CHAPTER 1

Overview of the Book

Introduction

Clinical work in the real world is challenging and demanding, and it can also be extremely fulfilling. Clinicians must continuously navigate an ever-evolving web of theory, research, and technique. Yet they do this while they are caught between the demands of organizational policies, managed care, and multisystemic barriers. Many therapists have told us they are so overwhelmed by these constant realities that they often do not experience the most rewarding aspects of their work. This book offers clinicians the opportunity to re-energize their clinical practice through the infusion of effective strategies. It presents a concise framework that can help therapists to navigate systemic issues as well as the flood of new therapies and developing trends, so they can become more effective at relieving the suffering and addressing the needs of their clients.

We have repeatedly encountered therapists and counselors who are committed to doing a good job in their clinical work, but are hampered by the disconnect they feel between their training and the often overwhelming demands they experience in the world of service delivery. Many clinicians treating poor clients in public agencies, whether in urban or rural communities, may find themselves unprepared for the cultural diversity and the challenging life circumstances of the clients and families they treat; while many of those in private practice struggle with the ongoing and increasing pressures of managed care.

This book offers a lifeline for clinicians coping with the realities of real-world practice. It validates therapists for the meaningful work that they do and for the difference that they make in their clients' lives. In addition, the following chapters distill the complex and disparate

theories and best practices that exist in the mental health field today and provide clinicians with a unified and accessible approach to healing. Therapists struggling to incorporate evidence-based practices into their clinical work will find a pragmatic integration of theory, research, and experience that also includes other respected therapeutic orientations and modalities.

We discuss methods of individual, group, and family therapy with diverse clients from many cultural backgrounds. In addition, we provide specific guidelines for risk assessment and crisis intervention in challenging situations involving sudden loss, violence, suicide, and homicide. Clinicians are often called upon to help intervene with their clients (and in families and communities) after these traumatic events. As news stories in recent years have demonstrated, therapists may face these challenges in small towns and college counseling centers, as well as in major urban areas. Although these topics have been covered elsewhere, this book is unique in that it discusses these issues and relevant interventions in one place with an emphasis on how mental health practice is actually carried out across the range of clinic, agency, hospital, school, community, and private practice settings. This book provides a comprehensive framework for addressing myriad clinical challenges, and the systemic and multisystemic barriers that most therapists will encounter at some point in their careers. It offers models for increasing supervisory, administrative, and organizational support to help clinicians avoid burnout and cope with the challenges of day-to-day practice. Strategies for self-care are discussed that can help therapists to apply to themselves the same compassion and caring that they generously give to their clients.

As we have indicated above, clinical work can be incredibly rewarding, yet extremely taxing. Ongoing supervision and training are essential for all clinicians if they are to remain positive and effective. Unfortunately, experienced and beginning therapists alike often receive little ongoing supervision, while financial considerations and productivity demands have led to fewer opportunities for on-site training. While nothing can take the place of supervision, it is our hope that this book will give isolated and overwhelmed clinicians the hope, encouragement, and antidote to burnout that good supervision and training provide. Ultimately, our goal throughout this book is to empower clinicians with the appropriate tools and interventions to use in the parallel process of empowering their clients.

The Importance of Lifelong Learning

The mental health field is clearly involved in one of the most challenging and important periods in its history as clinicians are expected to

apply research findings and use evidence-based practices in their clinical work. For beginning therapists, the numbers of these treatments alone can be staggering. For some senior, experienced clinicians who were trained in theoretical models and treatment modalities prior to this movement, evidence-based practices can also present a challenge. A part of this dilemma rests in the fact that many practitioners in mental health and health professions "continue to implement the practices they learned during training (Isaacs & Fitzgerald, 1999; Pagoto et al., 2007; Turner, 2001)" (Spring, 2007, p. 618) without incorporating advances in the field.

