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Exploring the Dynamics of High-Challenge Encounters in Residential Substance Abuse Treatment Settings

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Exploring the Dynamics of High-Challenge Encounters in Residential Substance Abuse Treatment Settings

Abstract

In 2012, 4 million people aged 12 or older received help for alcohol and illicit drug use in the United States with approximately 2.5 million treated as inpatients (SAMHSA, 2012). Studies show the majority of women, men, and adolescents obtaining substance abuse residential treatment have been traumatized before entering treatment. Traumatic events span past sexual abuse, physical abuse and victimization from violence; trauma also include experiences from disasters and war. Yet, trauma-informed treatment is not mandated for substance abuse treatment facilities, and the manner in which clients are handled upon entering substance abuse residential treatment facilities is largely unknown. In a survey reflecting the most comprehensive national data on treatment delivery, Capezza and Najavits (2012) found that 66% of the 13,233 substance abuse treatment facilities examined reported the use of trauma-related counseling with clients. However, a considerable 33.4% of these facilities rarely or did not provide trauma counseling. Alarming, similar residential structures such as nursing homes report rising annual abuse of patients while in care in a third of their institutions throughout the U.S. (U.S. House of Representatives, 2001), and client re-traumatization has been documented in psychiatric inpatient wards (Cusack et al., 2003; Freuh et al., 2000). This dissertation explores the triggers and consequences of high-challenge moments that occur within residential drug treatment settings; high-challenge moments are escalated moments between staff and clients that result in potential emotional and/or physical harm to clients. Client harm from high-challenge moments appears related to the absence of trauma-informed facilities, lack of staff training in client symptomatology, enactment of authoritarianism by staff, and inappropriate maintenance of staff-client boundaries. A qualitative study was conducted in which nine staff members working for at least six months in adult and adolescent residential substance abuse treatment milieus of varying treatment lengths engaged in intensive semi-structured interviews. Data were analyzed utilizing open-coding and category formation from grounded theory and theme formation surrounding a common concept from phenomenology. Subjects confirmed high-challenge moments do occur in residential substance abuse treatment settings. Results signify training as useful in preventing re-traumatization, overidentification, lack of staff understanding of trauma, client exploitation, use of shame, and excessive enforcement of residential setting rules. Implications indicate a need for trauma-informed facilities in treating substance abuse and an emphasis on changing hiring practices, training, supervision, and client treatment.

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**EXPLORING THE DYNAMICS OF HIGH-CHALLENGE ENCOUNTERS IN
RESIDENTIAL SUBSTANCE ABUSE TREATMENT SETTINGS**

Annapoorna Ayyagari

A DISSERTATION

in

Social Work

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ABSTRACT

EXPLORING THE DYNAMICS OF HIGH-CHALLENGE ENCOUNTERS IN RESIDENTIAL SUBSTANCE ABUSE TREATMENT SETTINGS

Annapoorna Ayyagari

Lani Nelson-Zlupko, PhD

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Dedication

ॐ गं गं गं गणपतये नमः

Om Gam Gam Gam Ganapataye Namaha

Salutations to Lord Ganapathi

मातृ ढेवो भव् पितृ ढेवो भव्

Maatru Devoh Bhavah Pitru Devoh Bhavah

Mother is God Father is God

ॐ श्री साई राम गुरुदेवदत्त

Om Sri Sai Ram Gurudevadatta

Salutations to Lord Dattatreya

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Introduction

In the United States, 4 million people aged 12 or older received help for alcohol and illicit drug use with approximately 2.5 million treated as inpatients in 2012. Of those 4 million, 1 million received inpatient treatment at a rehabilitation facility, 861,000 were inpatients at a hospital, and 597,000 received treatment in an emergency room (SAMHSA, 2012). The overall average annual cost expenditure for substance abuse in the U.S. is \$600 billion (U.S. Department of Health, 2012). While national statistics on the percentage of those treated in residential substance abuse treatment settings comorbid for trauma are not available, the Center for Substance Abuse Treatment (CSAT, 2007) does recognize the probability of co-occurrence between substance abuse and mental health in behavioral health settings. Studies show the majority of women, men, and adolescents obtaining substance abuse residential treatment have been traumatized before entering ; abuses are physical, psychological, sexual and/or assaultive (SAMHSA, 2006; U.S. House of Representatives, 2001). Trauma-informed treatment is not mandated for substance abuse treatment facilities (SAMHSA, 2005), and the manner in which clients are handled upon entering such residential facilities is largely unknown. In a survey reflecting the most comprehensive national data on treatment delivery, Capezza and Najavits (2012) found that 66% of the 13,233 substance abuse treatment facilities examined reported the use of trauma-related counseling with clients. However, a considerable 33.4% of these facilities rarely or did not provide trauma counseling. Alarming, similar residential structures such as nursing homes report rising annual abuse of clients while in care in a third of their institutions throughout the U.S. (U.S.

House of Representatives, 2001).

Those seeking residential drug treatment often have significant abuse histories, and a treatment facility is theoretically a place of sanctuary or a place of healing. This paper explores encounters that take place in such facilities which may harm or trigger re-experiencing of harm in clients. The psychiatric inpatient ward, another similar structure to residential substance abuse treatment settings, has documented client re-traumatization (Cusack et al., 2003; Frueh, Dalton, Johnson, Hiers, Gold, Magruder, & Santos, 2000). Frueh et al., (2000) explored harmful events in inpatient psychiatric units and provided definitions for them. “Sanctuary trauma” is identified as events that occur in a psychiatric setting that meet the criteria for trauma as set forth in the *Diagnostic and Statistical Manual for Mental Disorders (DSM-IV)* (American Psychiatric Association, 1994). In contrast, “sanctuary harm” is defined as

[E]vents that, while, not meeting the DSM-IV criteria for trauma, are nevertheless distressing, frightening, humiliating, and/or highly insensitive given the vulnerability of mental health consumers, and which may result in new or exacerbated psychiatric symptoms and/or a reduced participation in later mental health treatment. Examples of harmful events are: seclusion, restraint, strip searches, handcuffed transport, exposure to violent patients, and the like. These events may serve as traumatic cues or “triggers” that evoke memories of and/or responses to previous traumatic experiences (e.g., physical restraint may remind a former rape victim of being held down and violated). They may also result in mistrust toward mental health clinicians or settings and lead to poor adherence with treatment plans (Frueh et al., 2000 p.150)

In fact, the existence of sanctuary harm and sanctuary trauma has been confirmed by former clients in psychiatric hospital settings. Frueh, Knapp, Cusack, Grubaugh, Sauvageot, Cousins, Yim, Robins, Monnier, & Hiers (2005) conducted an empirical study in which 142 participants with severe mental illness recruited through hospital day programs reported having witnessed and experienced physical, sexual, and emotional abuse by staff during their past psychiatric hospitalizations. Responses on the Psychiatric

Experiences Questionnaire (PEQ) revealed 14 % were called names by staff, 19% heard staff calling other clients names, 20% reported medications used as a threat or punishment, 12 % were physically assaulted by staff, 18% witnessed staff physically assault another client, 3% were sexually assaulted by staff, and 5% witnessed staff sexually assault another client; 87% reported past trauma with 19% having probable PTSD (Freuh et al., 2005).

In a qualitative study of sanctuary harm, 27 randomly selected mental health clients engaged in semi-structured qualitative interviews, and 18 reported adverse experiences within psychiatric inpatient settings. Themes that emerged surround the threat of physical violence and arbitrarily enforced hospital rules for clients by staff. Beyond lack of individualized treatment, participants discussed being disrespected and humiliated by staff in their descriptions of such instances as cold water being thrown on them to rouse them out of bed, being placed in restraints for 24 hours, and being held in seclusion for long hours (Robins, Sauvageot, Cusack, Suffoletta-Maierle, & Frueh, 2005).

While studies on client harm and abuse have been conducted for inpatient psychiatric settings, the literature on damaging staff-client interactions has not been established. The literature on staff-client interactions in residential substance abuse treatment settings is deficient. The vast number of those seeking treatment for substance abuse in residential settings underscores the importance of understanding how clients receive care, particularly in the light of potential harm.

This dissertation explores a topic that has received very little attention from researchers and clinicians: the triggers and consequences of high-challenge moments that

occur within residential drug treatment settings. The concept of sanctuary harm (Freuh et al., 2000) is used to explore safety and healing as a goal for such clients, and it provides the base of the term “high-challenge encounter.” A high-challenge encounter is defined as an escalated moment between staff and clients that results in probable client emotional and/or physical harm. This study assesses various aspects that may factor into high-challenge moments in residential treatment settings that could contribute to client harm in residential substance abuse settings.

