in your attempts to address the DV?
- What ethical considerations did you make while assessing the members of the family?

OBJECTIVES

Participants will…

- …review the underlying virtues of ethical codes of practice.
- …learn about the prevalence of domestic violence.
- …learn ethical dimensions of assessing for intimate partner violence.
- …explore the tension between a therapist's duty to protect and client's right to self-determination and autonomy.
- …learn about and apply an ethical decision-making model.

ETHICAL VIRTUES AND CODES OF ETHICS

UNDERLYING VIRTUES OF PROFESSIONAL CODES OF ETHICS

- **Beneficence**: duty to do good and help others
- **Nonmalfeasance**: obligation to minimize harm in all actions we take as professionals
- **Fidelity**: need to carry out and fulfill our professional obligations to those we provide services
- **Autonomy**: goal of promoting the independence of those we serve and not taking any actions that would increase their dependence on us
- **Justice**: obligation to afford all individuals the opportunity for equal access to the same high-quality treatment
- **Self-Care**: obligation to adequately attend to our own healthy functioning

ETHICAL PRACTICE GUIDELINES

- Duty to care
  - Prepare to identify victimization through abuse-specific screening
  - Engage in complete risk assessment
  - Refer clients if this area is not their specialization
- Duty to warn and protect
  - The Tarasoff ruling established the duty to protect and warn victims of eminent threats
  - Safety planning with victims
  - Continue risk assessment
- Duty to report
  - Intimate partner violence and child abuse are correlated in 30 to 80% of cases.
  - Report if abuse to children is ongoing or very likely to reoccur in the future
  - Continue assessing the situation with care if children have not being directly abused at the time
- Duty to self-care
  - Varying impacts of hearing about accounts of physical, sexual, or emotional cruelty can result in experiences of secondary traumatization
    - Disappointment when the violence continues
    - Inflated sense of responsibility
    - Tension introducing systemic ideas into a conservative legal system
    - Transference and countertransference

Jordan et. al., (2004); Vetere (2001)

PROFESSIONAL CODES OF ETHICS & REGULATIONS

- A review of several professional codes of ethics revealed
  - No direct references to domestic violence
  - Some useful guidelines to guide ethical decision-making on issues involving domestic violence
- The Kansas Behavioral Sciences Regulatory Board (BSRB) website cites the Tarasoff ruling describing the duty to warn and protect

	CLIENT'S RIGHTS	CLIENT"S PROTECTION/RESPONSIBILITY TO CLIENTS		
	Inform Consent Autonomy/ Self-Determination	Confidentiality Duty to Protect/Warn/ Report	Scope of Practice/ Best Practice Beneficence-Non-Malfeasance	Ethical Practice
AAMFT	• Respect client's decisions • Obtain inform consent as early as feasible	• Guard confidentiality of each individual • Duty to report	• Protect clients from possible harm • Cannot provide therapy and perform forensic evaluations on the same family system	• Maintain competence through education and training
APA	• Respect the rights of individuals self-determination	• Respect the rights of individuals privacy and confidentiality	• Avoid conflicting roles • Attempt to resolve conflicts responsibly and avoid or minimize harm	• Consider ethical-decision making model
ACA	• Clients decide to enter and remain in a counseling relationship • Respect clients rights.	• Provide access to record when useful	• Act to avoid harm • Inform clients in changes in the role of the counselor	• When faced with ethical dilemmas engage in a carefully considered ethical decision making process
NASW	• Self-determination • Assist clients to identify and clarify their goals	• Confidentiality does not apply when it is necessary to protect	• Refer or recommend additional service if needed • Clarify with all parties which individuals will be considered clients	• Ethical decision making is a process to resolve complex ethical issues
FEM	• Empowering woman	• Committed to reduce pervasive influences or oppression	• Will contract to work with clients and issue within the real of her competencies	• Recognizes her personal and professional needs

OVERVIEW OF DOMESTIC VIOLENCE

DOMESTIC VIOLENCE DEFINED

- Domestic violence constitutes
  - Willful intimidation
  - Assault, battery, sexual assault or other abusive behavior
  - Perpetrated by one family member, household member, or intimate partner against another

  (The National Center for Victims of Crime)

- There is a lack of consensus of the definitions for family violence

TYPES OF DOMESTIC VIOLENCE

- Intimate partner violence (IPV)
  - Unilateral violence
  - Bilateral or reciprocal violence
- Elder Abuse
- Sibling violence
- Child abuse

EXPRESSIONS OF IPV

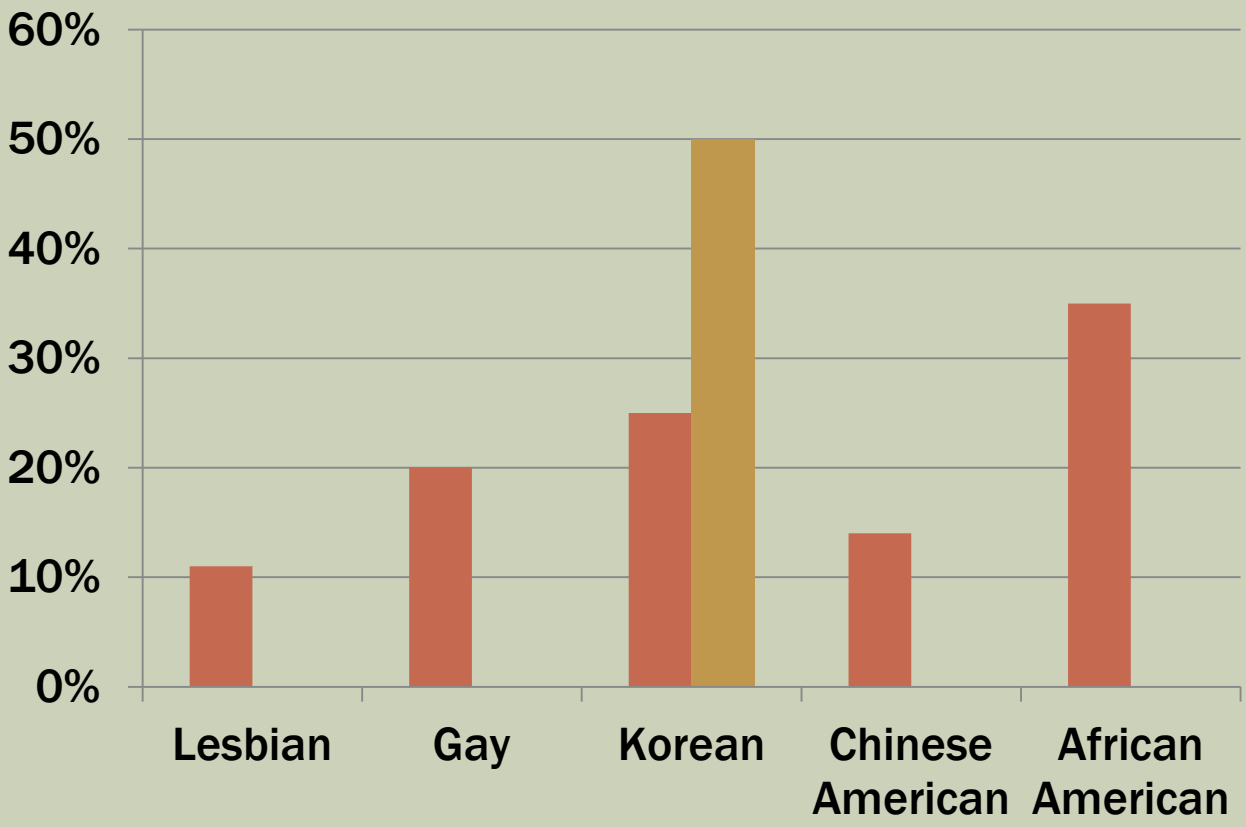
- Physical
  - Block the door, push, slap, punch, kick, burn, choke.
- Emotional/Psychological
  - Destroy personal property, threats with taking the children, “I don’t know why I marry you!” “You are worthless!”
- Sexual
  - “You are pushing me to look for sexual fulfillment outside the marriage!”
- Financial abuse
  - Withholding money from partner, spending the other person’s money.
- Deprivation or neglect
  - Storming out of the house during an argument and coming back late that night. Leaving your spouse for a week without telling her where you are going.

PREVALENCE OF IPV

- 1 in 4 women and 1 in 13 men are assaulted by a partner during their lifetime
- Domestic abuse occurs in 16% of marital relationships
- 18% of women report attempted or completed rape during their lifetime. 2/3 of the time the offender is her husband or boyfriend
- 1/3 of females are killed by intimate partners and out of these 76% were stalked by the person who killed them (Cobia, 2008).
- The rate of intimate–offender attacks on women separated from their husbands are 3 times higher than that of divorced women and about 25 times higher than that of married women (Jordan et al., 2004).

Stith, McCollum, & Rosen, (2007)

PREVALENCE OF IPV IN MINORITY COUPLES



Tjaden, Theones, & Allison (1999); McClennen, Summers, & Daley (2002); Yick (2007); Rennison & Welchns (2000)

ANNUAL PREVALENCE OF DOMESTIC VIOLENCE

- IPV
  - Spouse abuse- 1.3 million women and 835,000 men are physically assaulted
  - Marital rape– there are estimates an average of 201,394 U.S. women 18 or older that are raped by an intimate partner annually (Tjaden, Thoeness, 2000)
- Child abuse
  - A significant percentage of those who report IPV also report incidence of child abuse in the home (Lewis, 2003)

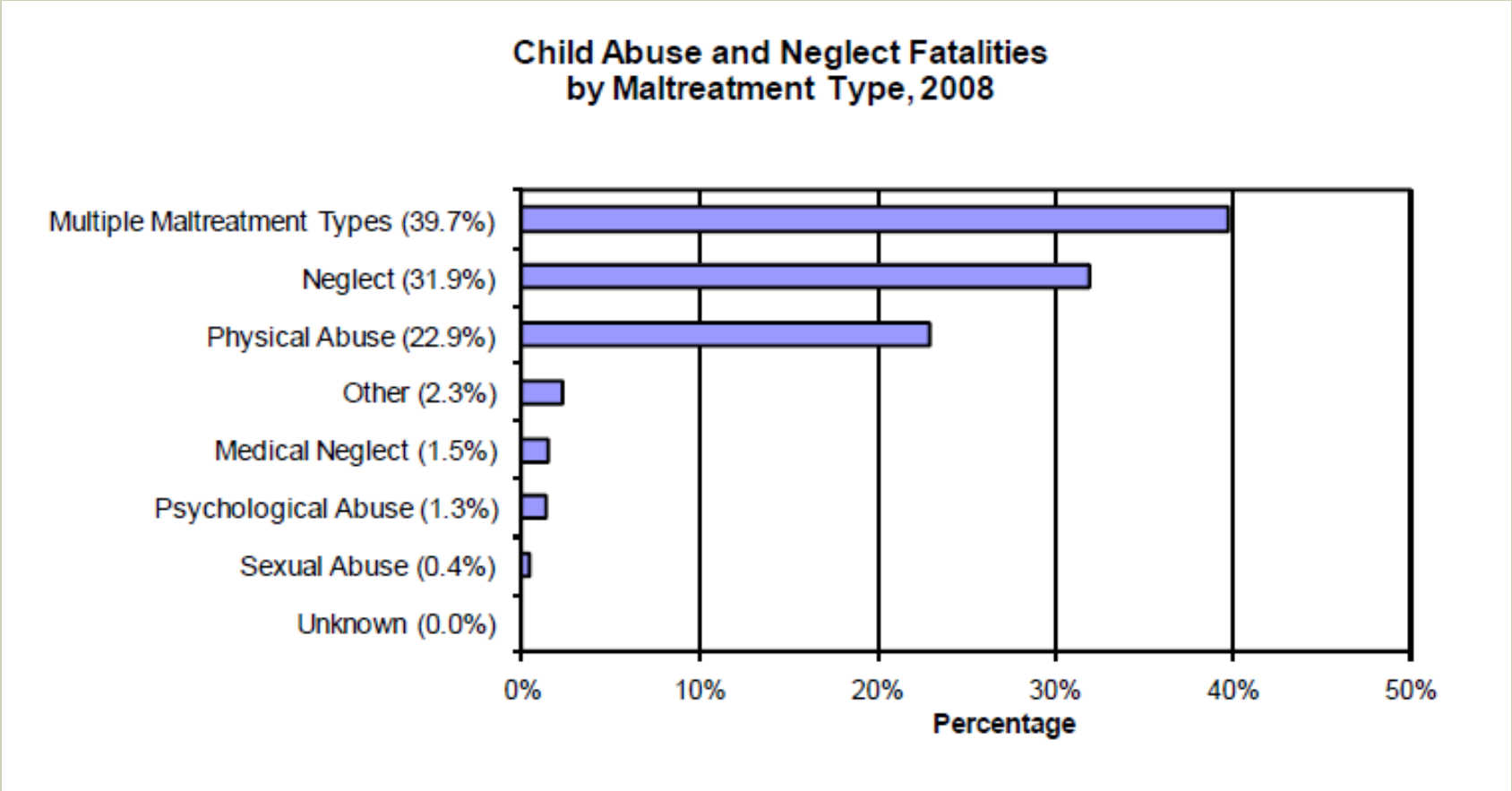
FACTS ABOUT THE CO-EXISTENCE OF IPV AND CHILD ABUSE

- Spouse, child, elder, and sibling violence tend to coexist (Carden, 1994)
- Men who batter their wives may also abuse their children. The victims can also take out their frustration by using violence against their children (Krishnakumar & Buehler, 2000)
- Children of 30%-80% of victimized women are also abused (Lewis, 2003)
- Children are more likely to assault their siblings and their parents, to commit violent crimes, and to assault their own intimate partners than children who have not witnessed violence (Stith, Rosen, McCollum, 2003)