Clinicians with many years of experience in a particular theoretical approach or modality of treatment can often become wedded to one way of working. This may result in clients not receiving the most advanced, best practices available. Orlinsky and Ronnestad (2005) have indicated that the therapists and counselors who are most effective with clients are those who have a commitment to lifelong learning and their personal and professional growth as clinicians.

We operate from a belief that the learning process not only enhances our therapeutic interventions but also helps to keep us engaged in and excited by our work. In Chapter 16, we indicate that ongoing, lifelong learning can often serve as an "antidote to burnout" for front-line clinicians in public agencies, as well as for therapists and counselors in private practice (Boyd-Franklin, 1989, 2003). Openness to change and the willingness to explore new ideas are two of the most important survival skills for therapists. It is our hope to encourage clinicians and agencies to continuously explore new treatment advances, including evidence-based practices, and to consider ways in which they might be incorporated in the service of our clients. This book is intended to provide therapists and counselors with an overview of the treatment approaches that we have found most helpful in our own work, and we strongly encourage clinicians to obtain further training in these treatment modalities.

Challenges of Providing Therapy in the Real World

Today's clinicians confront time pressures, productivity requirements, and expectations that they must do more with less. As managed care has increasingly become the norm, clinicians have to take into account insurance companies' guidelines regarding the types of treatments that can be reimbursed, restrictions on the length of treatment, and varied fee structures for clinical services (Huppert, Fabbro, & Barlow, 2006). Over time, all of these pressures can dampen the enthusiasm that many clinicians bring to their work in their early years. In addition, the

debate over evidence-based practices (Goodheart, Kazdin, & Sternberg, 2006; Kazdin, 2008; Norcross, Beutler, & Levant, 2006) and the pressure from federal, state, and local funding sources and managed care companies (Reed & Eisman, 2006) to provide evidence-based services are increasingly pervasive factors for many health and mental health practitioners. Furthermore, many graduate training programs have not prepared clinicians to function optimally in this new service delivery environment.

At the same time, the clients we hope to help may be ambivalent about accepting our services. Therapists are usually well trained in providing treatment to clients who want it, but many clients in the real world are not self-referred and may attach a stigma to therapy. Some clinicians are unprepared for the "resistance" that they may encounter from such clients. Resistance can be especially commonplace among clients who are mandated for treatment by outside agencies, such as the courts, police, child welfare systems, schools, and so on (Boyd-Franklin & Bry, 2000a). Clients unfamiliar with the concept of therapy may have difficulty understanding it as a helpful process. For many ethnic minority clients in poor, urban communities, therapy provided in public agencies may be responded to with understandable suspicion based on past experiences with racism, discrimination, and disrespect encountered in other multisystemic agencies (Boyd-Franklin, 2003). This book offers ways of addressing and working through the ambivalence and mistrust that these clients may bring to therapy (see Chapter 3).

Key Concepts

Evidence-Based Practice in the Real World

For therapists, counselors, and other practitioners, the last decade has been a time of unprecedented change. The evidence-based practice or EBP movement has been one of the most defining characteristics of the mental health field in the 21st century (American Psychological Association [APA] Presidential Task Force on Evidence-Based Practice, 2006; Goodheart et al., 2006; Kazdin, 2008; Norcross et al., 2006). Beginning with the Institute of Medicine (2001), health and mental health organizations have begun to clarify definitions of EBPs for mental health disciplines (APA Presidential Task Force on Evidence-Based Practice, 2006; Gambrill, 2010). The use of EBPs throughout the health and mental health fields has become mandated by funding sources, such as managed care companies (Hayes, Barlow, & Nelson-Gray, 1999; Huppert et al., 2006; Reed & Eisman, 2006) and federal, state, and local government agencies (Carpinello, Rosenberg, Stone, Schwager, & Felton, 2002;

Chambless et al., 1996; Chorpita et al., 2002; Lampropoulos & Spengler, 2002; President's New Freedom Commission on Mental Health, 2003).