Beginning with a literature review, Chapter 1 examines factors leading to client abuse in nursing homes as there is an established body of literature on this topic, and nursing homes have a staff structure similar to that found in residential substance abuse treatment facilities. Chapter 2 discusses client vulnerabilities with respect to co-occurrence of trauma in substance abuse, and Chapter 3 explores authoritarian aspects of the inpatient environment as it relates to client healing. Chapter 4 focuses on the inherent challenges of clients seeking help for substance abuse. Such challenges include clients’ propensity toward violence highlighted during the detoxification phase, clients’ low motivation and follow-through for treatment, and negative staff countertransference. Chapter 5 deals with issues surrounding role clarity of “wounded healers;” it will highlight the inherent conflicts of the disease concept, therapeutic community, and confrontation and potential for subsequent client confusion. And Chapter 6 delineates the stressors of the paraprofessional position and aspects of burnout in professionals as contributory factors towards compromised client care. Methods by which this study was conducted are addressed in Chapter 7, and Chapter 8 presents the findings with an integrated discussion. This dissertation closes with chapters 9 thru 11 that encompass the: limitations, conclusions,

and implications for more informed treatment, research and policy.

CHAPTER 1: NURSING HOME ABUSE

In attempting to understand potentially high-challenge moments between staff and clients in residential substance abuse treatment programs, it is important to understand the dynamics in nursing homes. The comparative staff profiles in both settings and the growing documentation of nursing home abuse highlight the need for careful study of the dynamics in residential substance abuse treatment settings. Similarities of these treatment settings are discussed next.

Both nursing homes and residential substance abuse treatment programs place heavy emphasis on high staff ratios or higher number of staff hours per resident for quality care, and both underscore the need for direct care aides. Nursing homes are required to have registered nurses (RNs), licensed practical nurses (LPNs), licensed vocational nurses (LVNs), certified nursing assistants (CNAs), and physical therapists (PTs) with enough staff to sufficiently care for their residents; emphasis is placed on the number of hours each of these staff members has per resident per day with better care correlated with higher number of hours. Clerical, administrative, and housekeeping staff hours were not highlighted in terms of quality care (“Staffing charts”, n.d.). Although there is a high occurrence of mental health issues other than dementia in nursing homes, the quality of treatment for mental illness is substandard with debate around the appropriate use of psychiatric medications and underutilized mental health consultations (Grabowski, Aschbrenner, Rome, & Bartls, 2010).

Residential substance abuse treatment programs are able to provide optimal treatment with a constellation of staff. The recommended number of staff for a 25 bed facility is 15, consisting of a full-time program director with drug and alcohol experience and 10 direct care staff with high school diplomas or associate's degrees. Employment of part-time staff is also suggested: a clinical coordinator who will guide program implementation, a nurse practitioner, a vocational rehabilitation counselor, and a benefits counselor. Consultative or collaborative care can be set for medical, psychological or psychiatric issues (Co-occurring disorders, 2005; Moos, Petit & Gruber, 1995). Staff types and staff-to-client ratios are proposed for the best quality care in nursing homes and residential substance abuse treatment settings. The next section will look at the ramifications of not following suggestions for quality care and employing abusive staff in nursing homes as a lens towards understanding the less studied but similar phenomenon found in substance use treatment settings.

Prevalence and types of abuse in nursing homes

There is a shockingly high occurrence of abuse in nursing homes. In the U.S. 5,283 nursing homes out of approximately 17,000 nursing homes with 1.5 million residents in the U.S. were cited for an abuse violation between January 1, 1999 and January 1, 2001 with actual harm or immediate jeopardy inflicted upon residents of 1,601 of these nursing homes. The number of nursing homes that did not sufficiently investigate and report resident abuse allegations, neglect or mistreatment or failed to perform proper background checks on their nursing home staff with respect to prospective histories of abuse, neglect or mistreatment of residents, totaled 3,797. Identified in 1,009 nursing homes was a failure to protect residents from sexual, physical and verbal abuse, corporal

punishment and involuntary seclusion. Since 1996, the percentage of abuse violations, in nursing homes documented in annual inspections, has tripled, and, while many violations are not reported, overall nursing home abuse is increasing (U.S. House of Representatives, 2001). One outcome of elder abuse is institutionalization; thus, elders who have already suffered abuse have a higher likelihood of becoming residents of nursing homes (Anetzberger, 2012).

Elders in and out of nursing homes experience abuse. Generally, psychological and emotional abuse can include ridiculing, cursing, infantilizing, humiliating, abrupt commands, threats of punishment, and violations of rights such as restrictions from those the residents love, but are difficult to substantiate. Physical abuse is infliction of pain or injury to the victim; such acts include striking, pushing, burning, strangling, inappropriate use of chemical or physical restraints, allowing pain to continue, exposure to cold, and food restrictions or denial. Neglect may present as lack of health care provision, continuance of poor hygiene, and dehydration. Financial abuse ranges from stealing to misappropriation of resident funds or property (Buzgova & Ivanova, 2009; National Association of State Units, 1998). Sexual abuse of elders include their reports of sexual assault and rape, and elder sexual abuse may also be evidenced in bruises around the breasts or genital areas, unexplained sexually transmitted diseases, genital bleeding, and torn or bloody underclothing (National Association of State Units, 1998).

The various types of elder abuse can occur in nursing homes, and factors leading to resident abuse have been identified. They include aides that have not been trained well, high staff stressors, high staff turnover, lack of staff screening, low staff to resident ratio, residents with dementia, residents with a history of violence, social isolation of residents,

facility complaint history, and facility environment (The National Association of State Units, 2005). The three main contributors to resident abuse and neglect are staffing shortages, staff burn-out, and poor staff training. Persistent staff shortages can demoralize staff members who feel they are neglecting residents as they are not able to attend to them fully, and this can create an overall stressful environment. Staff burn-out may result from required overtime or working more than one job to live, leading to inevitable staff exhaustion. Lack of staff training to understand and manage resident dementia and difficult behaviors can lead to negative attributions of resident behavior as intentional; thus, staff have reported feeling justified in treating those residents roughly, particularly if the resident hurt staff (Elder Abuse In Residential, 2002). Shaw (1998) further explored factors preventing and leading to client abuse in a qualitative study with nursing home staff. Interviews revealed that staff are safeguarded from harmful behaviors with residents if they have had positive involvements with elders, support from family, and were appreciated on the job. However, factors that could contribute to client abuse are staff members' physical fatigue, history of substance abuse, history and current experiences of domestic violence, and emotional exhaustion due to problems at work and at home. Staff domestic violence is of concern as affected staff members' physical space has already been violated increasing their reactivity to physically aggressive clients. Moreover, contributing to a lower threshold for violence is staff devaluation and perceptions of being the lowest in the staff hierarchy (Shaw, 1998). Shaw (1998) concluded that the majority of staff who inflict harm on clients had compromised environmental and personal factors. The study termed them as "reactive abusers," while

those who were intentional and methodical in their abuse of residents were labeled as “sadistic abusers” (p. 8).

Nursing home residents enter facilities to receive care for their very vulnerable physical and emotional states, but at least a third of this population is met with horrendous abuse (U.S. House of Representatives, 2001). As investigation into this travesty continues, the high frequency of nursing home abuse gives rise to conceivable abuse in other residential treatment settings. Those seeking substance abuse treatment are also susceptible to the actions of staff in residential substance abuse treatment settings, as so many of them have experienced trauma. The co-occurrence of trauma with substance abuse is assessed in the next chapter.

CHAPTER 2 : CO-OCCURRENCE, PREVALENCE AND TREATMENT OF TRAUMA AND SUBSTANCE ABUSE

The existence of sadistic and reactive abusers that Shaw (1998) points out in nursing home settings may also exist in other, similar settings. Thus, examination of client vulnerabilities, particularly past trauma, as they enter residential substance abuse treatment settings bears weight as they may be susceptible to re-traumatization by staff. Chapter 2 looks at the co-occurrence of trauma with substance abuse in terms of its incidence, the nature of trauma, ways to address co-occurrence, and limitations on staff training.

Existence of PTSD in clients

Women traumatized from recurrent childhood sexual assault comprise 30% to 59% of women co-morbid for post-traumatic stress disorder (PTSD) and substance abuse whereas co-morbidity in men was two to three times lower and resulted from combat or crime trauma (Najavits, Weiss & Shaw, 1997). Reported histories of sexual abuse are related to higher rates of alcohol and drug use among men, women and adolescents, and it is four times more likely that an adolescent with PTSD will experience alcohol abuse or dependence than adolescents without PTSD (Public Education Committee of the International, 2001). Adolescents in residential settings reported higher rates of abuse and drug use than those in outpatient settings. In a study of 975 adolescents in outpatient and residential settings, histories of victimization were reported in 87% of those in residential treatment compared to 60% in outpatient, with those in residential treatment reporting a larger range of types of victimization and more substance abuse-related problems and

marijuana use (Shane, Diamond, Mensinger, Shera, & Wintersteen, 2006). Studies show that the majority of women, men, and adolescents obtaining residential treatment have been traumatized, necessitating an understanding of the trauma they have undergone (Najavits, Weiss & Shaw, 1997; Public Education Committee of the International, 2001; Shane, et al., 2006). The ensuing section surveys a history of trauma theory and characteristics of trauma.