CHILDREN'S REPONSES TO OBSERVATIONS OF IPV

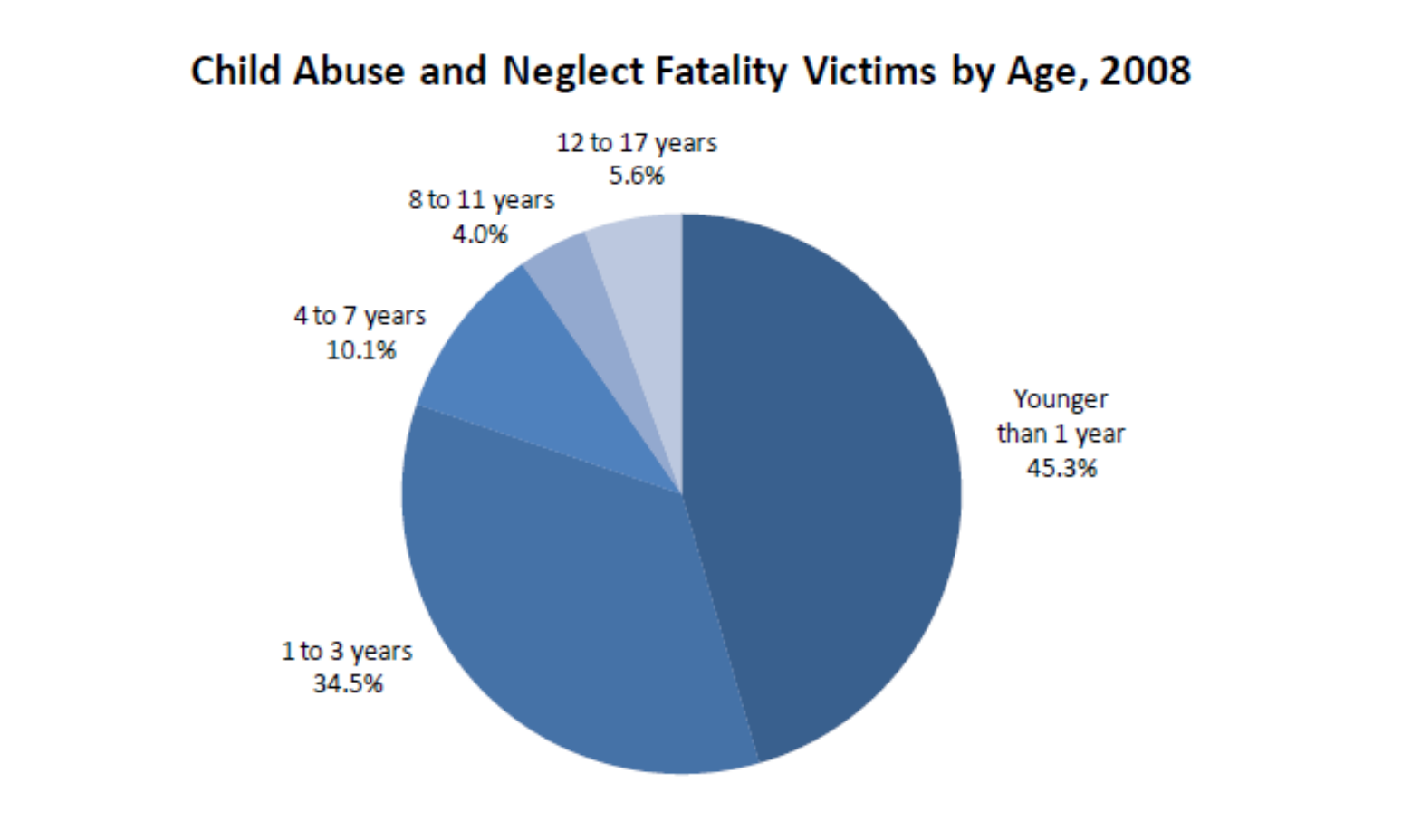
- Children respond differently than adults to domestic violence
- Responses vary considerably depending child's
  - Age
  - Gender
  - Level of violence in the home
  - Degree of the child exposure
  - Whether they are abused
  - Presence of other risk and protective factors
- NOTE: Therapists should be cautious of the assuming that witnessing domestic violence immediately requires child protective services (Margolin & Gordis, 2004)

CHILD ABUSE AND NEGLECT FATALITY BY TYPE OF ABUSE



Child Welfare Information Gateway, HHS (2008)

CHILD ABUSE AND NEGLECT RESULTING IN FATALITY



Child Welfare Information Gateway, HHS (2008)

ETHICAL ASSESSMENT OF DOMESTIC VIOLENCE IN HBFT

ETHICAL IMPLICATIONS OF ASSESSMENT

- Duty to care and do no harm are key in assessment
- If a therapist is unaware of a client's exposure to violence, accurate lethality assessment will not be possible
- Under-detected intimate partner violence leaves the clinician in the position of structuring a treatment intervention that could actually increase risk of harm to the client.
- Failure to inquire and document can result in charges of negligence.

Jordan et. al., (2004)

TYPES OF COUPLE VIOLENCE *INTIMATE TERRORISM*

- Offender's attempt to dominate one's partner with use of ***power and control***
- Physical abuse and nonviolent control tactics such as emotional abuse, isolation, economic abuse, threats, intimidation, using male privilege, and blaming the victim
- Victims suffer severe injuries, feel demoralized, afraid, incapacitated and trapped in the relationship

Stith, McCollum, & Rosen, (2007)

TYPES OF COUPLE VIOLENCE *SITUATIONAL VIOLENCE*

- Occurs as a result of ***occasional conflicts***
- Conflict results from ***reactivity, retaliation, and communication***
- Less injurious and less severe violence
- Usually used by both members
- There is no pattern of controlling behaviors
- Situational violence occurs often and many couples do not seek help

Stith, McCollum, & Rosen, (2007)

VIOLENCE RISK ASSESSMENT CRITERIA

- IPV
  - Context of violence
    - Frequency and severity
  - Management of anger responses
  - Use and misuse of psychoactive substances
    - Possible referral for drug and alcohol rehab
  - Offender's empathy towards the victim
  - Internal motivation for change
    - Personal choice or court-ordered

- Child abuse
  - Increased stress in the family
  - Marital conflict
  - Young or single parent
  - Unwanted pregnancy
  - Poverty

Vetere (2001); Levi (2008)

THRESHOLD OF ABUSE TRIGGERING REASONABLE SUSPICION

A survey of 2000 pediatricians describing reasonable suspicion leading to an abuse report

Respondents	Likelihood of Abuse to Qualify for Reasonable Suspicion
15%	75%
25%	60-70%
25%	40-50%
35%	15-35%

Levi (2008)

INCREASING TREND OF ASSESSMENT FOR VIOLENCE

	Harway & Hansen (1991)	Dudley, McCloskey, & Kustron (2008)
Identify IPV	60%	83%
Suggested crisis intervention	45%	80%
Identify possible lethal violence	2%	1%

ETHICAL CONTROVERSIES WORKING WITH DV

BALANCING THE TENSION
PROTECTION AND AUTONOMY

- Therapists have a duty to protect
- Clients have the right of self-determination and autonomy
- Occasionally clinicians are forced to make decisions when there is no obvious proper course of action
- Serious legal and ethical implications arise when outcomes are uncertain and desired ends appear to conflict

Ryan (1995)

BALANCING THE TENSION
PROTECTION AND AUTONOMY

- When an abused woman discloses concurrent abuse of her children, clinicians experience a tension between
  - Duty to report abuse
  - Reinforcing the self-determination and autonomy of the victim
- Two opposing philosophies for addressing that tension
  - Domestic violence agencies
  - Child protective services

Hill & Thies (2010); Lewis (2003)

COLLABORATIVE EFFORTS FROM DV AGENCIES AND CPS

- Evidence supports the view that many abused women provide competent parenting
- Encouraging abused women to make the report about child abuse aims at supporting her perceived empowerment
- In spite of the tension, mandatory reporting of suspected child abuse to law enforcement or CPS agency is the dictate of the laws of all 50 states

FACTORS COMPLICATING WOMEN'S DECISION TO REPORT

- Usually women face ultimatums involving
  - Safety and security of financial, instrumental, and physical needs
  - Decision to leave and keep the children or stay and lose them
- Women are usually held responsible to protect their children
- Who is required to leave the family home and find shelter?

GUIDELINES FOR REPORTING AND EMPOWERING

- Share the information with the mother of the overlapping of couples violence and child abuse
- Explain the mandate to report child abuse to SRS
- If child abuse is disclosed, offer to make the report with the mother
- Provide mother with information regarding SRS intervention
- Proceed together toward developing a safety plan

Lewis (2003)

ETHICALLY JUSTIFIABLE REFUSAL OF REPORT

- Genuinely believing that reporting will result in a net harm for the child
- Confident that the child is not at risk for subsequent injury
- You are willing to take responsibility for the child's safety
- Other law-abiding alternatives would also result in significant harm
- You are prepared to defend your decision publicly and accept legal penalties for not carrying out your responsibilities as a mandated reporter

Levi (2008)

ETHICAL DILEMMAS WITH IMMIGRANT FAMILIES

- Varying immigration status issues
  - One every 5 children have parents who are foreign-born
  - 85% of immigrant children reside in mixed status families (1 or more parents are non-citizen)
  - May impede access to federal resources
- Many do not speak English
  - Services may lack translators
  - Parents may have difficulties completing a plans involving suspension of parental rights and reunification with their children
  - Difficulty of self-advocacy that protects both their rights as women and as mothers

Earner (2010)

GUIDELINES RESTRICTING THE SCOPE OF CLINICAL PRACTICE

- Conjoint therapy is not offered if family members have a high risk of further violence
- Concern for risk of a member's safety must involve legal authorities
- Confidentiality is not offered in the aftermath of violence or where violent behavior is suspected

Vetere (2001)

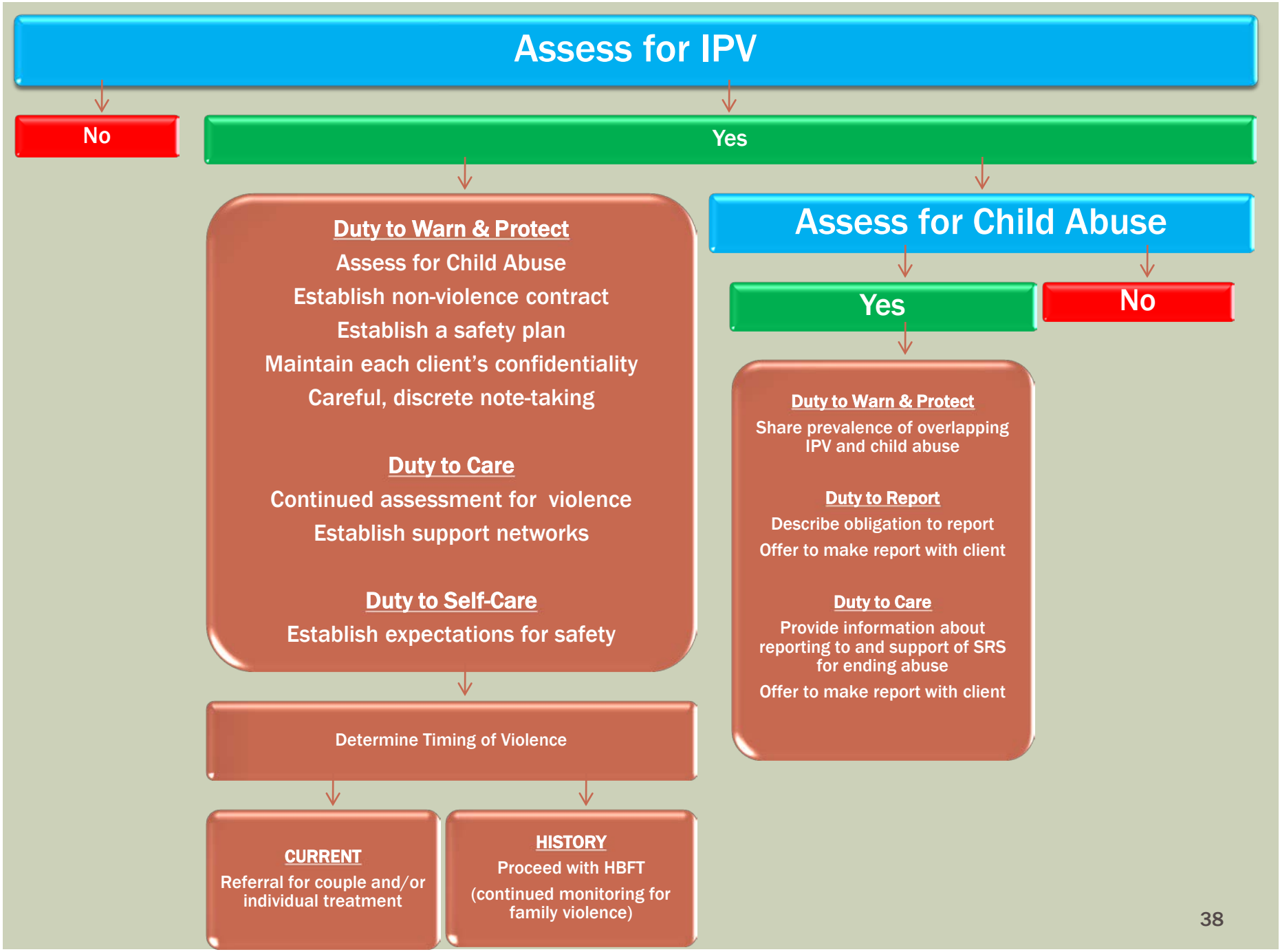
ETHICAL DECISION-MAKING MODEL

OBJECTIVES OF ETHICAL DECISION-MAKING

A clinician's ethical decision-making entails the following tasks and responsibilities

- Assesses for accurate and complete information
- Proceeds with caution if victim is not at imminent risk
- Involves ongoing assessment for violence
- Facilitates accomplishment of ethical duties to care, protect, and warn
- Assures own personal safety and self-care

Bourne (1995)


Assess for IPV
No
Yes
Duty to Warn & Protect
Assess for Child Abuse
Establish non-violence contract
Establish a safety plan
Maintain each client's confidentiality
Careful, discrete note-taking
Duty to Care
Continued assessment for violence
Establish support networks
Duty to Self-Care
Establish expectations for safety
Determine Timing of Violence
CURRENT
Referral for couple and/or individual treatment
HISTORY
Proceed with HBFT
(continued monitoring for family violence)
Assess for Child Abuse
Yes
No
Duty to Warn & Protect
Share prevalence of overlapping IPV and child abuse
Duty to Report
Describe obligation to report
Offer to make report with client
Duty to Care
Provide information about reporting to and support of SRS for ending abuse
Offer to make report with client

CASE STUDY

"Carol and James have been married ten years. They have two children, Dana, 9, and Tracy, 7. James is employed as a foreman in a concrete manufacturing plant. Carol is also employed. James is upset because on several occasions Carol did not return home from work until two or three in the morning and did not explain her whereabouts to him. He acknowledges privately to the therapist that the afternoon prior to the session he had seen her in a bar with a man. **Carol tells the therapist privately that she has made efforts to dissolve the marriage and to seek a protection order against her husband because he has repeatedly been physically violent with her and the kids. The day prior to the session, he grabbed her and threw her on the floor in a violent manner and then struck her.** The family has made plans to go shopping, rollerskating and out to dinner after the session."