Many clinicians who would like to incorporate EBPs feel impeded by real-world factors such as time pressures, productivity requirements, and budget cuts. Other clinicians, who were trained in the field before the advent of EBPs, and have achieved success with clients utilizing other approaches, may be overwhelmed by new expectations and unconvinced that implementing these strategies will benefit their clients.

Goodheart (2006), who was appointed by the president of the American Psychological Association to head the APA Presidential Task Force on Evidence-Based Practice (2006), has pointed out that the debate is centered on what constitutes evidence. We share her point of view regarding the value of evidence-based research interventions, as well as the importance of incorporating other respected findings from diverse theoretical orientations (Goodheart, 2006). With this in mind, we have combined both evidence-based and practice-informed interventions, with clinical expertise and client needs, into our discussions. This book considers the many different points of view regarding EBPs, presents a careful review of some of the main issues in the debate, and makes recommendations for clinicians in responding to these realities (see Chapter 2).

Providing Mental Health Services in a Multicultural World

The number of ethnic minority individuals and families living in the United States continues to grow (McGoldrick, Giordano, & Garcia-Preto, 2005). Although many professional disciplines and schools now address issues related to the treatment of multicultural clients, material is often presented in a superficial manner or relegated to a single course. Such educational efforts cannot adequately prepare therapists to address the needs of a diverse client base. Research has consistently shown that ethnic minority clients often drop out of treatment prematurely, sometimes after only one session (Whaley & Davis, 2007). With this in mind, it is extremely important that therapists emphasize the process of joining and establishing therapeutic rapport in treatment first, before presenting more intrusive assessment and intake forms (Boyd-Franklin, 2003; see Chapters 3 and 4).

Many therapists find themselves working with clients whose ethnic, racial, and socioeconomic backgrounds are different from their own. Each client and family has its own heritage, traditions, values, and survival skills that have helped them to weather adversity. It is important

for clinicians to learn how to search for and utilize the strengths and resiliency of their clients. One of the goals of this book is to help clinicians join effectively with clients from different cultural backgrounds and learn to make the most of differences (see Chapter 3). We will also discuss the importance of therapists exploring their own racial and/or ethnic identities, and understanding the ways in which clients may perceive them. The question of raising the issue of race or of cultural difference in the process of therapy and the timing of these interventions will also be explored.

Core Mediational Processes

The concepts of core mediational processes are among the most important contributions of this book. In view of the rapid proliferation of evidence-based practices and other theoretical approaches in the mental health field, there has been a call for the identification of the core underlying mechanisms that are common to many different EBPs (Chorpita, Becker, & Daleiden, 2007; Hayes, Strosahl, & Wilson, 2011; Meichenbaum, 2008). These principles have been described elsewhere as "core processes," "core tasks of psychotherapy" (Meichenbaum, 2008), or "core clinical processes" (Hayes et al., 2011).

The concept of core mediational processes has developed and evolved from our own professional experiences. One of our coauthors, a professor at a major university, also directs a community-based program. She has worked throughout her career to help students incorporate a wide range of therapeutic modalities and interventions in their work with diverse clients. Three of our coauthors are members of a department in which a primary objective is to ensure a greater fit between real-world practice conditions and the dissemination of evidence-based practice strategies. As with all agencies experiencing the currents of systemic change, the process of implementing evidence-based practice models developed at the highest levels of research design has taught these authors many lessons.

During the course of trainings on different evidence-based practice approaches, we often noted that the concepts discussed contained many common elements. This led to our speculation as to whether a core set of processes existed across evidence-based models. Simultaneously, the lessons learned from our implementation efforts inspired us to reconceptualize our approach to service delivery. We began to wonder if an agencywide standard of care comprising a core set of competencies and practice elements was possible. This dialogue and exploration was reinforced by presentations and trainings occurring at the time. For

example, Anthony Salerno, then codirector of Evidence-Based Practice Initiatives for the New York State Office of Mental Health, expressed his observation (Salerno, Margolies, & Cleek, 2007, 2008b) that every evidence-based model shares three common denominators: (1) some element of stage of change assessment and motivational interviewing, (2) some element of psychoeducation, and (3) some element of cognitive-behavioral therapy.