Understanding trauma

The development of trauma theory began in the late 1880s with the study of hysteria. Charcot, Janet, Freud, and Breuer had originally attributed hysteria that was then studied in women to traumatic events, namely sexual assault or abuse. “Shell shock” was recognized in returning World War I soldiers and treated with brief interventions to help return soldiers to war. Combat stress was recognized in World War II soldiers, and similar manifestations of stress were acknowledged in civilian contexts. Support groups were formed for soldiers returning from the Vietnam War due to their difficulties integrating into civilian life, and the women’s movement of the 1970s led to the formation of similar awareness support groups to help overcome denial and shame (Ringel & Brandell, 2012). However, by the 1970s, the trauma field was still unrecognized, and its legitimacy was questioned (Wylie, 2004). Finally, based on Vietnam War veteran symptom severity and the advocacy work for women, rape victims, and abused children, the Diagnostic Statistical Manual (DSM) recognized psychological trauma and PTSD in 1980 (Ringel & Brandell, 2012).

Prior to the recognition of the DSM trauma diagnoses, Bessel van der Kolk expressed surprise at the unavailability of information on combat stress when he began work at the VA in 1978. He conducted the first study on nightmares in veterans and, also, a first study showing matching patterns of hyper-arousal and dissociation in traumatized veterans. Since then, Van der Kolk has authored more than one hundred peer-reviewed scientific papers on the manifestations of trauma and effective treatments (Wylie, 2004). In addressing PTSD, Van der Kolk (2002) states trauma must be contextualized. In doing so, unwarranted reminders of the trauma are reduced, and “interpersonal relatedness” improves (Van der Kolk, 2002, p. 390). However, trauma may be buried in state-dependent memories in which the event details and associated emotional states cannot be accessed unless in a similar state of acute arousal. Trauma processing may be met with avoidance or harmful self-soothing such as drug use and self-mutilation unless affect tolerance is employed. Past trauma can be cued from environmental reminders; nightmares and flashbacks, and intense emotional reactions can be prompted if enough environmental stimuli similar to the traumatic occurrence are present. Studies have shown that psychophysiological and neuroendocrine responses conditioned to the traumatic event can occur if signaled, recreating the same helpless and dependent states experienced at the time of the trauma. Reactions stemming from trauma may be spontaneous as those affected have difficulty separating the events of the past from the present. Thus, those affected could benefit from skillful facilitation to help them gain space from the emotions and physical reactions incited by traumatic events (Van der Kolk, 2002). Addressing dual diagnoses of trauma and substance abuse requires even greater attention as discussed in the next section

Addressing co-occurrence of trauma with substance abuse

The diagnosis of PTSD is frequently co-morbid with several other Axis I diagnoses to include substance abuse, creating complex symptom presentations (Courtois & Bloom, 2009). In a study of 104 voluntary clients in an inpatient psychiatric unit, those presenting with current or past substance abuse had greater psychiatric symptom acuity, higher numbers of hospitalizations, and service use, than those without a substance use disorder. Substance abuse exacerbates psychiatric symptoms (Ries, Mullen & Cox, 1994).

The Center for Substance Abuse Treatment (CSAT) (2007) delineates guidelines to treat the complexity of co-occurring disorders. They maintain co-occurring disorders are probable in behavioral health settings and should be considered in evaluation and treatment planning. Treatment plans must reflect the varying nature of co-occurring disorder (COD) symptoms and address the relationship between mental health and substance abuse. Thus, a high quality system of care assimilating both mental health and addiction services, must utilize evidence-based and consensus-based practices. Care must be available at several entry points for consumers, and collaboration between professionals and agencies outside the inpatient setting is needed to help consumers meet their needs and help clients contribute to the community. Empathy and respect are essential throughout care, and treatment should be individualized to stages of change (Center for Substance Abuse Treatment, 2007; Prochaska & Diclemente, 1983). Furthermore, the needs of adolescents and children are to be addressed throughout

treatment (Center for Substance Abuse Treatment, 2007). The challenge arises in putting these principles into action.

Limited training on trauma

Professional training in addressing posttraumatic reactions is limited (Courtois & Bloom, 2009). Despite the benefits of integrated treatment for dual diagnoses reflected in research, integrated treatment is still not widely available. Lack of training, financial constraint, and the difficulty clients have in obtaining mental health and substance abuse treatment from the same provider prevent assimilated care for dual diagnosis (Burnett, Porter & Stallings, 2011).

A qualitative study conducted with staff from a psychiatric unit that had won state recognition in 2008 for their reduction of seclusion and restraints obtained staff perspectives on the unit's transition from a traditional approach to a trauma-informed model. In this treatment setting, the traditional model dictated clients be isolated when they self-mutilated because self-mutilation was considered manipulation that related to the client's diagnosis, and aggressive client expression of trauma symptomatology led to restraints. The transition toward the trauma-informed model involved an increased focus on client and staff safety, healthy client coping methods, and appropriate staff-client ratios. Additionally, hierarchical staff relationships in which the physician was the main source of information on client treatment shifted to client consultation about his/her treatment plans and the staff working as a team to fulfill client goals. Collaborative staff-client relationships led to decreases in chemical and physical restraints and rigid protocols, and the unit's overall culture of safety was enhanced. Staff awareness of the

prevalence of client trauma histories led to a safer environment for client healing (Chandler, 2008).

Although the benefits of a less rigid setting for clients dealing with trauma in an inpatient psychiatric unit were demonstrated in Chandler's (2008) study, traditional views may still carry over in residential substance abuse treatment settings. Recovery from client trauma and substance abuse may be inhibited. The next chapter discusses how limiting residential factors can suppress client healing and lead to high-challenge moments.

CHAPTER 3: CLIENT HARM AS A RESULT OF RESIDENTIAL SETTING AUTHORITARIANISM

The non-violent nature of the inpatient environment can allow for a corrective social experience with staff and others and help clients gain a sense of purpose. This can be especially useful for clients with persistent PTSD who have complicated symptoms and are at high risk for suicide and self-harm. PTSD symptoms may be co-morbid with other disorders and medical issues (Courtois & Bloom, 2009).

However, social healing is precluded by harmful practices such as seclusion and restraint that are still prevalent in psychiatric wards. On May 5, 2003, 200 mental health advocates, consumers, providers, researchers and State and Federal officials contributed to proceedings held at the National Call to Action to Eliminate Seclusion and Restraint. SAMHSA Administrator, Charles G. Curie, M.A., A.C.S.W. deemed seclusion and restraint of individuals with mental illness by persons meant to help them, as degrading and re-traumatizing, and that seclusion and restraint be used as a last resort. Data compiled by a mental health provider, Mary Ann Nihart, revealed that: 50-150 deaths occur nationally as a result of seclusion and restraint; clients are often restrained for trivial infractions; almost half of mental health technicians interviewed were not aware of substitutes for restraints; little research supports any benefit to seclusion and restraint; and clients find them humiliating (U.S. Department of Health, 2003).

Irrespective of seclusion and restraint practices, the hospital environment can be oppressive to client healing. Facility administrator W. Russell Hughes, Ph.D., M.B.A., expressed that staff are often trained in the medical model that focuses on illnesses and

treatments, and they work in hospitals in which they utilize policies to function. He asserted that staff sought control over their environment as in his view they are frequently trauma survivors (U.S. Department of Health, 2003). Clients may be harmed by aggressive instances with staff depending on the level of authoritarianism in the inpatient setting. If clients do not feel physically or emotionally safe enough to address traumatic events, the constriction of trauma symptoms can lead to re-traumatization (Brown, 2012).

Client emotional expression may be further constrained by staff intolerance to client symptomatology. Berman & Segal (1982) posit that in inpatient units, in-depth psychotherapeutic processes needed to work through issues such as client regression, yelling, and symptom amplification may not be tolerated by staff. Confidentiality between the therapist and client may not be maintained as the therapist may need to reveal session details to the treatment team, diminishing the rapport building and trust needed for client self-disclosure. In their review of three residential substance abuse treatment models, Moos, Petit & Gruber (1995) found that in all three settings, high expectations of client functioning precluded staff from accepting problem client behaviors. Thus, the narrowness of staff attitudes toward client manifestations of symptoms disconnects clients and their treatment.