RESOURCES

REFERRALS AFTER ASSESSMENT

- Presence of situational violence where both partners volunteer and desire to end the violence
  - Refer for conjoint treatment in a clinic
- Presence of intimate terrorism
  - Refer offender to a batterer intervention program
  - Refer victim to a women's shelter
- Presence of either type of IPV where one partner is abusing a substance and presents to therapy while impaired
  - Drug and alcohol rehabilitation treatment program

EXAMPLES OF AVAILABLE RESOURCES

- Services and agencies
  - National domestic violence hotline: 1-800-799-SAFE
  - The Crisis Center, Inc., Manhattan, KS: 785-539-2785

    It is the main hotline and completely confidential service available to those dealing with domestic violence in Manhattan, KS.
  - Sunflower CASA

    CASA is a program for the advocacy of abused and neglected children, but it can also be a place for spouses dealing with domestic violence to seek additional resources.
  - Pawnee Mental Health Services

    Provides with male batterer group treatment
  - St. Francis Community services

    An agency focused on family preservation. Offers in home therapy as well as classes and other resources for families battling domestic violence.

EXAMPLES OF AVAILABLE RESOURCES

- Additional resources
  - Amanda Rio by Steven Donahue

    A critically acclaimed novel about a family battling Domestic violence. It is realistic in the struggles and the damage to the family system. I recommend it be read by both therapists and clients.
  - Safehorizon.org

    An amazing website for families dealing with domestic violence. Has everything from counseling and legal services to a list of places for people to donate time and money.
  - Battered Women and Their Families: Intervention Strategies and Treatment Programs, Third Edition

    I wanted to make sure and find a good book for therapists, but there are so many. This one was the one I felt would be most helpful because it covers how domestic violence affects the family system and uses this to discuss strategies and therapies to help battered women and children.

ASSESSING FOR IPV
SAMPLE QUESTIONS

- Introduction
  - "I am so concerned about family violence that I ask every patient about this, just as I ask about other health issues."
- Screening
  - "Have you ever felt unsafe or been afraid of anyone? "
  - "Is anyone trying to control you?"
  - "Has anyone ever hurt you or threatened to hurt you or someone else that you care about?"
  - "Since you've been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone?"
- Additional questions
  - "When you and your partner argue, do you feel afraid?"
  - "When your partner is angry, how does he/she act?"

ASSESSMENT OF CHILD ABUSE *SAMPLE QUESTIONS*

- We do not have to prove that child abuse is occurring, we simply have to have a **reasonable suspicion**
- In Kansas, failure to report suspected child abuse is considered a misdemeanor

- What is the level of abuse?
- What was the intention?
- Do you believe the child is at risk for subsequent abuse?
- Have in mind that we are more likely to give the benefit of the doubt to parents who looks like us

Levi (2008)

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Social Networking

Ethical Issues of Therapists' Involvement in Social Networking

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Jurdene Ingram

The Family Center

Kansas State University

Objectives

Participants will…

- learn about potential risks associated with involvement in social networking.
- explore varying types of self-disclosure that are associated with therapists' involvement in social networking.
- explore principles for maintaining appropriate personal and professional boundaries through their use of social networking.
- review ways to set their Facebook privacy settings needed for maintaining personal/professional boundaries.

The Growth of Technology
What is the internet? (1994)

http://www.keepbusy.net/play.php?id=what-is-internet

Social Networking

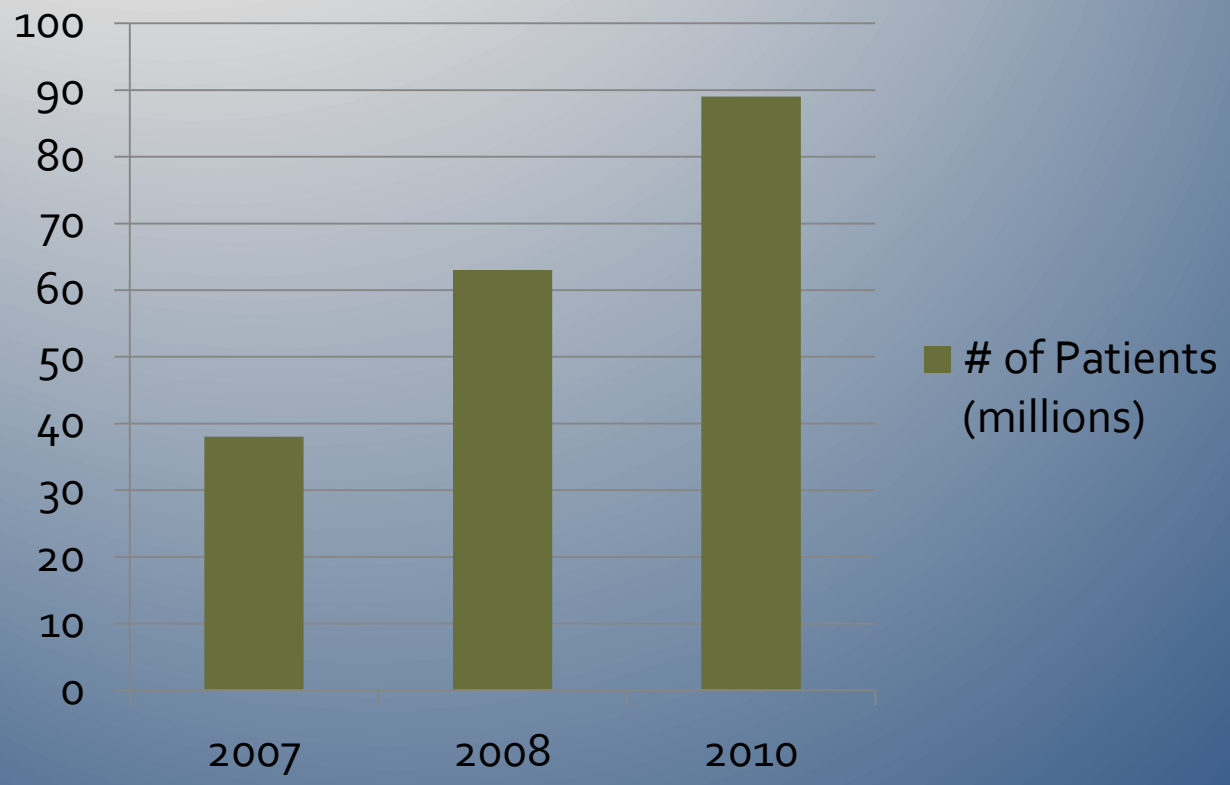
Defining terms

What is social networking?

- *Social networking* is an web-based, electronic medium involving participants' interactions with each other "focuses on building and reflecting of social networks or social relations among people, who, for example, that share interests and/or activities."*
- *Social networking* "allows users to share ideas, activities, events, and interests within their individual networks."*
- *Social networking* is different from
  - *Social media* is a broad term describing a new, quickly developing electronic technology that involves "the use of web-based and mobile technologies to turn communication into an interactive dialogue."*
  - *Social marketing* is specific form of social media that involves "the systematic application of marketing, along with other concepts and techniques, to achieve specific behavioral goals for a social good."*

*Wikipedia (2011). http://en.wikipedia.org/wiki/Social_networking

Use of Social Media for Health-Related Purposes



Devi, S. (2011). Facebook friend request from a patient? *Lancet Medical Journal, 33*, 11-41-1142. Retrieved from http://www.facebook.com/TheLancetMedicalJournal.

Clients' Use of Social Media

- Clients are increasingly using social media to access health-related resources and become better-informed consumers
- Types of social media most often used
  - Blogs
  - Chat rooms
  - Message boards
  - Online communities
  - Patient testimonials
- "New technology is empowering patients and enabling them to be much more assertive and health-care professionals have to spend more time helping them to sift through what might or might not be helpful online." (Neil Coulson, a chartered psychologist at the University of Nottingham, UK, p. 1142)

Devi, S. (2011). Facebook friend request from a patient? *Lancet Medical Journal, 33*, 11-41-1142. Retrieved from http://www.facebook.com/TheLancetMedicalJournal.

Social Networking Sites

- Twitter
  - The user can choose people to "follow" as well as accept or decline "followers"
  - Each update a person wishes to "tweet" (post) can be no more than 140 characters.
  - Tweets are comments the user makes that are shared with followers
  - Hash tags (#) provide a virtual link among tweets on the same topic
  - Tweets can be directed to a specific follower using @ followed by their user name

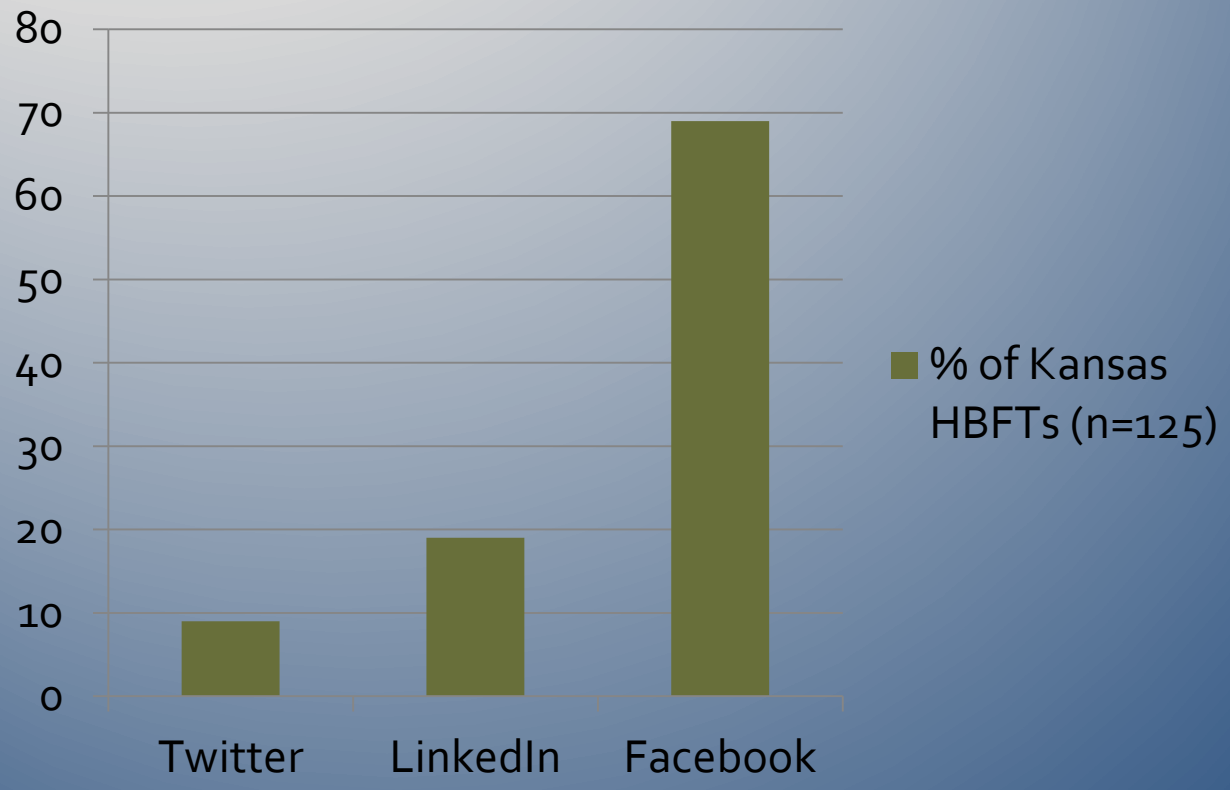
Social Networking Sites

- LinkedIn
  - The user can choose people to "connect" as well as accept or decline "connections"
  - A professional online arena for participants to post resumes, online applications, and marketing professional training, skills, experiences, and recommendations
  - Networks are formed by linking users of similar organizational affiliations (e.g., schools, businesses, interests)
  - A user can "connect" one's profile with other LinkedIn sites of programs, agencies, directors, clinicians, and others within the mental health field
  - Facilitates connections within and outside of Kansas and further drives online traffic to a professional website.
  - Some use the connections for marketing professional products and services

Social Networking Sites

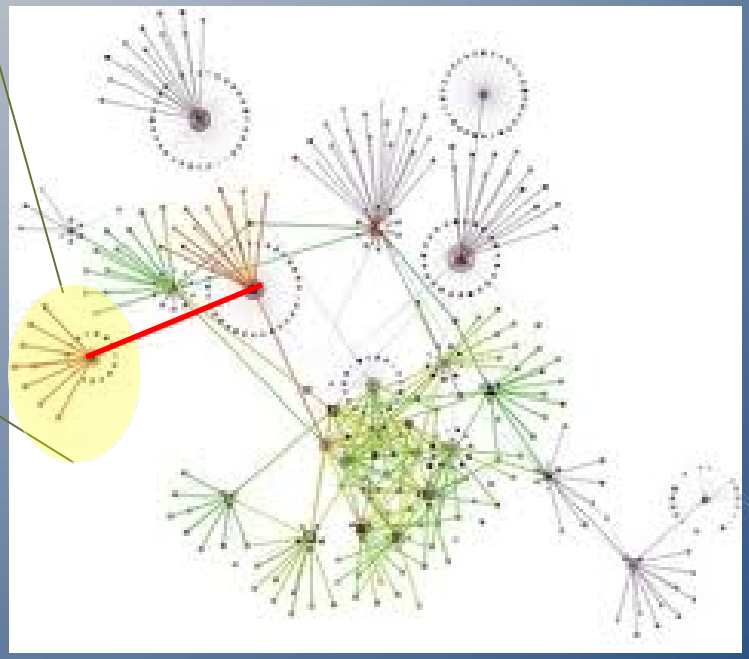
- Facebook
  - The user can choose people to "friend" as well as accept or decline "friends"
  - Pages can be designated as personal with significantly limited access or as a "Fan Page" that has a broader reach
  - Fan Pages can be open to allow anyone to "friend" or closed thus limiting access to those who are approved by the manager of the page
  - Often used to reconnect with old friends, promote causes, publicize events, and communicate information about a business or organization
  - A Fan Page provides a place where participants can obtain information about available programs, links to resources on a website, and foster connections with other fans

Therapists' Use of Social Networking



HBFT Partnership Survey (May 3, 2011)

How big is your social network?