Steven Hayes, author and founder of acceptance and commitment therapy (or ACT; Hayes et al., 2011), has spoken multiple times about moving away from prepackaged best-practice models toward key competencies. In a presentation on the future of social work practice, Lynn Videka, dean of the New York University School of Social Work, emphasized the importance of identifying time-tested best-practice "protocols" that are effective across settings and diagnoses (Videka, 2011). A similar call is reflected in the literature. Hoagwood, Burns, and Weisz (2002), in discussing the need for systematic research and translation of best practices to urban settings, indicate that the mental health community must identify effective mediators of improvement, in other words, change processes that influence outcomes. The authors propose that such mediators would lend themselves more effectively and flexibly to finding "goodness of fit" to organizational and clients' needs rather than some current prepackaged models.

While we are mindful that within each diagnostic category there are nuanced principles and strategies, the core mediational process approach emphasizes extracting common processes from multiple evidence-based models that, when grouped together, will influence change across a broad spectrum of diagnostic categories and presenting problems. This led us to develop a clinical approach, as described in Chapters 4 through 9, that could be broadly disseminated in our agency as well as other practice contexts incorporating a distillation of the common key strategies, interventions, and competencies inherent in evidence-based practices.

The concept of extracting the core components in a number of evidence-based treatments is not a new one. For example, Hayes et al. (2011), in the second edition of their book on acceptance and commitment therapy, discuss the following core clinical processes: (1) present-moment awareness, (2) dimensions of self, (3) defusion, (4) acceptance, (5) connecting with values, and (6) committed action. Present-moment awareness is a mindfulness principle that encourages clients to stay grounded in their present feelings and not be burdened by past pain or worries about the future. Awareness of the different dimensions of the self allows clients to stay open to many varying emotions and experiences. The concept of an observer self can help clients to recognize that

they can simply observe their experiences without making judgments about them (Hayes et al., 2011). Clients are encouraged to clarify their core values and connect with the things that are most important to them in life. Finally, while recognizing that they may continue to confront painful experiences, clients commit to pursuing actions that will lead to a meaningful life (Hayes et al., 2011). (See Chapter 8 for further discussion of this approach.) This model can also be helpful to clinicians working with clients with serious mental illnesses.

Meichenbaum has also identified the following core tasks of therapy: (1) developing a collaborative therapeutic relationship that involves empathy, cultural sensitivity and collaboration and assesses client stages of change; (2) educating the client about his or her problem and possible therapeutic solutions; (3) reconceptualizing client problems in a more hopeful fashion; (4) developing client coping skills in interpersonal relationships; (5) encouraging the client to perform "personal experiments" that challenge negative beliefs; (6) ensuring that the client takes credit for changes made; and (7) helping clients identify mental health triggers and coping strategies through relapse prevention (Meichenbaum, 2008, pp. 4–7). Many of these concepts have been incorporated into the core mediational processes discussed within this volume.

In this book, we have identified six key components or core mediational processes that have been especially helpful to clinicians working with clients in today's demanding service delivery systems. These mediational processes reflect a marriage of our core values as clinicians with evidence-based practices and other respected theoretical and clinical literature in the mental health field. The six core mediational processes that we have identified are consistent with those described above (Hayes et al., 2011; Meichenbaum, 2008) and include (1) Joining and Establishing the Therapeutic Relationship (Chapter 4); (2) Psychoeducation and Recovery Principles in Mental Health Services (Chapter 5); (3) Motivational Interviewing (Chapter 6); (4) Cognitive-Behavioral Therapy (Chapter 7); (5) Mindfulness- and Acceptance-Based Principles and Practices (Chapter 8); and (6) Relapse Prevention, Trigger Management, and the Completion of Treatment (Chapter 9). Each of these core mediational processes will be discussed below.