Staff control decreases client personal autonomy, input into treatment, and overall healing (Brown, 2012). Descriptions of decreased client autonomy in care decisions were elicited in Storm and Davidson's (2010) qualitative study. Both log reports and written minutes from staff were used as well as interviews of 20 inpatients. Inpatient composition consisted of 16 who were voluntarily admitted and 4 who were involuntarily admitted.

Inpatients ranged between 18 and 70 years of age, and they were diagnosed with schizophrenia, schizoaffective, or bipolar disorders. Some patients were forced to take medicine, and inpatients did not have much input into their care. Providers attributed the absences of client participation in treatment meetings to clients' exhausting mental health symptoms and lack of motivation. Providers also found it difficult to engage in dialogue with clients, and, likewise, clients did not feel understood (Storm & Davidson, 2010).

Social healing and recovery from the thorny and concurrent symptoms of trauma with substance abuse can begin in a peaceful residential treatment setting. However, the use of seclusion and restraints on psychiatric inpatients, staff intolerance to expressed client symptomatology, and little or no client input into treatment decisions thwart client efforts to emotionally heal; clients may in fact be re-traumatized. While these problems were discussed in reference to inpatient psychiatric settings, these issues can translate to residential substance abuse treatment settings leading to high-challenge moments and client harm. The inherent complexity clients bring to residential treatment can contribute to the escalation in high-challenge moments which is extensively treated in the next chapter.

CHAPTER 4: CHALLENGING CLIENTS

Although clients are vulnerable to staff abuse in the residential substance abuse treatment system, it is important to look at the challenges such clients can bring. Clients in psychiatric settings have reported violence toward staff, themselves and objects. The inclusion of substance abuse and the process of detoxification worsen psychiatric symptoms and client violence. The sections that follow highlight key findings about ways in which some clients may contribute to or even instigate abusive dynamics.

Client violence toward staff, self, and objects in psychiatric units

While clients can be harmed by staff, clients can also harm staff. It is expected that traumatized persons may test boundaries and may be aggressive or violent toward themselves or others (Courtois & Bloom, 2009). Hanrahan (2010) reported that 79% of 353 psychiatric registered nurses surveyed in 1999 from 67 Pennsylvania general hospitals reported patient verbal abuse toward nurses, and 39% reported work-related injuries to include violence from patients. In a study of 118 acute inpatients, Serper, Goldberg, Herman, Richarme, Chou, Dill, & Cancro, (2005) found that a diagnosis of substance abuse was a predictor of verbal aggression and aggression toward others, more so, than those with a sole diagnosis of schizophrenia or a history of homelessness; those with fewer learning and memory deficits and decreased psychiatric symptoms had a higher chance of committing object or self-directed aggression (Serper et al., 2005). Trauma and substance abuse worsen the levels of violence toward self and others in residential psychiatric milieus, which are already known to present danger toward nurses.

Client danger toward staff and themselves is further amplified with substance abuse as discussed in the next section.

Violence and worsened mental health issues as a result of substance abuse

The Substance Abuse and Mental Health Services Administration (SAMHSA) (2008) note that hallucinations, paranoia, anxiety and depression concomitant with alcohol, cocaine, amphetamine, and hallucinogen intoxication can jeopardize safety (SAMHSA, 2006). SAMHSA recommends patients in acute intoxication and withdrawal have frequent safety checks by staff to monitor suicidality and varying levels of depression. However, as patients undergoing withdrawal can express increased anger and aggression, they also suggest staff be trained in de-escalation techniques (SAMHSA, 2006).

Altered brain functioning as a result of drug use can impair symptoms of mental health diagnoses and revoke the stabilizing effects of medications (Burnett, Porter, & Stallings, 2011). As such, White (2004) suggests that addiction professionals in inpatient or acute settings should understand symptom presentations of abnormal brain functioning associated with violence. This awareness should also include “pseudoaddiction” in which a client minimizes his/her addiction, violent tendencies and boundary testing, and the client may even use the addiction as justification. White (2004) maintains it is rare for those who have an acute or a long history of drug use coupled with hallucinations and persecutory delusions to become violent, unless they have a history of violence. Consequently, it is necessary to understand a client’s history of violence even prior to drug use, as the drug use lowers the client’s threshold to existing violent tendencies that

may be activated by seemingly innocuous cues within a treatment setting, thus making the violence a separate issue relative to the drug use and not a direct result of the same (White, 2004). Client violence can be seen more acutely during detoxification as examined in the next section.

Detoxification and client agitation

Detoxification can be “a point of first contact with the treatment system and the first step to recovery” (SAMHSA, 2006, p. 4). Yet, it is also a tenuous time for the client, who often experiences acute distress and agitation. Patients presenting with acute intoxication warrant close monitoring as they begin withdrawal. They may present with suicidality, seizures or delirium tremens, and complicated withdrawal that may include sub-acute medical or psychiatric conditions, hallucinations, and high anxiety. Appropriate referrals to varied levels of care, e.g. inpatient versus outpatient, by trained staff are necessary. Stabilization entails medical monitoring toward a drug- free state, acquainting clients with their recovery and treatment process, and assessing their motivation for treatment (SAMHSA 2006). While there have been no direct empirical studies to date on the incidence of high-challenge or abusive episodes between patients and staff specifically in detoxification settings, given the acute and distressing nature of detox, this area needs to be examined. Adding to the stress of addressing critical substance abuse issues is the tenuous level of client commitment to treatment, which can engender staff frustration and lead to client harm.

Staff frustration related to low client motivation and treatment follow-up

It can be very difficult to convince clients to engage in substance abuse treatment. Adolescent substance abuse treatment with co-morbid trauma is confounded by the existing youth drug culture, low motivation for treatment, and psychosocial stressors (Shane et al., 2006). Substance abusers have copious emergency room admissions but repeatedly leave against medical advice (AMA) (Bradley & Zarkin, 1997). They have shorter life spans than the general population (Bradley & Zarkin, 1997), and they struggle to maintain housing (Burnett et al., 2011). In an examination of veteran characteristics, Lambert, Griffith, & Hendrickse (1996) surveyed 452 discharge summaries of a general VA unit over the course of six months. They found dually diagnosed veterans with poly-substance abuse have no-show rates as high as 80% for outpatient treatment and often leave AMA from inpatient treatment after short stays. Although they often use costly inpatient and crisis services, their ongoing substance abuse makes them too psychiatrically unsteady to participate in addiction programs or receive outpatient medication management (Lambert et al., 1996). Heavy service utilization but inconsistent involvement in treatment can exasperate staff investing efforts in helping clients benefit from substance abuse treatment. Weariness with client behaviors can result in high-challenge moments through negative countertransference.

Client harm through staff countertransference

Given the complexity of PTSD symptoms with substance abuse and the challenges a dually-diagnosed client can bring to treatment, factors contributing to staff reactions such as countertransference need to be understood. The American

Psychological Association (APA) defines countertransference as the “conscious or unconscious emotional reaction of the therapist to the patient, which may interfere with treatment” (“Countertransference”, 2014). Freud (1910) said of countertransference:

“ We have become aware of the countertransference, which arises in the therapist as a result of the patient’s influence on his unconscious feelings, and we are almost inclined to insist that he shall recognize it, this countertransference in himself and overcome it...” (p. 144)

Countertransference may manifest as

...the counselor's emotional, cognitive, and behavioral reactions to clients that are grounded in the counselor's unresolved conflicts and are psychodynamically determined (Perfass & Spross, 2007, p. 75).

Thus, the professional’s past relationships and feelings can fuel countertransference (White, 2003). Within the therapeutic community setting, countertransferential reactions and inappropriate relationships by staff can be abusive to clients who have come from histories of abuse, and harmful staff reactions can potentially have lasting negative effects on clients whose ability to form positive relationships is tenuous. Derived from broader cultural attitudes toward addicted persons, pejorative descriptors such as “manipulative” and “deceptive” rather than terms highlighting client healing such as “suffering” or “impaired” may be applied to dually-diagnosed clients (White, 2003, p. 74).