Who has access to your personal information?

To Social Network or Not??

Challenges to Therapists' Ethical Practice

Initial Considerations of Using Social Networking

- Determine if social networking is right for your personal involvement or for your practice or both
- Decide if your professional involvement in social networking is an added benefit to your therapeutic work
- Consider the potential risks and challenges that your involvement in social networking may present to your therapeutic relationships and work
- An informed consent is necessary to provide guidelines for the therapeutic relationship and to make a policy of social networking explicit

Zur, O., Williams, M., Lehavot, K., & Knapp, S. (2009). Psychotherapist self-disclosure and transparency in the internet age. *Professional Psychology: Research and Practice, 40*(1), 22-30.

Professional Codes of Ethics

Underlying Virtues of Professional Codes of Ethics

- **Beneficence**: duty to do good and help others
- **Nonmalfeasance**: obligation to minimize harm in all actions we take as professionals
- **Fidelity**: need to carry out and fulfill our professional obligations to those we provide services
- **Autonomy**: goal of promoting the independence of those we serve and not taking any actions that would increase their dependence on us
- **Justice**: obligation to afford all individuals the opportunity for equal access to the same high-quality treatment
- **Self-Care**: obligation to adequately attend to our own healthy functioning

Purposes of and Challenges to Professional Ethical Codes

Codes of ethics are designed to protect the client and the integrity of the therapeutic process.

The development of codes of ethics is generally delayed and reactive to changing social norms, practices, and the innovations brought about by emerging technologies.

Codes of Ethics

- Current ethical codes do not offer specific guidelines for involvement in social networking, however, each provides useful principles:
- ACA
  - A.12 – Focuses on multiple uses of technology, but no information specifically addresses counselor's use of social networking
- AAMFT, APA, NASW
  - Discusses universal terms such as "dual or multiple relationships" and "client's right to privacy", but nothing specifically on clinicians' use of technology or social networking

Kansas Regulations

Current Kansas Regulations do not provide specific guidelines for involvement in social networking

- Psychology and Social Work Regulations
  - "harmful dual relationships in which competency is impaired due to … social [relationship]"(102-1-1.Definitions, f, (3) – Psychology Regulations)
- Professional Counseling and Marriage and Family Therapy Regulations
  - Do not reference social relationships in their definitions of dual relationships

Ethical Issues Associated with Social Networking

- *Client privacy* – client controls the timing, types, amounts, and ways personal information is shared with the therapist
- *Client confidentiality* – therapist protects the information that the client shares with the therapist
- *Therapist self-disclosure and transparency* – therapist reveals personal information with the client
- *Dual relationships* – occurs when the therapist enters into an additional relationship with the client

Taylor, L., McMinn, M., Bufford, R., & Chang, K. (2010). Psychologists' attitudes and ethical concerns regarding the use of social networking web sites. *Professional Psychology: Research and Practice, 41*(2), 153-159.

Zur, O., Williams, M., Lehavot, K., & Knapp, S. (2009). Psychotherapist self-disclosure and transparency in the internet age. *Professional Psychology: Research and Practice, 40*(1), 22-30.

Client Privacy

Clients have the right to control the ways information is shared with the therapist. The following reflect the clients' perceptions and efforts to determine relevance and readiness:

- *Types of information* - Implicitly and explicitly demonstrating perceptions of the relevance the shared information has with the presenting problems and treatment goals
- *Amount of information* - Testing the therapist's ability to receive and process information; monitoring therapist reaction to information
- *Timing of sharing* - Perceived trust of the therapeutic relationship; reflection of client readiness to change

Kaslow, F., Patterson, T., & Gottlieb, M. (2011). Ethical dilemmas in psychologists accessing internet data: Is it justified? *Professional Psychology: Research and Practice, 42*(2), 105-112.

Client Confidentiality

At the heart of a safe therapeutic space and explicitly stated in the therapeutic contract is the therapist's agreement to protect the clients' information.

Consider the following examples that potentially violate client confidentiality:

- You are meeting with a client addressing a certain issue. Later that day, the client views your Facebook page where you have provided a link to access to information related to their issue… a link that is viewed by others with access to that site.

- You "friend" a client providing them access to your Facebook page. While perusing your site, the client gains access to the list of other clients who have been granted access.

Therapist Self-Disclosure and Transparency

- *Deliberate* – the information a therapist chooses to share
  - Ex: verbal disclosure of personal information, nonverbal disclosure of displaying personal photos or affective reactions to client information
- *Unavoidable* – therapist "disclosure that is neither deliberate nor avoidable… [information shared that is] part of everyday life" (p. 23)
  - Ex: personal appearance, office décor, etc.
- *Accidental* – the information a therapist inadvertently shares due to overlooking or ignoring safeguards
  - Ex: unplanned emotional, affective responses to client information; encounter in a public venue

Zur, O., Williams, M., Lehavot, K., & Knapp, S. (2009). Psychotherapist self-disclosure and transparency in the internet age. *Professional Psychology: Research and Practice*, *40*(1), 22-30.

Contraindications for Therapist Self-Disclosure

- Client exhibits poor boundaries
- Client is vulnerable to boundary violations based upon past experiences

Taylor, L., McMinn, M., Bufford, R., & Chang, K. (2010). Psychologists' attitudes and ethical concerns regarding the use of social networking web sites. *Professional Psychology: Research and Practice, 41*(2), 153-159.

Dual Relationships

- Prevented by maintaining clear, personal/ professional boundaries
- Occur more often within smaller communities
  - Client and therapist involvement in churches, schools, civic groups
  - Encounters at the grocery store or other public venues
- "Boundary crossings" are inevitable and must be monitored and managed

Zur, O. (2009). Therapeutic boundaries and effective therapy: Exploring the relationships. In W. Donohue & S. Graybar (Eds.), *Handbook of contemporary psychotherapy: Toward an improved understanding of effective psychotherapy* (pp. 341-357). Thousand Oaks, CA: Sage.

Zur, O., Williams, M., Lehavot, K., & Knapp, S. (2009). Psychotherapist self-disclosure and transparency in the internet age. *Professional Psychology: Research and Practice, 40*(1), 22-30.

Journal Questions

Consider the following questions during the break:

- What are some main differences between a personal page and a professional page on Facebook?
- List three things a therapist would not tell his/her client during a therapy session that may be posted about on a personal Facebook page.
- What are some things to consider when deciding to develop and maintain a professional page on Facebook?

BREAK

Principles of Social Networking

Summary of General Therapeutic Principles

- Protect client's right to privacy and the ability to control the information that is shared in therapy
- Protect client confidentiality
- Protect the integrity of the therapeutic relationship
- Limit therapist self-disclosure and transparency
- Support therapist professional development

What are your motivations?

Kaslow (2009) suggests reviewing your motivations for obtaining client information and offers cautions about obtaining information outside of the therapeutic space:

- Avoiding confrontation
- Intuition about gaps in client's story
- Verifying information

Kaslow, F., Patterson, T., & Gottlieb, M. (2011). Ethical dilemmas in psychologists accessing internet data: Is it justified? *Professional Psychology: Research and Practice, 42*(2), 105-112.

Therapist Access to Client Information on Facebook

- Disrupts the client's control of personal information and the pacing of treatment
  - Ex: Therapist views information on FB page that appears to be relevant to the therapeutic work that the client has not yet revealed
- Discover a client secret
  - Ex: Client working on extra-marital affair is pictured with that person on his FB page while his partner remains unaware
- Switching roles to one of an investigator verifying client information
  - Ex: Client reports about having written books and attending certain schools while the internet reveals no information
- Learning information through posts and pictures that may differ from the information the client has divulged
  - Ex: Client describes she has been sober for three months. A picture on FB shows her holding a drink at a recent party

Kaslow, F., Patterson, T., & Gottlieb, M. (2011). Ethical dilemmas in psychologists accessing internet data: Is it justified? *Professional Psychology: Research and Practice, 42*(2), 105-112.

Facebook "Friend" Request from a Client

- Altering client's perception of the therapeutic relationship
  - Ex: Client learns about therapist's political and social views listed on profile
- Client develops an expectation that contacting the therapist outside of therapy is acceptable and even invited
  - Ex: Client posts questions about problems or requests for solutions on the therapist's wall

Kaslow, F., Patterson, T., & Gottlieb, M. (2011). Ethical dilemmas in psychologists accessing internet data: Is it justified? *Professional Psychology: Research and Practice, 42*(2), 105-112.
Devi, S. (2011). Facebook friend request from a patient? *Lancet Medical Journal, 33*, 11-41-1142. Retrieved from http://www.facebook.com/TheLancetMedicalJournal.

Strategies and Practical Guidelines for Use of Social Networking

An Ethical Practice Approach

Establishing Strategies for Social Networking

Begin by addressing some questions to refine your purpose and strategy for using social networking

- What are you trying to accomplish through social networking?
- Can you accomplish the same objectives through some other means while limiting risk?
- How will social networking provide an added benefit to your therapeutic work and your practice?

Taylor, L., McMinn, M., Bufford, R., & Chang, K. (2010). Psychologists' attitudes and ethical concerns regarding the use of social networking web sites. *Professional Psychology: Research and Practice, 41*(2), 153-159.

Zur, O., Williams, M., Lehavot, K., & Knapp, S. (2009). Psychotherapist self-disclosure and transparency in the internet age. *Professional Psychology: Research and Practice, 40*(1), 22-30.

Practical Guidelines for Social Networking

- All clinical activities, including communications, should support the therapeutic benefits of the client
- Remember: ***everything posted online remains indefinitely***
- Anything posted online is potentially available for anyone to view
- *Google* yourself regularly to be aware of the information about you that is available to your clients online
  - Use varying combinations of your name for conducting a thorough search (i.e. Sarah Jones; Sarah Jones, MFT; Sarah Jones, PhD, LMFT; etc.).
- Set personal accounts to the highest privacy setting in order to control the amount and types of information that are available to the general public, and thus to your clients
  - Higher settings limit access to those with whom the therapist has chosen to "friend" or connect.
- Monitoring and adjustment of your online presence is critical - ***Information posted online may be inaccurate***

Practical Guidelines for Social Networking

- Maintain separate accounts for professional and personal involvement in social networking
  - A professional account can be established to promote practice and disseminate therapeutic resources, however, therapists should be mindful of unavoidable and accidental forms of self-disclosure that may affect others' perceptions and the therapy process.
- Anticipate potential challenges to confidentiality and to the process of therapy that could arise from clients access to information or postings to the professional page
- Limit site affiliations and access to affiliated professions – "identity by association"
- Provide clear guidelines for participant postings

Professional Use of Facebook

Notes from the School Psychologist Blog

This clinician provides general resources and information that may help supplement treatment

Controlling Access of Your Information

Adjusting Your Facebook Settings

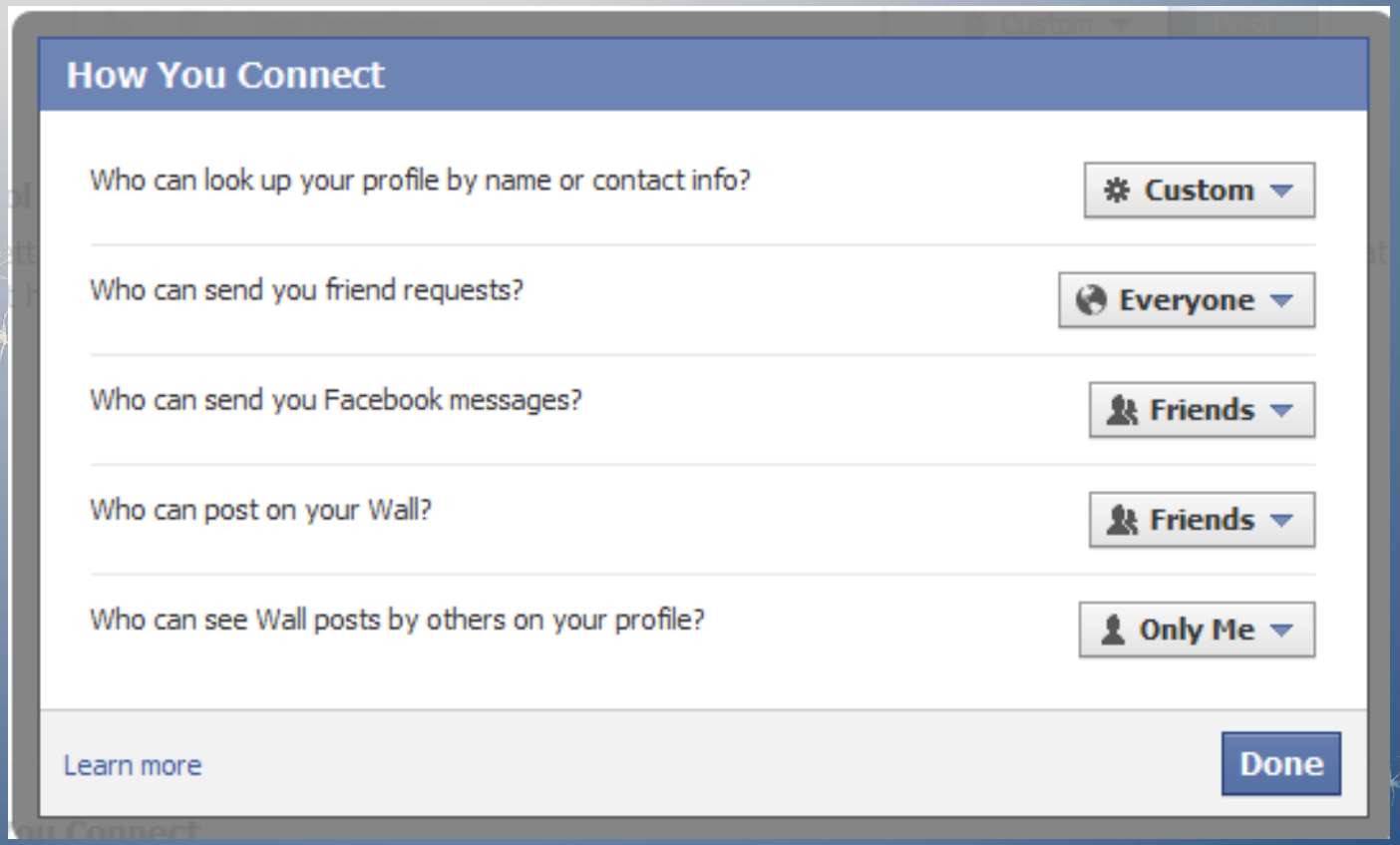
Discussion

- What are your greatest concerns about your online presence in Facebook?
- If your Facebook information were seen by clients…
  - …how might that information be misinterpreted?
  - …how might that information influence your therapeutic relationships?
- What changes do you want to make to your Facebook account?