Establishing the Therapeutic Relationship

One of the most consistent research findings in the mental health field has been that the therapeutic relationship is one of the major contributors to treatment outcome, regardless of theoretical orientation, technique, or treatment modality (Horvath & Bedi, 2002; Horvath & Symonds, 1991; Norcross, 2002, 2011a). Thus, this is a central concept stressed

throughout this book and we have identified joining and establishing the therapeutic relationship as our first core mediational process.

With the emphasis on evidence-based practice in the field, we have noted a disturbing trend of students and new clinicians becoming so focused on learning and using techniques, that they discount or even ignore the importance of the therapeutic relationship. This tendency, of course, is counter to the underlying message from all schools of therapy that have emphasized the importance of the therapeutic relationship, including cognitive-behavioral therapy (CBT) (J. S. Beck, 2011; Meichenbaum, 2008); mindfulness-based approaches (Hick & Bien, 2010); acceptance and commitment therapy (ACT) (Eifert & Forsyth, 2005; Hayes, Strosahl, & Wilson, 1999, 2011); dialectical behavior therapy (DBT) (Linehan, 1993); motivational interviewing (MI) (W. R. Miller & Rollnick, 2013); psychodynamic therapy (McWilliams, 1999, 2004, 2011; Messer, 2004, 2006); family therapy (Liddle, 2005; Liddle & Rowe, 2010; Liddle, Santisteban, & Levant, 2002; S. Minuchin, 1974; Nichols, 2011; Scapoznik, Hervis, & Schwartz, 2003); and group therapy (Yalom & Leszcz, 2005).

Psychoeducation and Recovery Principles in Mental Health Services

The second core mediational process combines the need for psychoeducation and the incorporation of recovery principles in the delivery of mental health services. Psychoeducation is the process in which the client is provided necessary information about his or her diagnosis, symptoms, and treatment options in order to empower the decisions that he or she makes about treatment. This process can be used to engender a sense of normalization, universality, and destigmatization regarding one's illness (Colom, Vieta, & Scott, 2006; Lefley, 2009; McFarlane, 2002). Additionally, it can help to make the treatment process more transparent, as psychoeducation should include a discussion about the nature of the treatment course and process itself. Psychoeducation can also drive a wedge in a person's overidentification with symptoms, as people tend to misinterpret symptoms as innate truths about themselves. Of course, any psychoeducation effort should be coupled with hope and optimism regarding clients' ability to be self-directed and to achieve a life consistent with their values. In this way, the term recovery, the second part of this mediational process, can help a client to establish a life that is fulfilling both in and apart from his or her mental illness and struggles.

The term *recovery,* originating in the addictions literature (W. White, Boyle, & Loveland, 2005), now has been expanded to include clients who are dealing with mental health issues including serious mental illness

(Ralph & Corrigan, 2005). W. White et al. (2005) have described recovery as a "process of retrieval (regaining what was lost because of one's illness and its treatment) and a process of discovery (moving beyond the illness and its limitations)" (p. 235). Within the mental health field, the idea of recovery has expanded even further, as noted in the Surgeon General's report, with the message "that hope and restoration of a meaningful life are possible, despite serious mental illness" (U.S. Department of Health and Human Services, 1999). Recovery is an integral concept to support individuals to live their lives in the way that is most meaningful to them. Chapter 5 explores the link between psychoeducation and recovery principles in our treatment approach.