The therapeutic community has many examples of volatile reactions from residents (Perfass & Spross, 2007), and countertransference may be a result of the high amount of contact between staff and clients in the hospital setting (Berman & Segel, 1982). The close relationships clients may have with paraprofessionals and their shared community background raises concerns with respect to countertransference, breaches of

confidentiality and boundary violations (Nittoli & Giloth, 1997; Walter & Petr, 2006). Lambert & Davidson (1999) propose front-line staff may not be trained in the therapeutic use of boundaries, which is disquieting as it is necessary for staff to understand that reciprocal relationships are precluded by the power differential between staff and the seriously mentally ill. Cultural and residential factors and importance placed on professional boundaries can influence the nature of countertransference. If influenced negatively, staff can have countertransference reactions that can cause resident harm. There are innate hurdles in working with clients seeking help for substance abuse. Clients pose the potential to harm staff and themselves, and they present with a complex undercurrent of PTSD symptoms that may not fully be addressed due to the treatment setting. Inconsistent client engagement in treatment despite their frequent treatment utilization can exhaust staff and contribute to preconceived staff notions and reactivity about clients seeking treatment, leading to escalated staff-client interactions and possible client harm. More about this situation needs to be studied to more fully understand what transpires in such circumstances and how staff can best respond in ways that protect the integrity of the client. Tension arising from staff-client relationships may also be influenced by varied interpretations of the ethos of the drug and alcohol treatment culture. The next chapter researches substance abuse treatment history and methods and their interplay with high-challenge encounters.

CHAPTER 5: ADDICTION TREATMENT MODALITIES

The overall average annual cost expenditure for substance abuse in the U.S. is \$600 billion (U.S. Department of Health, 2012). While this estimate does not consider damage done to social supports, it does include costs related to health, productivity, and crime. Compulsion to use substances is fueled by alterations in the brain chemistry of addicts resulting from drug-induced changes to their biology as well as influences from the environment and their developmental phases. Due to these complex biological changes, treating substance abuse is not a simple matter of will power (U.S. Department of Health, 2012). The treatment of addiction has been met historically with numerous, varied methods and practices. The assumptions held by both staff and clients regarding substance abuse recovery practices can contribute to misunderstandings and high-challenge encounters between these parties. This chapter examines variation in treatment methods beginning with the concept of “wounded healers,” formulation of the disease concept within the therapeutic community, and concludes with analysis of helpful versus harmful confrontation.

Wounded healers

The concept of the “wounded healer” is found in several religious traditions, folk lore, and literature, with the common thread being that one cannot help others’ suffering unless one too has suffered (Benziman, Kannai, Ahmand, 2012; Jackson, 2001). Jung attributed his “wounded physician” archetype to Chiron, a centaur of Greek Mythology. Chiron healed others using his skills in medicine, but was unable to heal himself from his painful wound. Through reflection upon Chiron’s tragic condition, Jung intimately

understood the concept of the wounded healer. In fact, all analytical psychologists undergo some form of reflection upon their own “wounds” to improve their ability to treat their patients. In a similar manner, members of self-help groups draw upon their own personal challenges to help others in similar circumstances. Mutual aid is a pillar of Alcoholics Anonymous (AA) where group members are invited to share their personal battles with addiction for the benefit of other participants, and the Twelfth Step of AA’s Twelve Steps summons sponsorship of other members (Jackson, 2001).

Within the substance abuse treatment setting, staff who treat clients often have recovery backgrounds from drug and alcohol addiction themselves (Humphreys, Noke, & Moos, 1996). Paraprofessionals with similar addiction histories to their clients are described:

Wounded healers have long experienced a strain between an avocation (calling) to work with the addicted and the more formal demands of vocation--the use of one’s addiction and recovery experience as a credential for professional employment (White, 2000, p. 12).

However, wounded healers make paradoxical contributions to addiction treatment. Their experiential knowledge of recovery may conflict with professional recovery approaches, and their alliance with addicts may result in an overextension of themselves to counterweigh the absence of professional credentials. Their mutual vulnerabilities and mission to aid in client recovery may result in attempting to replicate personal recovery experiences for a particular client, and staff members with addiction histories may attempt to fulfill personal and emotional needs within the treatment setting by relating their personal stories of growth. They may experience role confusion due to the overlap between their duties and professional counseling duties, and they can be

overly direct in their form of communication than professionals would be at the initial stage of treatment. Furthermore, although they serve as examples of success stories within the treatment system, staff in recovery from addiction are themselves prone to relapse (White, 2000).

The noble intent of wounded healers in helping clients similar to themselves is undermined by the contradicting ways in which they are identified. Misperceptions regarding their role within the staff/client relationship may instigate high-challenge moments that stem from the confused messages clients receive from opposing treatment approaches. The disease concept is discussed in the next section.

The Disease Concept and its conflicting treatment messages

Clients are often given conflicting therapeutic messages in terms of whether their conditions require self-help or have a deeper biological mechanism. Members of Alcoholics Anonymous (AA) recognize both psychosocial dimensions and biological origins of alcoholism (Kurtz, 2000; Mann, Hermann & Heinz, 2000). However, confusion may arise when there is pressure to espouse either self-help or the disease concept within an integrated approach. In emphasizing a biological basis, those dealing with addiction can be spared of the low self-esteem stemming from the belief that they are inadequate (Schneider et al., 2000). The concept of addiction as disease is based on a biophysical understanding of alcoholism that can be misinterpreted by addicts as the primary determinant of their recovery likelihood. Ford (1996) states addicts see themselves as unable to change and are therefore will be perpetual victims of their

disease. When the disease is considered untreatable, this viewpoint can falsely exonerate alcoholics of their problems (Ford, 1996; Miller, 1993).

However, Miller (1993) espouses that the dispositional disease model is limited in focus. It does not recognize the continuum of alcohol use, and it does not address the interacting psychosocial and environmental influences that prolong alcohol use (Miller, 1993). Not all forms of alcohol or drug problems require the same treatment given for chronic use, and the responsibility of actively managing serious drug and alcohol abuse is expected. Recovery processes are unique to the individual (White & McClellan, 2008).

The understanding that addiction may not always be chronic is not necessarily recognized in treatment settings (White & McClellan, 2008). Miller (1993) claims the disease concept can restrict the range of treatment and prevention programs offered to clients. The pressure to espouse alcoholism as a disease can discourage the use of non-addictive medication and limit consideration of social and environmental influences. The recognition of dual diagnoses can be discredited as alcoholism is often considered the cause of psychological and social problems rather than the result of these issues. While co-occurrence of psychiatric and substance use disorders are well known to behavioral healthcare providers, Ducharme, Knudsen, & Roman (2006) found that integrated care in substance abuse facilities is not guaranteed. In their survey of substance abuse treatment centers nationwide, a little more than half provided integrated care for clients diagnosed with substance abuse and psychiatric disorders. Facilities offering psychiatric assessments upon intake were more likely to offer services for both mental health and substance abuse disorders. Less integrated care was offered by centers with more

addictions-certified staff and centers dependent on public funds. Also, accreditation status was not a significant factor in the provision of dual-diagnosis treatment.

Although the disease concept provides respite from personal shame on the part of the client, sole emphasis on the biological mechanisms of addiction subverts client agency toward change. Its invalidation of emotional components impacting addiction can deepen client harm, and providers espousing differing views can intensify client frustration, promoting high-challenge moments. The therapeutic community (TC) is another disputed construct used in addiction treatment, and its origins and use are discussed in the next section.

Divergent Therapeutic Community (TC) approaches

The two key concepts of the therapeutic community (TC), a model often used in substance abuse rehabilitation programs, are “self-help” and “community” (NIDA, 2002, p. 2). Residents develop the philosophy of self-help in progressing through a hierarchy of goals with increasing levels of privileges and consequences for behavioral deviations. The substance abuse TC emphasis on community involvement allows for appropriate management of feelings and social responsibility; structure and leadership not reachable within the general chaos of addiction becomes accessible via movement through an ordered echelon of roles; and change of resident behavior based on peer critique (NIDA, 2002). The residential TC for addiction allows for clients to comprehensively change their ways of living. Opportunities are provided for clients to abstain from drugs, reject criminal behavior, and develop job skills. TCs also help clients cultivate self-reliance, demonstrate responsibility, and enhance honesty and nonviolence (DeLeon, 1985).

TCs treating substance abuse have been molded by both the substance abuse and mental health approaches. The TC specific to substance abuse originated outside of the addiction treatment system, whereas the TC for mental health treatment developed within the psychiatric system (DeLeon, 1985), and there is built-in conflict in combining the two TC approaches. The mental health approach requires clients to use personal insight to change, yet the drug and alcohol treatment TC approach emphasizes the importance of community members for behavioral change via group activities. To complicate matters, there are a wide range of drug and alcohol TCs, and the various elements of the treatment process are not completely understood (DeLeon, 2000). Psychiatric TCs encourage clients to decrease reliance on psychiatric staff, increase socialization, emphasize individual therapy, and provide medications. While medications aim to address psychiatric symptoms, side effects can also prevent residents from effectively reaching their TC goals. Moreover, the psychiatric approach in a substance abuse TC is opposed by the influences of Synanon, a 1950s era organization instituted in response to psychiatry's failure to treat addiction. Representatives of Synanon have claimed that the use of psychotropic medications have endorsed drug dependency and perpetuated substance abuse (Perfass & Spross, 2007).