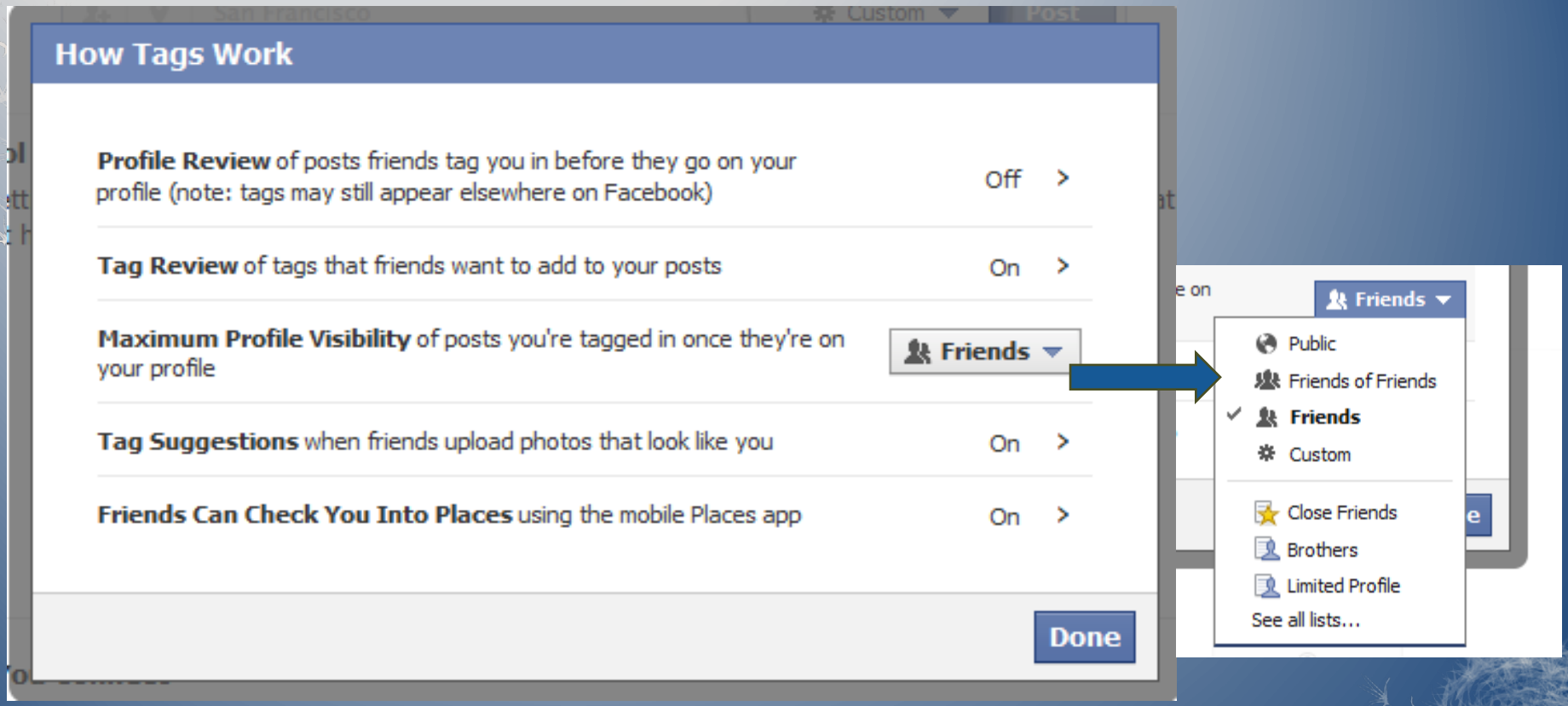
Adjusting your Facebook Settings

- Navigate to www.facebook.com and log in
- In the upper right corner of the screen, select the downward arrow next to the HOME button
- In this menu, select PRIVACY SETTINGS
- http://www.facebook.com/settings/?tab=privacy
  - This screen lists all the various privacy settings available
- *Facebook settings should be routinely checked to insure that the account maintains your preferred settings*

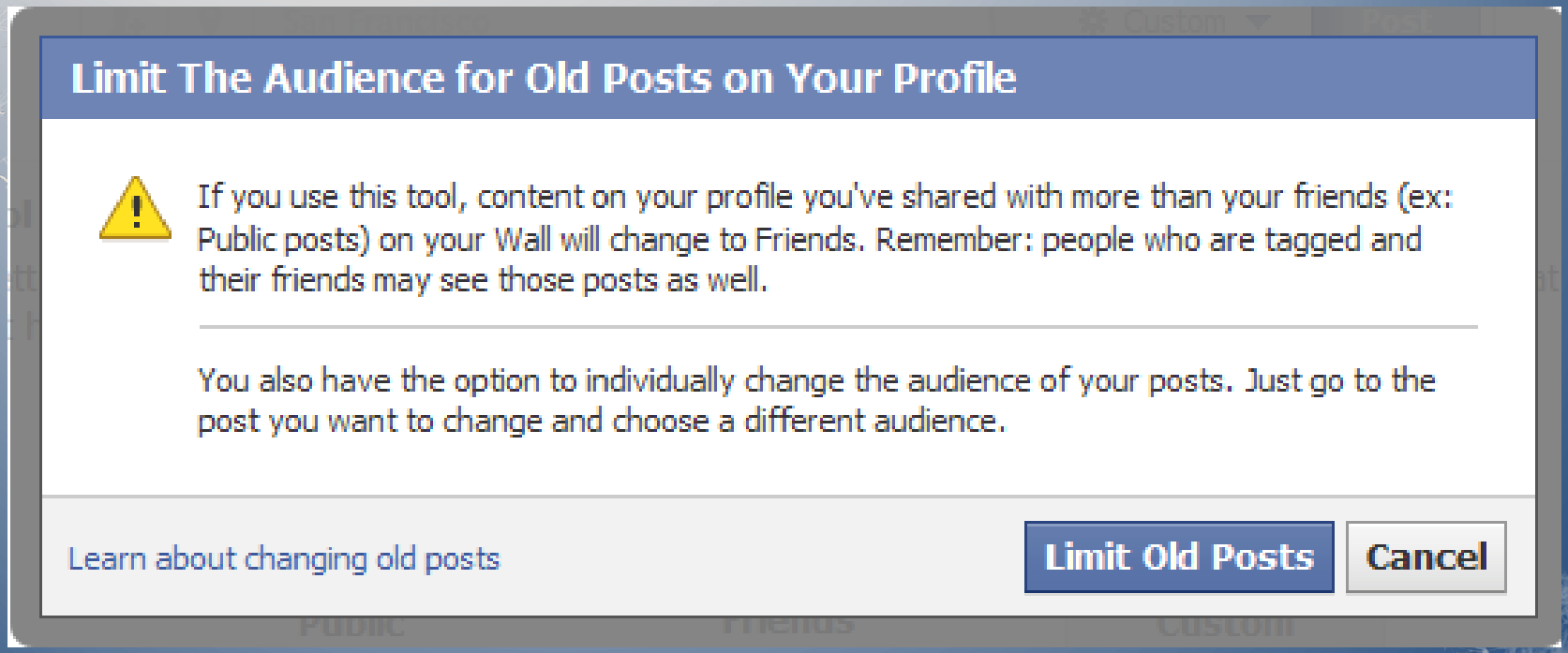
Privacy Menus: Connecting with others



Privacy Settings Menus: Tags



Privacy Settings Menus: Limiting past content



Comments!!!
Questions???

Child Sexual Abuse

The Ethics of Treating Child Sexual Abuse in Families

Camille Lafleur, PhD, LCMFT

Una Henry, MA

Objectives

- Participants will…
  - Learn about the prevalence of child sexual abuse
  - Review the underlying virtues of ethical codes of practice
  - Gain an understanding of how to assess for child sexual abuse
  - Understand child sexual abuse as a systemic issue

Therapeutic Experiences

- Intrafamilial vs. Extrafamilial abuse

Definition of Sexual Abuse

- Any contact or interaction with a child in which the child is being used for the sexual stimulation of the perpetrator, the child, or another person
- Shall include allowing, permitting, or encouraging a child to engage in prostitution or to be photographed, filmed, or depicted in obscene or pornographic material
- Contact solely between children shall meet the criteria only if the contact also involves force, intimidation, difference in maturity, or coercion
- Sexual exploitation of a child is also to be reported
  - "employing, using, persuading, inducing, enticing, or coercing a child under 16 years of age to engage in sexually explicit conduct for the purport of promoting any performance"

Prevalence of CSA in Kansas

- In 2003, based upon 8,488 children in the care of the state, 1,023 cases involved sexual abuse
- In 2010, 1,552 children were victims of abuse or neglect in Kansas, a rate of 2.2 per 1000 children, representing a 13.9% increase from 2009.
  - Of these children, 22.3% were neglected, 22.3% were physically abused, and 34.6% were sexually abused

Code of Ethics

- AAMFT
  - 2.1 Disclosing Limits of Confidentiality
    - Marriage and family therapists disclose to clients and other interested parties, as early as feasible in their professional contacts, the nature of confidentiality and possible limitations of the clients' right to confidentiality. Therapists review with clients the circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. Circumstances may necessitate repeated disclosures.
  - 3.2 Knowledge of Regulatory Standards
    - Marriage and family therapists maintain adequate knowledge of and adhere to applicable laws, ethics, and professional standards

Code of Ethics

- APA
  - **4.05 Disclosures**
  - Psychologists may disclose confidential information with the appropriate consent of the organizational client, the individual client/patient or another legally authorized person on behalf of the client/patient unless prohibited by law.
  - Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed services; (2) obtain appropriate consultations; (3) protect the client/patient, psychologist, or others from harm; or (4) obtain payment for services from a client/patient, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose.

Code of Ethics

- APA
  - **4.06 Consultation**
    - When consulting with colleagues, (1) psychologists do not disclose confidential information that reasonably could lead to the identification of a client/patient, research participant or other person or organization with whom they have a confidential relationship unless they have obtained the prior consent of the person or organization or the disclosure cannot be avoided, and (2) they disclose information only to the extent necessary to achieve the purposes of the consultation.

Code of Ethics

- NASW
  - **1.07 Privacy and Confidentiality**
    - (c) Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person. In all instances, social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed.
    - (d) Social workers should inform clients, to the extent possible, about the disclosure of confidential information and the potential consequences, when feasible before the disclosure is made. This applies whether social workers disclose confidential information on the basis of a legal requirement or client consent.

Code of Ethics

- ACA
  - **B.2.a. Danger and Legal Requirements**
    - The general requirement that counselors keep information confidential does not apply when disclosure is required to protect clients or identified others from serious and foreseeable harm or when legal requirements demand that confidential information must be revealed. Counselors consult with other professionals when in doubt as to the validity of an exception. Additional considerations apply when addressing end-of-life issues.
  - **B.2.d. Minimal Disclosure**
    - To the extent possible, clients are informed before confidential information is disclosed and are involved in the disclosure decision-making process. When circumstances require the disclosure of confidential information, only essential information is revealed.

Kansas Reporting Laws

- Every report should contain:
  - The name and address of the child, the child's parents, or other individuals responsible for the child's care
  - The child's location
  - The child's condition, including the nature and extent of the child's injury
  - Whether the alleged perpetrator has access to the child
  - Any other information that the reporter believes might be helpful in showing the cause of the injuries or the extent to which the child might be in danger
- Willful and knowing failure to make a report is a class B misdemeanor and could result in a $1,000 fine or up to 6 months in jail
  - It is not a defense that another mandatory reporter made a report.
- Intentionally preventing or interfering with the making of a report is also a class B misdemeanor.
- Anyone who, without malice, participates in the making of a report has immunity from civil liability.

http://media.kansas.com/smedia/2010/12/11/19/Guide_to_Reporting_Child_Abuse_and_Neglect-_FINAL.source.prod_affiliate.80.pdf

System Issues for Therapists

- Court Testimony
  - The Child's Testimony
    - The child is usually the state's most important witness
    - When children are prepared for court testimony in advance, and have emotional support through the process, most testify effectively and with limited trauma
    - Children must usually testify in the physical proximity of the defendant, their abuser
    - The judge has some limited authority to close the courtroom if a child will be traumatized by public proceedings.
    - http://www.lifehousechildadvocacycenter.com/programs/kids-in-court

van Eys, P. & Beneke, B. (2012). Navigating the System: The Complexities of the Multidisciplinary Team in Cases of Child Sexual Abuse. Handbook of Child Sexual Abuse: Identification, Assessment, and Treatment. Hoboken, NJ: John Wiley & Sons, Inc.