Motivational Interviewing

One of the most challenging experiences for new therapists is the realization that clients who are not self-referred may not have made a commitment to change their behaviors prior to treatment. This is particularly problematic because many of the treatment models that therapists have been taught assume a willing client. One of the most powerful models for addressing this issue has been motivational interviewing (W. R. Miller & Rollnick, 1991, 2002, 2013). Motivational interviewing is a collaborative process in which therapists and clients work together to strengthen a "person's own motivation and commitment to change" (W. R. Miller & Rollnick, 2013, p. 12). Given the importance of this approach, we have identified motivational interviewing as the third core mediational process. Chapter 6 discusses the evolution and the changes in this approach over time (W. R. Miller & Rollnick, 1991, 2002, 2013). It also explores the spirit of MI (W. R. Miller & Rollnick, 2013)—its essential orientation to clients—that is composed of four key elements: partnership, acceptance, compassion, and evocation (W. R. Miller & Rollnick, 2013).

Cognitive–Behavioral Therapy

Cognitive-behavioral therapy (CBT) is an evidence-based treatment model that has been adapted and incorporated into evidence-based practices (EBPs) for many different psychological conditions (Barlow, 2008). Given this reality, it is important that clinicians involved in providing therapy in the real world have a solid grasp of this treatment model and be able to incorporate it when appropriate to the needs and presenting problems of their clients. It provides clinicians with a case formulation approach (Persons, 2008) that clarifies the relationship between thoughts

(cognitions), emotions, and behaviors (J. S. Beck, 2011). With this in mind, we have identified CBT as the fourth core mediational process. Chapter 7 discusses this model and describes intervention strategies.

Mindfulness- and Acceptance-Based Principles and Practices

Mindfulness- (Bien, 2010; Hick & Bien, 2010; Kabat-Zinn, 1990; M. G. Williams, Teasdale, Segal, & Kabat-Zinn, 2007) and acceptance-based principles (Hayes, Follette, & Linehan, 2004) have been incorporated into a number of evidence-based practices that provide not only excellent treatment interventions but also a philosophical shift in the way in which the treatment of mental illness is viewed by many clients and therapists. These interventions have included acceptance and commitment therapy (ACT) (Hayes, Strosahl, & Wilson, 1999, 2011), dialectical behavior therapy (DBT) (Linehan, 1993), mindfulness-based cognitive therapy (MBCT; Segal, Williams, & Teasdale, 2001), mindfulness-based stress reduction (MBSR; Goldstein, Stahl, Santorelli, & Kabat-Zinn, 2010), and mindfulness-based relapse prevention (MBRP; Bowen, Chawla, & Marlatt, 2011; Marlatt, Bowen, Chawla, & Witkiewitz, 2008).

Mindfulness- and acceptance-based principles and practices are the fifth core mediational process because they represent an approach to empower clients struggling with a wide range of mental health issues. (See Chapter 8 for a discussion of these principles.) Mindfulness, grounded in Eastern philosophy, encourages clients to live in the present. It builds on the observation that human beings often experience difficulty staying grounded in their feelings or experiences, particularly when these are upsetting (Bien, 2010; Hick & Bien, 2010). It addresses the ways in which clinicians can utilize mindfulness in order to stay present in their treatment with each client despite time pressures and productivity demands (Bien, 2010; Hick & Bien, 2010), and incorporates mindful listening (Shafir, 2010) as a key part of the therapeutic relationship and treatment process.

Mindfulness- and acceptance-based principles encourage individuals to accept the fact that they may continue to have some painful emotions in the course of their lives (Hayes et al., 2011). Hayes et al. (2004) have noted that emotional pain in the form of anxiety, depression, grief and loss, etc. is a normal human experience and that it is not the experience of pain that is problematic but our reactions to it and attempts to control it. Rather than engage in self-blame and a judgmental stance, it emphasizes that individuals should not allow upsetting feelings to stop them from pursuing meaningful activities and a productive life.