Thus, the merger of the TC approaches to treat dual diagnoses presents a significant challenge. Staff taught the two different TC approaches may not be willing to compromise one for the other, and since parts of each method can be incompatible with the other, this inconsistency may give rise to high-challenge moments. Another key aspect of TCs is explored in the next section, which deals with the potential for high-challenge moments due to the varying uses and effects of confrontation.

Confrontation and its impact

Confrontation diverges from the dispassionate approach of therapists (Polcin, 2003). Confrontation is implemented within the TC in order to instill member accountability by instituting consequences for actions and for inspiring member behavioral change (Perfass & Spross, 2007). However, there remains debate in the addiction literature as to whether confrontation is helpful or harmful to clients (Polcin, 2003).

Beneficial confrontation

Clients can benefit from confrontation if presented under specific conditions.

Polcin, Mulia, & Jones (2012) outlined several themes related to helpful confrontation:

- 1) Perceived as legitimate
- 2) Offer hope and practical support
- 3) Delivered by persons who are trusted or respected
- 4) Delivered by persons who are very important relationships
- 5) Received after experiencing a severe event or an accumulation of negative events related to substance use
- 6) Received during early recovery (p. 147)

While clients are often more receptive to confrontation about their behaviors upon entry to treatment programs (Polcin, 2009), the timing of the confrontation, length of time client has been in treatment, the client's connection to the program, and psychiatric symptom severity also factor into how beneficial or detrimental confrontation can be (Polcin, 2003). Clients are more receptive to confrontation when educated about the purpose of confrontation in recovery, how well they are personally prepared for confrontation, how much they have seen peers accept confrontation, and how well they associate their addiction to any underlying emotional issues (Polcin, 2003).

In a study looking at 103 motivational interviewing sessions, therapist confrontation that included warning and direction had a positive effect on the client-therapist relationship if delivered with honesty, acceptance of the client, and empathy (Moyers, Miller, & Hendrickson, 2005). In Polcin, et al.'s (2012) study, 323 persons entering recovery houses at six- and twelve- month follow-ups were administered the Alcohol and Drug Confrontation Scale (ADCS) which measured confrontation as warnings or possible harm resulting from substance abuse from family, professionals, friends, and criminal justice staff; the scale also addressed the situations in which confrontation occurred. Upon entry into treatment facilities, individuals received more confrontation about their behaviors, but at their six- and twelve- month follow-ups, those who relapsed reported receiving less confrontation, particularly from family and friends. At baseline, the accuracy of the confrontation weighed more heavily to the clients than the clients' personal relationships with the particular confronter. Interestingly, upon follow-up, the degree of closeness with the particular confronter became more of a concern to the clients. The perception of confrontation changes over time, but the confrontation in the study was always perceived as supportive, particularly by those with higher problem severity to include alcohol, drug, psychiatric, and related issues.

Helpful confrontation relies on many complex factors to ensure the receiver is truly assisted. Thus, if not careful, clients can be harmed by confrontation. The next section will discuss the history and characteristics of harmful confrontation.

Harmful confrontation

Confrontation in addiction treatment arose from a cultural phenomenon rather than out of scientific support. Between the 1920s and 1950s, the confrontation method was increasingly used with addiction treatment programs, and it was more aggressive than neutral and supportive approaches. Rather than emphasizing the biological causes of addiction, the “flawed character” (p.2) of the addict was addressed through attempts at breaking down the addict’s denial regarding their addiction. Additionally, concepts of “tough love” (p.4) and “enabling” (p.4) were borrowed from Al Anon. Tough love entails holding an addicted person accountable for his/her actions; enabling protects the addict from the consequences of his/her behavior, leading to more substance abuse (White & Miller, 2007). Synanon, founded in 1958 by Charles Deidrich promoted “attack therapy” (Polcin, 2003, p.168), in which an addicted person was challenged by his/her peers about any of the addicted person’s behaviors (Polcin, 2003; White & Miller, 2007). Early therapeutic communities utilized the practices of Synanon methodologies which could be characterized as harsh and humiliating as illustrated by the Motivational Litmus Tests:

Motivational Litmus Tests at Admission: Forced confession at the end of a confrontational intake interview that one was a baby, was stupid and needed help, and the surrendering of something of value to demonstrate one’s commitment to recovery (e.g., money, property, one’s hair)” (White & Miller, 2007, p. 4).

Other questionable practices included members being forced to wear diapers and/or toilet seats with degrading signs. *The Fireplace Ritual* was a practice in which the entire community would condemn one member’s behavior, and the *Haircut* allowed community elders to dissect and correct a member’s negative behaviors (White & Miller, 2007). The harsh practices of Synanon in therapeutic communities were eventually

censured as they were deemed abusive and reminiscent of clients' abuse histories (Polcin, 2003). However, with few addiction treatment centers in the U.S. to provide alternatives and reports of sobriety from Synanon members, the use of confrontation spread, and these authoritarian practices of the therapeutic community spread to professionals (White & Miller, 2007).

While therapeutic communities have received continued support, information regarding which TC components are most effective has not been ascertained (Polcin, 2003). White & Miller (2007) point out that in four decades of research, confrontational or aggressive counseling to at-risk groups results only in deleterious effects. Polcin et al. (2012) listed the following descriptions of unhelpful confrontations:

- 1) Hypocritical
- 2) Overtly hostile
- 3) Occur within embattled relationships (p. 147)

Polcin (2003) points out that confrontations conducted at inappropriate times or not directed at specific behaviors may underlie client regression or treatment termination. Those with low self-esteem are most prone to relapse and harm when given confrontational therapy (White & Miller, 2007). In a study with 42 problem drinkers, directive-confrontational counseling, client-centered counseling, or no counseling in two-session motivational check-ups was offered. Clients receiving the directive-confrontational style were more resistant and relapsed more, and the one-year outcome showed that higher levels of therapist confrontation led to increased drinking (Miller, Benefield, & Tonigan, 1993). White & Miller (2007) point out confrontation can increase client defensiveness, and considering the potential of client harm, these techniques are professionally unprincipled.

The history of confrontation in TCs addressing substance abuse is multifaceted. Stemming from a reaction to ineffective psychiatric practices, community confrontation developed in order to change behaviors and reinforce actions leading to sobriety of those dealing with addiction. However, this confrontation became harmful, mirroring the trauma underlying the addiction. Later studies looking at beneficial confrontation found its usefulness under specific constraints. Yet, it is uncertain whether staff working in substance abuse treatment settings who may be familiar with the older confrontation and TC approaches are cognizant of and amenable to beneficial confrontation. The manners in which staff execute substance abuse treatment approaches, and the use of multiple conflicting approaches, can lead to high-challenge moments. The next chapter discusses more discrepancies present in residential substance abuse treatment settings and surveys the challenges present to staff of paraprofessional and professional status.

CHAPTER 6: CHALLENGES FACING PARAPROFESSIONALS AND PROFESSIONALS

Regardless of treatment approach, paraprofessionals and professionals in residential substance abuse treatment settings face ingrained challenges by virtue of their positions. The stressors they experience can stem from their job duties, pay grade, educational level, and work status. The next sections will review how these parameters affect paraprofessionals, counselors, nurses, and psychiatrists.

Paraprofessional characteristics and challenges

Paraprofessionals in human services serve essential functions. They provide outreach and emotional support to clients who are difficult to engage, skills training for adults and children, mentoring, monitoring of behavioral goals and medical treatment, and clerical work. Human service paraprofessionals also deliver concrete services which include acting as a liaison to clients for formal service systems, transporting clients, help with housing, and other necessary daily tasks (Nittoli & Giloth, 1997). However, it is unknown how paraprofessionals contribute in other clinical areas such as individualization of treatment. Therefore, a more complete characterization of the capabilities of paraprofessionals in the residential substance abuse treatment setting may be gained from understanding characteristics these providers hold both outside and inside treatment milieus.

Low paraprofessional pay

One out of twelve low-wage workers in the U.S. is a paraprofessional (Dawson, 2007), and, due to the similarly low reimbursement, they are forced to choose between receiving welfare benefits and work (Nittoli & Giloth, 1997; Wallach & Mueller, 2006). As of 2012, the median pay for psychiatric technicians and aides was \$27,440 per year at \$13.19 per hour (Bureau of Labor Statistics, 2014). In addition to low pay, paraprofessionals are constrained by their education and training.