System Issues for Therapists

- Court Testimony
  - Expert Witness Role
    - Three main forms of expert testimony
      - Opinion testimony – the expert gives opinion that a child's symptoms, for example, are consistent with child sexual abuse
      - Lecture to the judge or jury in which the expert could educate the jury on the common occurrence of sexually abused children recanting abuse
      - Hypothetical questions – the expert is asked about a hypothetical set of facts that mirror the facts of the case on trial and the expert gives opinion on the hypothetical case

Assessment

- The Forensic Interview
  - Usually conducted by a professional interviewer
    - Relatively new
- Developmentally Sensitive Assessment Methods in CSA Cases
  - Step 1: Interview of Primary Caretaker(s)
    - Part 1: History and Current Status
      - The Child's Developmental History
      - Current status
      - Sexual History
      - Possible Risk Factors
    - Part 2: Abuse Concerns
      - History of Concerns
      - Screening for Significant Behaviors
        - Dimensions of Behavioral Assessment
    - Part 3: Rule-Out Hypothesis

Hewitt, S. (2012). Developmentally Sensitive Assessment Methods in Child Sexual Abuse Cases. Handbook of Child Sexual Abuse: Identification, Assessment, and Treatment. Hoboken, NJ: John Wiley & Sons, Inc.

Assessment

- Developmentally Sensitive Assessment Methods in CSA Cases
  - Step 2: Observation and Assessment of the Child
    - Observation of the Parent and Child in Free Play
    - Create a Relationship with the Child
    - Interview with techniques matching the child's developmental stage
  - Step 3: Writing Findings

The Relational Approach to Intrafamilial Abuse

- When a child is sexually abused, they struggle with a number of relational binds, contradictions, confusions, and dilemmas
  - Whether to attempt to resist the person who offended
  - If this is impossible, how to participate physically without participating emotionally
  - May struggle between the desperate need to protect oneself and the wish not to threaten the unity of the family
  - If disclosing, may wonder if it is best to tell the non-offending parent who the child may fear will blame and be angry, or side with the person who offended, or just not believe them

Sheinberg, M. & Fraenkel, P. (2001). The Relational Trauma of Incest: A Family-Based Approach to Treatment. New York: The Guilford Press

Treatment Goals of the Relational Approach to Incest

- The Abused Child
  - To develop *personal agency* – the ability to affect what happens to them in relationships and to control outcomes in their lives
  - To not blame themselves for the abuse
  - To reconnect with a trustworthy family member (usually the mother)
  - To become asymptomatic in terms of emotional and behavioral complications from the abuse
- The Non-Offending Parent
  - To be a trustworthy parent, who makes morally sound and protective decisions on behalf of their child
  - To be able to tolerate expression of a range of feelings from the child
  - To identify, clarify, and accept her many feelings about the offending person

Treatment Goals of the Relational Approach to Incest

- The Person Who Offended
  - To take responsibility for the abuse
  - To show empathy for the child
  - To participate in generating a safety plan
- The Family as a Whole
  - To regain and build upon stories of pride without diminishing the significance of the incest "story"
  - To resume and/or strengthen relationships with supportive others in the extended family and community
  - To become a place of safety, nurturance, and growth – protection from the possibility of future abuses

Special Issues in Working with CSA

- Clinical Considerations when Children have Problematic Sexual Behavior
  - Sexual Behavior Problems (SBP) – child initiated behaviors that involve sexual body parts and are developmentally inappropriate or potentially harmful to self or others
  - Children with SBP are first and foremost children. Life circumstances combined with individual factors lead to the children learning wrong rules about personal safety and sexual behaviors
  - Assess the types, frequency, duration, severity, history, responsivity to adult intervention, and social and cultural contexts of sexual behaviors
  - Gather relevant information regarding supports for the family to provide the child supervision and guidance they need to learn healthy rules about interpersonal behaviors

Clinical Considerations when Children have Problematic Sexual Behavior

- Components of treatment most strongly related to SBP reduction
  - Behavior Parent Training
    - Relationship-building skills, developmentally appropriate behavior management strategies
    - Reduce children's behavior problems by providing consistent environments that support and reinforce adaptive behavior, teach appropriate behavior, and provide developmentally appropriate consequences to behavior problems.
  - Rules about Sexual Behavior and Boundaries
    - Directly addresses expectations for the child's behavior and respect for privacy and modesty
    - Helps parents identify how to prevent sexual behavior problems in children by identifying clear rules regarding appropriate behavior and how to teach and maintain appropriate sexual behavior in the home

Clinical Considerations when Children have Problematic Sexual Behavior

- Components of treatment most strongly related to SBP reduction
  - Sex Education
    - Often children with sexual behavior problems have some misunderstandings and would benefit from developmentally appropriate sex education
  - Abuse Prevention Skills
    - Promotes generalization of knowledge with the purpose of teaching children how to stay safe in situations in which someone attempts to engage in inappropriate sexual behavior
    - Should include being assertive, knowing how to exit a situation in which someone is attempting to engage in inappropriate behavior, identifying adults to whom they can go and tell about the incident, and continuing to tell adults until they are protected.
    - For caregivers, teaches how to ensure safety in the child's many ecologies and establishes the caregiver as a safe person for the child

Special Issues in Working with CSA

- Clinical Considerations when Children have Problematic Sexual Behavior
  - It is critical for parents to be involved in treatment for sexual behavior problems
    - To successfully treat a child's sexual behavior problems, several environmental factors need to be addressed to provide the supervision and guidance to reduce the likelihood of further sexual behavior problems.

Special Issues in Working with CSA

- Clinical Considerations when Children have Problematic Sexual Behavior
  - Reunification with Siblings and Transition to Home
    - Several factors should be considered when making the decision to reunify a child with his/her siblings
      - Active involvement of children and parents is treatment process
      - Demonstrating understanding, support and consistent application of the supervision and safety plan is a prerequisite
      - A pattern of prosocial behavior in which the child with SBP is following rules, including sexual behavior rules at home, school and in the community is an indication that the child can consistently demonstrate self-control
      - Consideration of visitation to facilitate positive interaction with sibling in recommended.
      - Focus on what the siblings can and should do together

Cultural Issues in Child Sexual Abuse Intervention and Prevention

- Child sexual abuse typically has certain similarities across cultures: secrecy, shame, trauma, and the possible involvement with outside systems
- Different cultural contexts can also shape how children become vulnerable, who is most likely to prey upon them, and what kinds of protective mechanisms are available to them
  - May shape both the abuse that occurs and how victims and their families respond

Special Issues in Working with CSA

- Cultural Issues in Child Sexual Abuse Intervention and Prevention
  - It is important to note that people who offend sexually against children will use any and all explanations to justify or excuse their actions, including a version of "My culture made me do it."
    - Any "cultural" explanations for CSA should be investigated carefully by holding confidential conversations with others (especially professionals) from the culture, and not simply accepted at face value.
    - Even if a given practice has some kind of cultural origin, if the practice is harmful to children and/or illegal in the country where it occurs, children must be protected from it.

Special Issues in Working with CSA

- Cultural Issues in Child Sexual Abuse Intervention and Prevention
  - Research has shown that prior to any official systems intervention, families make decisions and try to handle the problem themselves
    - This is likely especially true for cultures where distrust of authorities and previous negative experiences with police and other officials are prevalent.
  - Regardless of cultural background, most sexually abused children do not reveal the abuse during childhood.
    - Children who are part of a minority culture in the US may be even less likely to reveal abuse to authorities.

Special Issues in Working with CSA

- Cultural Issues in Child Sexual Abuse Intervention and Prevention
  - When considering reporting abuse to authorities, both adults and children weigh the costs of disclosing; and sometimes they decide these costs offset any possible benefit.
  - Children from minority groups face culture-specific barriers to disclosure that could contribute to delays or denials
    - Strong prohibitions regarding sexual behaviors
    - Improper to discuss personal matters with outsiders
    - Marginalized cultures who suffer from discrimination, instability, and poverty

Special Issues in Working with CSA

- Cultural Issues in Child Sexual Abuse Intervention and Prevention
  - Most sexual abuse is perpetrated by an adult who is from the same family and community as the child victims, so minority children who have been abused may feel as if they are being asked to betray not only a family member, but also their cultural group.
  - Details of how the abuse happened and how secrecy is maintained may be distinctive based on culture.
  - The differences among members of a particular group are apt to be vast, and often more significant than differences between groups.

Cultural Issues in Child Sexual Abuse Intervention and Prevention

- ADDRESSING
  - Age (effects of generation)
  - Disability (born and acquired)
  - Developmental (individual development and stage of life)
  - Religion and spirituality
  - Ethnic identity
  - Social class (including occupation, education, income, rural or urban, current and former class status and especially the influence of childhood social class status)
  - Sexual orientation
  - Indigenous heritage
  - National origin (immigrant, refugee, international student, native born)
  - Gender (biological sex and gender roles)

Assessment and Diagnosis

The Ethics of Diagnosis and Assessment

UNA HENRY, M.A.
CAMILLE LAFLEUR, PH.D., LCMFT

Ethics Meets Diagnosis

- Informed Consent and Confidentiality
  - Diagnosis, along with its risks and benefits, is a counseling procedure for which practitioners should obtain clients' consent
  - Informed Consent and Diagnosis
    - Diagnosis (if not careful) can provide an excuse for irresponsibility; rob people of their uniqueness by reducing their individual totality to a single word; and lead clients to resignation about who they are, with accompanying despair or self-fulfilling prophecies

Informed Consent and Confidentiality

- Informed Consent and Diagnosis
  - Giving a client a diagnosis may also make it easier to see the client as different from the practitioner
  - If, as often occurs, the diagnosed person is the scapegoat in the family, a diagnosis may reinforce the family's perceptions that the identified patient is "the problem," thus reducing the likelihood of family efforts at change
  - It is important that clients be made aware of the risks and benefits associated with practitioners' ascription of DSM diagnoses, just as with any other counseling procedure

Confidentiality and Diagnosis

- Clients may not have full control over what others know about their therapy.
- Parents have the right to see their children's records.
- Guardian spouses or family members have the right to see the records of those for whom they are guardians.

Confidentiality and Diagnosis

- Clinicians are to be present when people are reviewing such records so as to explain the material in a manner that is understandable to those requesting the information.
  - Clients might be seriously harmed by family members who use another's diagnosis for an agenda that is inconsistent with the therapeutic agenda; it is the clinician's responsibility to ensure that such harm does not occur.
- Also note confidentiality in groups

Confidentiality and Diagnosis

- Informing clients about the risks of revealing diagnostic codes to insurance companies.
- Some insurance companies do not want to pay for the treatment of disorders that existed before their policy was purchased. Clients often remain unaware that their future care or insurability may be affected by accepting a psychiatric (or any other) diagnosis and by receiving treatment for that diagnosis.
  - However, the Affordable Healthcare Act no longer allows pre-existing diagnoses to prevent insurance companies from paying for services.

Confidentiality and Diagnosis

- Know what HIPAA covers, what is protected and what is not.
- Therapists should inform clients about the risks of diagnosis.

Informing About the Risks of Not Diagnosing

- Once family members know that a person has a diagnosable disorder, they may stop blaming that person.
- Once family members know that *they* will not be blamed, they may be more willing to participate with their family in treatment.

Informing About the Risks of Not Diagnosing

- Clients' health insurance may not reimburse for counseling services without the client receiving a DSM diagnosis, and clients may then have to pay large sums of money out-of-pocket in order to receive such services.
- Without engaging in the diagnostic process, it may be difficult to tell if the client meets the criteria for a disorder for which medication would help to alleviate distress.

Informing About the Risks of Not Diagnosing

- Without a diagnosis, children may not qualify for special services in school.
- The benefits that incur to those with DSM diagnoses are, as these situations illustrate, clearly too important to justify dismissing the diagnostic process out of hand or to justify failing to inform clients of the risks of *not* diagnosing.

Responsible Informed Consent

- Recommend that clinicians openly discuss facts that are likely to impact clients, and favor offering assistance to clients as they carefully weigh their choices.
- Informed consent discussion as part of the ongoing assessment and counseling process.
  - Who does informed consent at your agency?

Responsible Informed Consent

- Recommend that clients be made aware of the diagnostic process, the risks and benefits of receiving a DSM diagnosis process, and ultimately any diagnoses that they are given.
  - Extent to which one provides information about informed consent issues be based upon the setting the practitioner works in, the presenting client concern and client needs, and the personal ramifications to a client of receiving a diagnosis.

Competence

- Even if practitioners have received what licensure laws and accreditation standards consider to be adequate training in diagnosis, the question of competency remains.

Competence

- If providers' commitment to the diagnostic process is limited for philosophical and value reasons, would these professionals be inclined to invest in maintaining or upgrading their levels of diagnostic competence after an initial, required course in diagnosis?

Accuracy Versus Misrepresentation

- If mental health professionals choose to participate in a system that only reimburses medically necessary treatment as defined by a DSM diagnosis – and often in order to continue practicing they must so choose – then they need to accurately indicate such a diagnosis.

Accuracy Versus Misrepresentation

- Professionals may report the diagnosis that they know will be reimbursed, rather than one that will not, despite the greater accuracy of the unreimbursable diagnosis.
- It is critically important that practitioners recognize that their choices to misrepresent a client's diagnosis do not protect clients from the potential harms of diagnosis.