Relapse Prevention

Relapse prevention is the sixth core mediational process identified in this book. It is extremely important because the process of recovery does not occur in a straight line (Ralph & Corrigan, 2005; W. White et al., 2005) but rather takes many turns and detours along the way (J. S. Beck, 2011). It is up to the clinician to embrace this perspective and cultivate a sense of universality and learning regarding the natural ebb and flow of the change process. Lapses often provide an opportunity to uncover, learn about, and grow from the existing areas of vulnerability in one's recovery path. When clients are able to recognize what they are experiencing and to utilize strategies to recover, a lapse does not have to lead to a full relapse. In fact, we would argue that, most often, recovery is more fully integrated after one undergoes and weathers the inevitable lapses associated with this process, and emerges with resiliency.

Although the terms *relapse prevention* and *trigger management* originated in the addictions field (Marlatt & Gordon, 1985), these concepts are now widely used in the mental health field, particularly in cognitive-behavioral therapy approaches (J. S. Beck, 2011; Ludgate, 2009; Meichenbaum, 2008). In her discussion of relapse prevention, J. S. Beck describes the way in which she helps clients with the essential process of recognizing the plateaus and valleys that they may encounter. When clinicians maintain a consistent stance, helping clients to continuously identify, learn, and internalize ongoing trigger management strategies, it creates a context that fosters lifelong acceptance and change. Chapter 9 discusses this core mediational process in more detail.

Systems Interventions in the Real World

Family Therapy

Many clinicians enter the field with training only in individual treatment approaches. This is unfortunate because it restricts their ability to provide effective care to clients across treatment modalities. Family systems theory provides a key conceptual framework and many important concepts essential for therapists even when treating individual clients. This is particularly true in work with ethnic minority clients and others from more collectivistic cultures, where frequent contact with family and extended family members is expected and continues over a client's lifetime. In such cases, it is critical for therapists to be able to understand the dynamics of the family system as well as the familial and cultural values that affect our clients.

The exposure to family therapy is essential whether clinicians work primarily with children, adolescents, or adults. The ability to provide family therapy is especially valuable when working with children and adolescents. Too often, we have seen cases where three or four children in one family are each assigned to individual treatment with separate therapists, when family therapy is clearly indicated and would provide a more coherent and coordinated treatment approach. In addition, many clinicians may overlook the value of family therapy and psychoeducational approaches with the families of adults, particularly those who are experiencing serious mental illness. Chapter 10 discusses these perspectives.

The Multisystems Model and Interdisciplinary Coordination of Care

Among the greatest challenges clinicians face in the real world of service delivery is the fragmentation of care and the duplication of services (Boyd-Franklin & Bry, 2000a). As a consequence, we have incorporated the multisystems model (Boyd-Franklin, 2003; Boyd-Franklin & Bry, 2000a) and the need for an approach that emphasizes interdisciplinary coordination of care as central concepts in all of our work. Clinicians working with exceptionally stressed inner-city, poor clients and families may find these clients at the mercy of multiple systems (e.g., schools, courts, police, child welfare) that exert a tremendous amount of power in their lives. These clients and families face the daunting task of coordination between agencies that share sparse communication, if any, and may prescribe divergent and possibly mutually exclusive directives. With these multiple players and systems in mind, this book addresses the need for multisystemic interventions and the coordination and streamlining of care (see Chapter 11). Examples are given of ways that clinicians can help such families. In addition, the value of interdisciplinary case conferences that provide the opportunity for service providers from a range of agencies to meet together with the client or family to discuss current issues and formulate an effective treatment plan are discussed.

Group Treatment

The productivity pressures and large caseloads inherent in today's demanding service delivery environments have led to a renewed recognition of the value of group treatment approaches. In treatment settings where there are too few clinicians to serve client needs, groups provide the opportunity to offer excellent treatment to more clients. Many new

clinicians have relatively little training in group therapy, as it is often treated as an elective in clinical training programs.

It is important to be sure groups are conceptualized with the real world in mind. For example, we have found that the traditional position that therapy groups forbid contact among group members outside of sessions is often unrealistic. We visualize groups as therapeutic support groups, assume outside contact, and encourage group members to bring these experiences into group discussions. This approach is particularly helpful for isolated clients who may not have family members and friends to support them in their process of change.