Limited paraprofessional education and training

Paraprofessional knowledge comes from multiple sources. Their educational backgrounds often consist of high school diplomas and some community college, and training may be received on the job or from prior work experience (Nittoli & Giloth, 1997; Wallach & Mueller, 2006; Walter & Petr, 2006). For example, psychiatric aides often receive training from an experienced aide and/or an employer via workshops and in-services (U.S. Bureau of Labor, 2010). Much training is dependent upon individual supervisors and agency-specific guidelines (Nittoli & Giloth, 1997), but paraprofessionals are provided little supervision (Giangreco, Edelman, Broer, & Doyle, 2001; Nittoli & Giloth, 1997). An additional training constraint is placed on staff during periods of agency budget cuts, and inadequate training for direct-care workers exists outside of their jobs (Dracy & Yutrzenka, 1997). Paraprofessional training is not standardized (Giangreco et al., 2001; Menne, Ejaz, Noelker & Jones, 2007), and it is considered virtually non-existent (Giangreco et al., 2001). Because a comparison of paraprofessional capacities is limited (Nittoli & Giloth, 1997), tension and shared fear of

displacement arise when paraprofessional roles are interchanged with those of professionals (Nittoli & Giloth, 1997; Walter & Petr, 2006). One possible outcome of limited training is that paraprofessionals are uncertain of their role, resulting in inefficacious performance, which is further hindered by a lowered work status.

Compromised paraprofessional position

Bayes & Neill (1978) proposed that rehabilitation organizations have “a functional hierarchy of positions and a caste system of professions” with paraprofessionals occupying the lowest caste (p.139). Seldom included in participatory administrative decisions, particularly in public agencies (Wallach & Mueller, 2006), paraprofessionals are voiceless when said decisions affect them adversely (Dracy & Yutrzenka, 1997; Menne, et al., 2007). Also, due to their perceived flexibility, paraprofessionals are forced to hold multiple job titles (Nittoli & Giloth, 1997; Wallach & Mueller, 2006; Walter & Petr, 2006) that diffuse their roles, alienate them from their original duties, and leave them feeling overwhelmed (Nittoli & Giloth, 1997). These expanded roles of paraprofessionals may not be well supported at an organizational level (Bayes & Neill, 1978; Walter & Petr, 2006). In addition, direct-care paraprofessionals may be subject to longer hours for less pay (Dracy & Yutrzenka, 1997; Menne, et.al., 2007). Despite their contributions to health care systems, the work of paraprofessionals is rarely considered reimbursable by third-party coverage (Gartner, 1973). Viewed as expendable (Shaw, 1998), paraprofessionals can serve as repositories for professional and client frustrations, and they often carry out unwanted professional duties without due compensation (Bayes & Neill, 1978).

It has been assumed that paraprofessionals who have familiarity with client communities might allow them greater ability to broker services, as they share common experiences of poverty and other life stressors (Carkhuff, 1968; Nittoli & Giloth, 1997). However, as the preceding section highlights, there are many stresses experienced by paraprofessionals that may make it harder, not easier, to engage in abuse-free interactions with clients. Adding to potential high-challenge moments in substance abuse residential settings are professional job stressors as discussed in the following section.

Professional characteristics and challenges

Unlike paraprofessionals, the median salaries of professionals often prevent them from identifying with any poverty experienced by their clients (U.S. Bureau of Labor, 2010). The common challenge facing professionals in residential substance abuse treatment settings is burnout. The dimensions of burnout being considered here are emotional exhaustion, depersonalization, and personal accomplishment. The factors contributing to burnout in counselors, nurses and psychiatrists will also be further discussed in this section.

Counselor burnout

In a study in which 79 randomly selected therapists from 12 inpatient substance abuse treatment settings in eastern Ohio and southwestern Pennsylvania were administered measures relating to burnout, Barnett & Dowd (1997) identified several elements that contribute to this condition:

Excessive job demands, lack of proper performance recognition, unclear performance expectations, role conflicts, poor attitudes toward work, emotional distress, and frequent physical symptoms seem to be the most salient features that correlated with burnout (p. 62).

In a study surveying 134 counselors working with HIV-infected clients from 34 substance abuse counseling clinics in the United States, three facets of burnout were examined: emotional exhaustion, depersonalization, and personal accomplishment. The factors associated with burnout were large client caseloads, limited client contact due to a stronger focus on pharmacotherapy, and lack of hope in client improvement. Staff working in methadone clinics are particularly vulnerable to burnout (Shoptaw, Stein & Rawson, 2000).

In discussing staff stress amongst counselors in therapeutic communities, Winick (1990) proposed differences in salary, educational degree, and occupational duties are contributors. For counselors in substance abuse residential treatment settings that do not provide equal pay, counselors with professional degrees may be paid up to 50% more than counselors with an experiential background. Although both degreed and non-degreed counselors have similar responsibilities in this setting, the non-degreed counselor may have extra responsibilities such as chores or weekend work. Thus, friction may occur based on the lack of recognition of the non-degreed counselor's experience. In a TC with occupational parity, experientially based and degreed counselors may have the same pay and responsibilities, but the educational training of the degreed counselor is not recognized. Additionally, supervisors of professional counselors may not have a degree in these programs.

A supportive work environment can mitigate burnout. Salary, individual autonomy, and ability for expression of creativity were found to be important factors in

counselor retention (Knudsen, Johnson, & Roman, 2003). McNulty, Oser, Johnson, Knudsen, Roman (2006) found organizational commitment by the employee led to lower turnover rates and was fostered by participatory management structures such as development of positive work relationships and environmental stability in the office. Supporting this finding, Knudsen, et al. (2003) used data from 817 counselors from 253 therapeutic communities and found a direct relationship between going through a hierarchical chain of command to high employee turnover and increased counselor exhaustion. Additionally, workplaces perceived as fair with distributive justice were associated with higher retention. A supportive work environment with performance-based rewards was noteworthy (Knudsen, Johnson, & Roman, 2003), and more job support has been linked with an increased sense of personal accomplishment (Shoptaw, et al., 2000).

Counselor burnout is related to work in stressful settings such as methadone clinics (Shoptaw, 2000), intensely tiered work environments (McNulty, 2006), and unequal recognition of a non-degreed counselor's experience versus a degreed counselor's education environment (Winick, 1990). Autonomy, creative expression, and a supportive work environment have been associated with less burnout (Knudsen, 2003; McNulty, 2006; Shoptaw, 2000). A counselor's experience of burnout can lead to decreased quality in client care and subsequent high-challenge moments. Burnout is also seen in nurses as discussed in the next section.

Nurse burnout

Nurses can be protected from burnout. Factors mitigating burnout in nurses include having satisfactory informal relationships and feeling support from family (Hare,

Pratt & Andrews, 1988). Also negatively associated with burnout are staff backing, satisfying employment, and participation with the organization (Melchior, Bours, Schmitz, & Wittich, 1997).

Nursing burnout is exacerbated by a work environment deficient in employee support (Jennings, 2008). Risk factors for nurse burnout include patient aggression and suicidality, the type of patient group, unrealistic nurse expectations of patient improvement, and the lack of reciprocity with respect to the effort nurses put into the nurse-patient relationship. A decreased sense of personal accomplishment adds to burnout amongst nurses (Hare et al., 1988). Hare et al. (1988) surveyed 312 paraprofessional and professional nurses in three acute care hospitals and seven nursing homes. Findings showed that lack of supportive work relationships and inadequate administrative support at work engendered an environment of burnout. Additionally, higher burnout related to a higher occurrence of negative behaviors such as smoking, cursing, and avoidance, contrasting with beneficial coping skills such as problem solving and examining situations objectively. The next section discusses overlapping factors contributing to psychiatrist burnout with regard to psychiatric parameters.

Psychiatrist burnout

In a review of definitions of burnout, Kumar (2007) found factors contributing to stress amongst psychiatrists can include the risk of patient violence, crowded wards, an organizational tendency to blame psychiatrists, lack of authority, high work demands, and isolation. Psychiatrists also have a very difficult time coping with patient suicide (Fothergill, Edwards, & Burnard, 2004; Kumar, 2007). In a systemic review of 23

international studies on stressors and burnout in psychiatry, psychiatrists in the United States, United Kingdom, and Europe experienced more frustration and burnout if they were overworked, received little administrative support, were underpaid, received little validation, and female (Fothergill et al., 2004). Strikingly, the review did not find any studies on the implementation of stress management techniques for psychiatrists. The personal nature of a psychiatrist's work with patients and the challenges of the psychiatric work setting make psychiatrists, similar to their colleagues, vulnerable to burnout.

Though there are distinct issues affecting each professional group (counselors, nurses, and psychiatrists), they share many causal elements of burnout: patient suicidality and aggression, lack of support in the work environment, isolation, role confusion, being overworked. Staff members experiencing burnout can further inculcate a work environment of increased burnout among others (Hare et al., 1988), and, if several professionals in the residential substance abuse treatment have this common experience, then client care can be compromised and can lead to client harm.