Case Example

- DaShawn is a 7-year-old African American boy who attends a primarily White school. A year ago he was diagnosed by his family physician with ADHD. On receiving this diagnosis, his parents and teachers began to attribute all of his undesirable behaviors to his ADHD. His teachers would frequently make him stand in the hall and would disregard much of what he said as being caused by his disorder. DaShawn became increasingly isolated from his family, friends, and school peers. Simultaneously, noting DaShawn's vulnerability and increasing isolation, a school bully began to tease and harass DaShawn. This harassment only increased DaShawn's sense of isolation. DaShawn was unable to express his pain and frustration, and he began to increasingly act out in order to get people to notice his increasing frustration.

Values

- Ethical practice requires that mental health professionals become aware of their own values, attitudes, beliefs, and behaviors and how these factors influence their work in a diverse society.
- Practitioners are also expected to avoid imposing their values on clients

Values Inherent in the DSM

- The mere act of specifying what to observe asks practitioners to be both “objective” and to make judgments about what is normal versus abnormal behavior; values will always be central to making such important decisions.
- The DSM as a diagnostic system seeks to mimic the medical approach, and so leaves many assuming that there is a palpable disease underlying each diagnosis

Values Inherent in the DSM

- Core values of the medical model:
  - Assumes that mental disorders are in a person, regardless of what is happening in the family or in wider social contexts
- The understanding that life stressors may be a factor in symptomatology or result from symptomatology has been included as a factor relevant to understanding clients' functioning

Promoting Growth & Development

- Embracing wellness – rather than merely the absence of infirmity, which is the aim of the medical model
- Wellness focus extends into the whole of the client's life
- Two parts to diagnosis:
  - Identifying the problem and doing an assessment
  - Committing to attain the ultimate goal of diagnosis – the client's wellness

Questions to Consider

- Does the DSM focus on the possibilities for change, and if not, what are the implications for practice?
- Do DSM diagnoses foster movement toward optimal health, and if not, what does this mean for practice?
- Does the DSM focus enough on a person's strength, on how well the client is, and on the rest of the client's life beyond the diagnosis?
- Does the ascription of a DSM diagnosis preclude the ability to focus on the clients' strengths and resources, and if so, how could this affect the services rendered?

Promoting Growth & Development

- Sanity and insanity overlap; the "sane" are not sane all the time, nor are the "insane" insane all the time. Diagnostic labels draw attention to the "insane" part, rather than affirming the other parts

Promoting Growth & Development

- Absence of symptoms is one step in the journey toward optimal mental health or wellness

Rosenhan's 1973 study

- Rosenhan claims that the diagnostic process promotes permanent explanation about people, not developmental ones; that once labeled, there is really nothing the client can do to overcome the diagnosis. Once a person is designated abnormal, all of the person's other behaviors and characteristics are colored by that designation, even to the point that professionals overlook or misinterpret normal behaviors. The label thus becomes a self-fulfilling prophecy, promoting a reality that might not have occurred without the diagnosis

“A Dozen General tips for Accurate and Safe Diagnosis”

- 1. Hippocrates said that knowing the patient is just as important as knowing the disease. KNOW CONTEXT: Time, Place, and Person.
- 2. Take the time and make the effort. Adequate time. Multiple Interviews.
- 3. If you hear hoof beats on Broadway, think horses, not zebras! When in doubt... go with the odds. Stick with the more common diagnoses.
- 4. Get all the information you can. No one source is ever complete. Triangulation of data.

A dozen tips continued…

- 5. Consider previous diagnoses, but don’t blindly believe them. Incorrect diagnoses tend to have a long half-life and unfortunately staying power.
- 6. Constantly revisit the diagnosis. Don’t be blind. Be open to contradictory data.
- 7. Children and teenagers are especially hard to diagnose. They have a short track record, mature at varying rates, may be using drugs or alcohol, and are reactive to family and environmental stresses. The initial diagnosis is likely to change.
- 8. The elderly are hard to diagnose. Their psychiatric symptoms may be caused by neurological or other medical illness, and they are prone to drug side effects, interactions, and overdoses.

A dozen tips continued…

- 9. The less severe the presentation, the more difficult it is to diagnose. There is no bright line demarcating the very heavily populated boundary between mental disorder and normality. Milder problems often resolve spontaneously with time and without need for diagnosis and treatment.
- 10. When you are in doubt, it is safer and more accurate to underdiagnose. It is easier to step up to a more severe diagnosis than to step down from it.
- 11. Accurate diagnosis can bring great benefits; inaccurate diagnosis can bring disaster.
- 12. Always remember the other enduring dictum from Hippocrates: “First, do no harm.”

Francis, A. 2013. Essential of Psychiatric Diagnosis: Responding to the Challenges of DSM-5.

Multicultural challenges to the DSM

- All ethical codes prohibit mental health professionals from discriminating on the basis of such factors as age, disability, sex, race, ethnicity, religion, socioeconomic class, sexual orientation, or any other difference of the client from the mainstream.

Awareness in Cultural competency

- Understanding the cultural framework of the client's identity
- Cultural explanations of illness experiences and help-seeking behavior
- Cultural meanings of adaptive functioning and social context
- Cultural elements in the practitioner-patient relationship

Keys to Developing Awareness in Cultural Competency

- Try to avoid jumping to conclusions about clients on the basis of their cultural group
- Acquire knowledge about different cultural norms and interaction styles
- Commit to ongoing awareness about their own biases, assumptions, and cultural encapsulation

Multicultural challenges to the DSM

- Constructing problems as existing only or largely at the level of the individual draws attention away from the effects of social conditions, such as the results of sexism, racism, and poverty, that are inevitable contextualities in individual experiences.

Overdiagnosis, Underdiagnosis, and Misdiagnosis

- African Americans are overdiagnosed with psychosis and underdiagnosed with depression
- Afro-Caribbean patients who were actually suffering from affective disorders were found to be misdiagnosed with schizophrenia.
- People of varying ethnic populations receive more frequent diagnoses of schizophrenia.

Overdiagnosis, Underdiagnosis, and Misdiagnosis

- Overdiagnosis of severe chronic mental illness to African American clients
  - African Americans may use more extreme language to communicate their feelings of despair or frustration than that used by European Americans, this may lead to diagnosis of more severe disorders.
- Overdiagnosis of personality disorders to African American clients
  - Paranoid personality disorder
- Underdiagnosis of depression among African Americans
  - Expression of depression tends to be more active and self-destructive

Overdiagnosis, Underdiagnosis, and Misdiagnosis

- Underdiagnosis of mood disorders among Asian clients.
- Underdiagnosis of women's substance abuse problems.

Case Example

- Jada is a 17-year-old girl brought to counseling by her parents because of the concerns and anxieties that Jada has about her English class. She indicates that it is hard for her to pay attention because her teacher is boring. She adds that she does not like her teacher because the teacher call on her when she doesn’t have her hand up. She says that the teacher tries to pick on her knowing that it will upset her. Jada is embarrassed when this happens because she does not like to be put on the spot when she doesn’t know the answer. She says that it is not normal for teachers to call on girls in class; she indicates that in her other classes, it is the boys who mostly talk in class.

Case Example (cont.)

- Jada feels that it is not important for her to learn English. She says she speaks English just fine and doesn’t understand the point of the class. She adds that she doesn’t plan on working when she graduates and has no intentions of going to college. She wants to get married and support her husband in his work while she develops as a homemaker.

Case Example (cont.)

- Jada says that she hates school because she has no friends and people pick on her because she is different. She wishes she could drop out of school, but her parents won’t let her. She says she has only one friend, but that she and her friend don’t have much in common. Jada says that the only reason that they are friends is because they are both “losers.” Jada adds that she is used to being a “nerd,” so this really doesn’t bother her. The only problem is her mean English teacher.

Case Example (cont.)

- Jada indicates mounting anxiety prior to attending her class. She says that her stomach starts to hurt about 1 hour before English class everyday. She used to go to the school nurse instead of going to class, but the nurse told her that she couldn't come anymore. She says that sometimes she doesn't even want to come to school because she hates English so much. When she's in English class, her palms are sweaty and she has trouble breathing. She says that her chest feels tight and she is afraid she is going to have a heart attack.

Case Example (cont.)

- She says she has trouble eating lunch because she is so nervous about going to English class. She also says that if she thinks about English class before bed, she cannot sleep and often has nightmares about going to her class. Jada wishes that she could drop out of English class and take something else so that she can get rid of her anxiety.

Conclusion

- “Naming things is never innocent nor without costs and consequences. The fundamental changes in the diagnostic classification systems since its inception suggest that what may appear to be unalterable facts are actually modifiable, whether by virtue of new knowledge, changing terminology, or political pressures.”

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Questions?

Comments?

Advanced Topics

Advanced Supervision

Advanced Supervision

Advanced Supervision Training

HBFT Partnership
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Objectives

- Clinical supervisors will review the different definitions of clinical supervision including their role in this process.
- Clinical supervisors will learn about different theoretical approaches to supervision.
- Clinical supervisors will review different ways of conducting clinical supervision.
- Clinical supervisors will learn what home-based family therapists need in order to feel supported and to provide quality in-home family therapy.
- Clinical supervisors will learn about how to develop their personal philosophy of supervision.

What is Clinical Supervision?

- A continuous relationship focused on the therapists' practice settings and their specific development of competency as they gain practical experience. Involves an experienced therapist, safeguarding the welfare of clients by monitoring a less experienced therapist's performance, with real clients in clinical settings, and with the intent to change therapists' behavior to reassemble that of an exemplar therapist. (Mead, 1990)
- "Clinical supervision is an intervention that is provided by a senior member of a profession to a junior member or members of that same profession. This relationship is evaluative and hierarchical, extends over time, and has the simultaneous purposes of enhancing the professional functioning of the junior member, monitoring the quality of professional services offered to the clients she sees, and serving as a gatekeeper for the particular profession." (Bernard and Goodyear, 2009).

Questions to Ponder

- What are your **field's** standards about clinical supervision?
- What are you **agency's** standards about clinical supervision?
- What are your **supervisees** standards about clinical supervision?
- What are your **personal** standards about clinical supervision?

Roles of the Clinical Supervisor

- Supervisors must:
  - Help the clinical fully understand, utilize, and manage the context
  - Equip clinicians with knowledge of their role and challenges faced
  - Assist supervisees in negotiating and balancing tasks
  - Safety issues must be monitored and adjusted as treatment progresses
  - Help clinicians understand how to create emotional and physical safety concerns
  - Help clinicians explore ethical issues involving boundaries and confidentiality
  - Teach clinicians how to empower families by monitoring their tendency to do things for the family
  - Monitor his or her own tendencies to disempower clinicians

Role of the Clinical Supervisor

- The Agency Supervisor
  - Isomorphism – replication of similar patterns at all levels of a system
  - Continuous evaluation of the supervisory relationship
- Managing Multiple Realities
- Wearing two hats

Importance of the Supervisory Relationship

- Positive supervisory relationship creates safety for the clinician
- The “power” of collaborative supervision
- Dual Relationships - Administrative
- Gatekeeper for the field

“I believe assuming supervisors and supervisees are on equal footing is unethical. In fact, I even believe that the relationship of supervisor and supervisee should not be too isomorphic to the relationship of the therapist and family.” ~Braulio Montalvo (1973)

Confidentiality in Supervision

Dimensions of confidentiality that the supervisor must safeguard:

- The supervisee must keep confidential all client information except for the purposes of supervision.
- The supervisee must also be informed that any discussions that take place in supervision are also confidential.
- The ***supervisee*** has a right to privacy— Supervisees must understand what will happen to information that they divulge in supervision.

Ethics and Clinical Supervision

- Clinical supervisors have accepted ethical responsibility for the following:
  - Clients
  - Supervisees
  - The Profession
  - The Public at Large
- Supervisors who provide ethically-informed supervision:
  - Take a proactive stance
  - Use their greater professional experience and knowledge
  - Help supervisees avoid inadvertent unethical decisions

Ethical Case Study

- Susanne supervises Jim at the agency. They listen to an audiotape of Jim's session with an exhausted mother of a willful 5-year old girl. The mother describes with frustration and helplessness how her daughter refuses to listen to her, especially when she calls her in from playing in the yard. Susanne nods approvingly when she hears Jim tell the mother that she needs to assert her parental authority. Her approval quickly turns to alarm when she hears Jim and the mother plan to lock the child out of the house for an extended period of time to "teacher her a lesson" and help her become more compliant.
  - How would you handle this?
  - What questions would you ask?
  - Does this qualify as child abuse? What are your responsibilities as a supervisor?

Models of Clinical Supervision

- “A master clinician may not always be a master supervisor.”
- Clinical supervision and counseling/therapy have much in common.
- Theory is a way to bridge science and the practice of supervision.
- Models of supervision:
  - Psychotherapy-based Supervision models
  - Cognitive Behavioral Supervision
  - Person Centered
  - Developmental Models of Supervision
  - Social Role Models

Models of Clinical Supervision

- Psychotherapy-based Supervision Model
  - “Theoretical orientation informs the observation and selection of clinical data for discussion in supervision as well as the meaning and relevance of those data” (Falender & Shafaanske, 2008).
- Cognitive Behavioral Supervision
  - Uses observable cognitions and behaviors of the supervisee
  - Cognitive Behavioral techniques are used
- Person Centered Supervision (Carl Rogers)
  - Provide an open, safe environment

Models of Clinical Supervision

- Developmental Models of Supervision
  - Identify supervisee's current stage
  - Scaffolding
- Social Role Models
  - Five tasks or areas of focus
    - Counseling Skills
    - Case Conceptualization
    - Professional Role
    - Emotional Awareness
    - Self-Evaluation

Supervision Formats

- Case Consultation – “Stories about stories”
  - Goal: present information about cases to receive ideas
  - Commonly used do to lack of live supervision options
  - Relies on the therapist’s accounts
  - Supervisors can explore, deconstruct, and reconstruct therapist’s account of events
  - Advantages
    - Allows time to discuss larger political, social, and cultural contexts
    - Allows for the discussion of a variety of questions and concerns
    - Allows the consideration of alternative approaches simultaneously
  - Limitations
    - Cannot capture or reveal all of the important details

Case Consultation Questions

- Describe the Context
  - Does the neighborhood have a concentration of certain ethnic groups that the clinic serves?
  - What is the clinic's reputation among its neighbors?
  - Is it known as a good place to go or is it seen as cold and indifferent?
  - Is it known as responsive to its setting or does the clinic ignore the people in its neighborhood?
  - What difference might that make to therapists or therapy?
- Importance of Physical Appearance of Clients
  - Are they neat or slovenly?
  - Considerably overweight or underweight?
  - What conclusions do therapists draw from the body language and appearance of their clients?