Another acknowledgment that clinicians need to make regarding the reality of clinical practice today is that modalities of treatment can and often should be combined in the real world (e.g., individual + concurrent family or group treatment). In Chapter 12, we offer examples of the ways in which these combined treatment modalities can address specific clinical issues. Similarly, therapists working with clients in groups may choose to meet with clients individually in order to address specific treatment issues or in pairs in order to resolve conflicts that may arise in the group process. In this book we reiterate the need to be flexible, in combining modalities in order to address client or family issues.

Risk Assessment, Suicide Prevention, and Crisis Intervention

There are few topics in the mental health field that create more anxiety in clinicians than the process of evaluating risk, particularly with suicidal and homicidal clients (Jobes, 2006; Shea, 2002; Underwood, Fell, & Spinazzola, 2010). This is an extraordinarily challenging aspect of doing therapy in the real world, and graduate programs frequently do not prepare clinicians with the skills to accomplish such a task. With this in mind, Chapter 13 presents an overview of risk assessment and management and discusses implementation in the case of suicide prevention. In this chapter, we also discuss organizational interventions that have been developed to support clinicians in making difficult assessments.

Crises are a normal part of ongoing clinical work, and clinicians in the real world may encounter one of these situations in the course of their careers, but many have received no training in appropriate responses to such events. Chapter 14 explores crisis intervention and postcrisis responses to an act of violence in a mental health clinic, a suicide of a young adolescent in a school, and a homicide in a community.

This chapter presents frameworks that clinicians can adapt to crises in their own work.

Clinician Self-Care

Clinical work can be especially challenging and demanding with clients who have experienced multiple traumas in their lives. Often clinicians and counselors in agencies, clinics, hospitals, and schools have had no training in trauma therapy or counseling. In addition, they may not be prepared for the possibility that they may develop compassion fatigue (as well as vicarious or secondary traumatization; Dass-Brailsford, 2007) as a result of their compassion and empathy for traumatized clients. We draw on the extensive trauma literature on these issues in Chapter 15 to offer guidelines for clinicians in recognizing the effects of vicarious traumatization and to provide the steps they can take to address and prevent it.

We have also drawn upon the literature on vicarious resilience and posttraumatic growth that asserts the positive benefits for clinicians working with traumatized clients. Clinician burnout will also be addressed. Ironically, unlike the other conditions that we have discussed, burnout often results from systemic and organizational issues within our clinics and agencies, which can profoundly affect clinicians over time (Dass-Brailsford, 2007). With these considerations in mind, we have emphasized the importance of self-care for all therapists and counselors throughout their careers. We offer specific suggestions that have been helpful to both new and seasoned clinicians who may experience such challenges in their clinical work.

Supervision, Training, and Organizational Support as Antidotes to Burnout

Over the course of our careers, we have been involved in developing and providing supervision, training, and organizational support to therapists and counselors in clinics and agencies throughout the mental health field. We view these interventions as antidotes to clinician burnout (see Chapter 16). As we mentioned in the first part of this chapter, the process of lifelong learning is a major survival mechanism for therapists and counselors. In our experience, learning innovative ideas and new ways to approach difficult cases, and implementing them in our practices so that more effective treatment can be provided to our clients, can help to invigorate clinicians and enhance their commitment to this work. It is also a useful professional self-care strategy.

Conclusion

In summary, we hope that this book will energize clinicians and encourage them to learn new clinical interventions and to seek diverse forms of training throughout their careers. We also hope supervisors, administrators, and clinic and agency directors will adopt many of the examples of organizational support we have included. Ongoing training and supervision for clinicians is one of the most important investments an agency can make in its staff and is a potent antidote to burnout. Ultimately, through this book, we hope to empower clinicians and provide them with the appropriate tools, anchored in best practices, to more effectively meet the needs of their clients.

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