Case Consultation Questions

- Note Key Words and Phrases
  - Is there a history of this behavior in the therapist's life that informs the current use of the term?
  - Are there degrees of this behavior, times when the behaviors strongly manifest themselves and times when they are barely apparent?
  - If that is the case, what words could be used to more accurately describe this continuum of behavior?

Case Consultation Questions

- Review the Received Definition of the Problem
  - How have you arrived at a definition of the problem?
  - If the client says it is one thing and you think it might be something else, how have you negotiated this difference?
  - If there have been competing definitions between family members and one definition has been adopted, has it been the exclusion or detriment of someone else in the family?
  - Have you attempted to consolidate them into one global definition; or have competing definitions been acknowledged while attempting to work with each of them?

Supervision Formats

- Live Supervision – present in session or video-audio tapes
  - Supervisees can learn therapy skills by practicing them with support; learning is accelerated
  - Provides quality control for clients
- Critiques of Live Supervision
  - Intrusive, pushy, dehumanizing
  - Supervisors feel overly responsible for supervisee's therapy
  - Experienced supervisees apprehensive about power and control issues with supervisors
- Synoptic Supervision
  - Supervisees summarize several therapy session with a case
  - Use live supervision bi-weekly, monthly, bi-monthly
  - Supervisors able to see growth

What do therapists learn from live supervision?

- When live supervision is effective:
  - Therapists learn to modify interpersonal sequences that uphold maladaptive behavior
  - Initiate sequences that may solve problems
  - Recognize who starts, upholds, and finishes sequences is not always obvious
  - Block negative sequences
  - Protect new decisions and the productive sequence that follows
  - Motive the unfolding of problem-solving sequences away from the session
  - Encourages changing inflexible positions, loosening rigid situations

Supervisory Needs of Home-Based Therapists

- Important supervisor/supervision traits:
  - Give freedom to choose own therapy model
  - Provides information on community resources
  - Deals with issues of client's safety
  - Provides specific intervention strategies and techniques
  - Uses supervisee's personal biases to facilitate personal growth
- Supervisors:
  - Assist in the therapist's style
  - Emphasizes basic skills
  - Teaches how to handle specific issues
  - Teaches techniques to engender trust in relationships
  - Revises and gives constructive feedback on documentation
  - Encourages development of therapist's personal style.

Supervising the Home-Based Therapist

- Supervision should focus on four areas
  - Session management
    - Discuss balancing scheduling and pacing
    - Discuss interruptions and distractions
    - Discuss ways to shift the focus of the session
  - Using the home environment
    - Maintain focus by using probing questions
    - Focus on how the environment reflects the structure of the family
  - Systems thinking
    - Identify the most salient treatment needs and monitoring progress
    - Develop a strategy for transitioning services to the next provider
  - Safety issues
    - Provide ongoing safety assessments
    - Address safety of the family

Supervising the Home-Based Therapist

- Case consultation is frequently inadequate
  - Live supervision
  - Specific presession and postsession debriefing
  - Utilizing video – audiotaped sessions
- Needs of new or inexperienced therapists (Immersion training)
  - Observe more developed counselors at work
  - High level of supervision and support
  - Teamwork
- "Supervisors should assess supervisees' skills and experience in order to establish standards for competent professional behavior. Supervisors should restrict supervisees' activities to those that are commensurate with their current level of skills and experience." (Association for Counselor Education & Supervision, 1993)

Supervising the Home-Based Therapist

- Focus of Supervision for Inexperienced Therapists
  - Utilizing the Home-based modality
  - Monitoring abilities
  - Safeguarding client families
- Focus of Supervision for Experienced Therapists
  - Issues of safety
  - Systems thinking
  - Using the home environment
  - Managing the sessions
- Additional Forms of Supervision
  - Group: therapist presents a case for group feedback
  - Field: therapists ride along with different colleagues to observe

Myths About Clinical Supervision

- Theories accurately capture clinical supervision.
- Supervisees are already anxious so monitoring/recording sessions overwhelms therapists and their clients and is counter therapeutic.
- Supervisors (or supervisees) do not need to monitor sessions.
- Supervision is all about the using the right theory and techniques.
- Clinical supervisors are doing a good job protecting clients and supervisees from harm.

Dos and Don’ts of Clinical Supervision

- DO work to establish and maintain a solid working supervisory relationship.
- DO use basic communication skills and active listening.
- DO provide empathy and support.
- DO strive to empower the supervisee.
- DO foster the professional development of supervisees.
- DO respect and maintain interpersonal boundaries.
- DO use an informed consent and contract for clinical supervision.
- DO monitor-observe in-session behaviors and give feedback.
- DO pay attention to the –isms and other microaggressions.
- DO focus on supervisee competencies vs impairments.

Dos and Don’ts of Clinical Supervision

- DO focus on supervisees attaining minimal level competencies.
- DO document what transpires in supervision, problems encountered and resolved, intervention and skill competencies and deficiencies.
- DO what you know is right.
- DO work to bridge the science and practice of clinical supervision.
- DO read the clinical supervision literature.
- DO learn and use supervisory skills.
  - ***Trust yourself, trust your supervisees, trust the process of therapy, and trust the process of supervision.***

Dos and Don’ts of Clinical Supervision

- Do NOT neglect diversity issues and the “-isms”
- Do NOT avoid confronting fears and anxieties about being a man or woman in a position of authority, power, and privilege.
- Do NOT provide inadequate or harmful clinical supervision.
- Do NOT let somebody else continue to provide inadequate supervision or harm to their supervisees.

Personal Philosophy of Supervision

- The supervisor ’s philosophical and theoretical assumptions about supervision should be related to her/his practice of supervision.
  - *What are your thoughts about treatment and supervision in relational terms?*
  - *What is your level of awareness about patterns and sequences of replication at various systems levels?*
  - *What is your theoretical orientation based on your philosophy of therapy and supervision as well as their connection?*
  - *What are your personal values, beliefs, life experiences, and theoretical assumptions and how do they impact your practice of supervision?*
  - *What is your rationale for your choice of supervisory methods and how do they facilitate achievement of supervision goals?*

QUESTIONS OR COMMENTS?

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ELECTRONIC RESOURCES

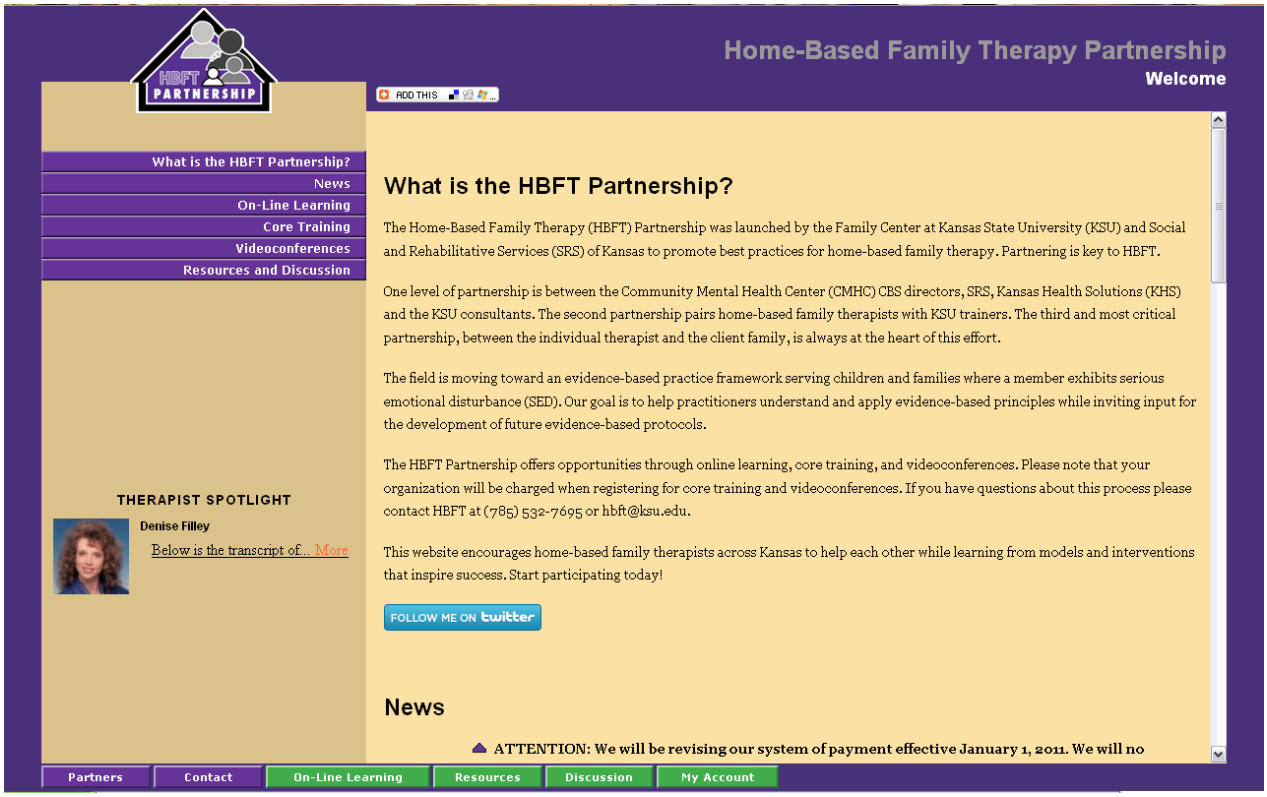
ELECTRONIC RESOURCES

"New and improved interactive modules will offer wisdom on home-based therapeutic skills, family issues, therapist self-care, and supervision. As you apply those learnings directly to your own cases, you'll engage in on-going dialogue with your HBFT colleagues throughout Kansas by joining threaded discussions. Your survey responses also help us identify new training opportunities, influencing the development of future modules… On-line training includes downloadable articles, book references, supervision forms, and links. If you want to quickly find a resource you saw in one of our courses, visit the HBFT Resources Index."

-HBFTPartnership.com

The Website

The website, www.HBFTPartnership.com, is the hub for all of our users. From the website, practitioners can access free online modules, download audio versions of modules, stream archived videoconferences, register for events, access resources and connect with one another through our threaded discussion. Recently we have added social networking to our website to grab the attention of more users. We have 932 users registered with our website. Among those, only 30 have completed modules. We have taken time to consider why we have such low traffic on our website and after speaking with our web designer and graphics coordinator, we concluded that the site is not as user friendly as we had hoped it to be. Technology and internet usage has change so much since we began this project and our site needs to evolve to keep up with these current trends. In this next quarter we plan to redesign our home page, making it easier to navigate and more eye-catching with less text and more graphics. We hope that with this redesign, the site will be more inviting and encourage users to visit the site and stay a while.



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MODULES LISTING

Understanding & Working with Stepfamilies

Families & Domestic Violence

Families & Chronic Illness

Crisis Intervention & Manage-ment

Evaluating Models of Cultural Competence

Integrating Play Therapy in the Home-Based setting

Challenges to Therapist Self-Care with In-Home Work

Balancing Professional and Personal Lives through Self-Care

Utilizing Supervision for Supporting HBFT

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MODULE CATEGORIES

Family Issues focuses on presenting problems from the family's perspective. We focus on those issues that give most home based therapists trouble.

Therapeutic Skills focuses on the expertise that a home based therapist can bring to the families they work with.

Self-Care is such an important part of one's therapeutic practice and often the most overlooked. These modules focus on how important it is to make self-care a priority and some tips on just how to accomplish this.

In our research, we found that supervision is vastly under utilized by home based therapists. The supervision modules stresses the importance of supervision and teaches practioners how to get the most out of their supervision experience.

Audio CD Companion & MP3 Audio Files

Home-based family therapists' time each day is spread across office work, paper work, sessions with clients, and driving between each session. With the use of an Audio CD Companion & MP3 Audio files, therapists would have the ability to listen to the modules that have been created by HBFT in their time between client visits. The Audio CD Companion & MP3 Audio files act as a compliment to the existing resources available on our website. Home-based family therapists are able to engage in learning at their own pace whenever and where ever they can, and then take their knowledge to the website in the use of discussion threads, vignettes, and focus questions. Below are the steps to navigate the Audio CD Companion.

Instructions for receiving the maximum benefit from listening to your CD:

1) Begin by visiting the online learning module on the HBFTPartnership.com website
2) Take the pretest at the beginning of the online module
3) ENJOY LISTENING TO THE CD
4) Review the CD jacket containing important concepts discussed in the CD
5) Return to the online learning module for the following resources:
    a. Articles, books and websites cited in the module
    b. Discussion threads to further discuss the topic with your fellow colleagues around Kansas
6) Take the posttest at the end of the online module to receive your 2.0 CEUs for completing the module
7) Feel free to provide us with feedback at hbft@ksu.edu

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Core Training Resources

Collaborations

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Center for Effective Collaboration and Practice © 2001 The CECP is part of the American Institutes for Research (AIR), and is funded under a cooperative agreement with the Office of Special Education Programs (OSEP), U.S. Department of Education (ED), with supplemental funding from the Center for Mental Health Services (CMHS), U.S. Department of Health and Human Services (HHS).

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Home-Based Family Therapy

Core Training PowerPoint slides.

HBFT Handbook - Created by a previous intern, this handbook can be given to families to familiarize them the in-home therapy process. Includes rules for fighting fair and a contract. To order, please send an email to hbft@ksu.edu with number requested (multiple of 25). Note that the colors, design, or layout of the handbook cannot be altered for your agency.

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HBFT Resource Guide - Lists current products available from the HBFT Partnership.

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DSM

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DSM - ADHD

Addressing ADHD in Home-Based Family Therapy - Part I (PowerPoint)

ADHD Monitoring Tool

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Behavioral Symptoms for ADHD

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