Given the many elements creating stress in residential substance abuse treatment settings, it is reasonable to explore the potential for client harm enacted by staff of these organizations. Supporting this query is the documentation of sanctuary trauma and sanctuary harm in psychiatric residential treatment settings (Cusack et al., 2003; Freuh et al., 2000). Prevailing factors also include documented abuse in psychiatric residential substance abuse treatment settings and nursing homes, the inadequate recognition and treatment of trauma in dually diagnosed clients, the suppression of healing in the inpatient environment, and authoritarianism in hospital wards. Clients have inherent

challenges such as their tendencies to violence that arise predominantly during detoxification, low motivation for and completion of treatment, and negative staff countertransference.

Residential treatment settings can house various and theoretically divergent staff approaches to treatment, often exasperating clients, and staff may continue to engage in harmful confrontation based on historical precedence. The role of the paraprofessional is fraught with stressors, from a low pay grade comparable to welfare, disrespect in a hierarchical system, ambiguity and isolation in their roles, and lack of quality training and supervision. Despite higher pay, even professionals are not protected from the many causes of burnout. In light of these factors, paraprofessionals and professionals have developed a substandard ability to care. The problematic characteristics of the client, negative aspects of the residential system, challenges within the history of treatment for trauma and substance abuse, and professional and paraprofessional difficulties in providing quality client care collectively importune the inquiry of potential client harm in residential substance abuse treatment settings.

Substance abuse clients within residential treatment settings are dependent on the staff for their well-being. The high rates of verbal and physical abuse in client histories and the limited psycho-social skills, with which many of them enter treatment, often contribute to high-challenge encounters between staff and clients, affecting client outcomes. However, such client-staff interactions in residential substance abuse treatment settings have been poorly investigated. The limited evidence to-date suggests that provocative encounters indeed occur in residential abuse treatment settings and include verbal aggression and physical altercations. The impact of such events on client and staff

emotional well-being, staff burnout, client retention and other outcomes merits further investigation. This dissertation draws from Freuh et al.'s (2000) definition of sanctuary harm to explore what happens in residential treatment between staff and clients during high-challenge encounters, the impact of such encounters, and the factors among staff members – educational, psychosocial and/or personal, that might be associated with particular encounter outcomes. The next chapter will discuss the methods employed to understand factors leading to high-challenge moments in residential substance abuse treatment settings.

CHAPTER 7: METHODS

Background

The nature of staff- client interactions in residential substance abuse treatment settings is undocumented in the literature, particularly as they relate to client harm. However, the literature does establish client harm and abuse in nursing homes which have similar settings to residential substance abuse treatment (U.S. House of Representatives, 2001), and client harm in inpatient psychiatric settings is being explored with a focus on the eradication of seclusion and restraint (Chandler, 2008; U.S. Department of Health, 2003). Thus, given similarities in staff and treatment environment, this dissertation proposed an exploration of potential client harm in residential substance abuse treatment settings. Original research using purposive sampling was conducted with nine key informant staff members consisting of paraprofessionals and master's level therapists; these subjects have worked in residential substance abuse treatment for at least six months. In this study, the staff shared their insights about high-challenge encounters between clients and paraprofessional and professional staff members. Semi-structured and qualitative intensive interviews were individually conducted both in person and over the phone where interviewees provided information about the types of encounters they witnessed between clients and staff and their perceptions of the impact of these encounters. The results of this study will be used to develop future staff training and treatment protocols to protect both clients and staff and improve the quality of care for historically vulnerable clients.

Research question

This study poses the question: How do paraprofessionals and professionals approach, deal with, and perceive the impact of high-challenge encounters with clients in residential substance abuse treatment settings?

Research Design

A qualitative study was conducted utilizing both phenomenological and grounded theory approaches to data collection. The phenomenological approach was applied in an attempt to comprehend differing perspectives on the same phenomena through individual interviews from which common themes were drawn (Creswell, 2012). This study asked interviewees to describe their individual experiences with the phenomena of the high-challenge encounter which was described in Freuh et al.'s (2000) writings on sanctuary harm, and themes from subject responses comprised the findings. Intensive, semi-structured qualitative interviews were enacted via phone and in-person with nine paraprofessional and professional respondents in such settings to gain an understanding of the occurrence and surrounding dynamics of high-challenge moments between staff and clients in residential substance abuse treatment settings. Through the grounded theory approach, data analysis began through open or line-by-line coding and category formation (Creswell, 2012; Glaser & Strauss, 1967). While a theory, per se, did not result from data analysis, categories and subsequent themes were originated from transcribed interviews analyzed with line-by-line codes, and excerpts of subject responses were integrated with the discussion. The overall results may influence guidelines in protecting clients entering residential substance abuse treatment.

Sampling and recruitment strategy

Purposive sampling was employed with participants of paraprofessional and professional backgrounds. Respondents were sought to discuss their own or other staff members' involvement in high-challenge encounters. Subjects were also asked to discuss effective client approaches in which they or other staff members have engaged.

Paraprofessional respondent inclusion criteria

- Six months of full-time work in a residential substance abuse treatment center
- Daily contact with clients in roles akin to nursing aides
- No master's level education

Professional respondent inclusion criteria

- Six months of full-time work in a residential substance abuse treatment center
- Daily contact with clients in counseling roles
- Master's level education

Recruitment

To recruit subjects, directors of hospitals and residential setting treatment centers treating substance abuse were contacted in Philadelphia and its surrounding areas. As responses from Pennsylvania initially did not provide a large enough sample size, the recruitment was expanded to treatment centers throughout the United States. Within a five month recruitment period, subjects responded from Pennsylvania and Tennessee and were included in this study. Directors were informed that not all respondents may be

ultimately included, and they were notified when recruiting ended. Subjects were also recruited via the National Association of Social Workers (NASW) listserv, the Pennsylvania Society for Clinical Social Work (PSCSW) listserv, and other professional listservs. This researcher also utilized a personal contact within an insurance company who provided this study's Letter of Contact to residential settings within her professional network.

One week after initial contact, directors were encouraged to have potential respondents call this researcher within one week. Upon response, they were provided a Letter of Contact (Appendix B).

Protection of human subjects

To protect human subjects, responses were completely confidential and were not shared with his/her employer (see Informed Consent, Appendix A). Although the subjects do not constitute a vulnerable population, their privacy was guarded. Only this researcher had access to the collected transcripts, notes, tapes and audio recordings along with the audio recorders. All data collected was locked in a file drawer in this researcher's home, and all data was destroyed after the findings were transcribed and analyzed. Inclusions of quotes or analyses of transcripts did not have subjects' identifying information such as their names, ages, or work places.

The University of Pennsylvania's Institutional Review Board of the Office of Regulatory Affairs ensured this proposed study is in compliance with Federal and University regulations regarding human subjects prior to contact with human subjects.

Consent

In the interest of time, a Consent Form (see Appendix A) was provided to potential subjects prior to the scheduled interview time to allow for time to convey questions or concerns; this researcher was available for response via e-mail and phone. The subjects were informed the interview was designed to gather their perceptions of challenges relating to clients in residential substance abuse treatment settings. Upon clarification of any concerns, the subjects were expected to sign a reviewed Consent Form at the time of interview.

Data collection

Following a grounded theory approach, theoretical sampling was performed in which responses from subjects' interviews were compared. While a theory was not generated from the interviews in this study, category properties were obtained, compared and contrasted; themes emerged. Detailed information from the interviews aided the depth of theoretical sampling (Glaser & Strauss, 1967). This researcher did not have a set number of respondents needed to commence interviewing, so interviews began with the first subject who met study criteria. The subject could choose the form of the interview: in-person, over the phone, or via Skype. If the subject was unable to use those options, an e-mail option was provided, but it was suggested sparingly. For this study, subjects did not choose the Skype or e-mail option. One interview was conducted as a private meeting in a library room agreed upon by the subject and researcher. An audio recorder was utilized to capture subject interviews. The time(s) and date(s) of each interview were documented and reported (Alexander, 2009b).

Based on their qualitative study utilizing in-person and phone interviews, Sturges & Hanrahan (2004) concluded the quality of the data was not affected by the type of interview format given the comparable nature, depth and magnitude of responses. Respondents were not able to compare formats, but none reported dissatisfaction based on interview mode. The two most common reasons for choosing an interview type was based on convenience and confidentiality, and respondents reported an appreciation of having available options. Probing upon visual cues was not possible in telephone interviews, and further exploration needs to be conducted regarding the effects of other signals such as sighing or pausing. One advantage of telephone interviews was the ability for the interviewer to take notes without distracting the subject (Sturges & Hanrahan, 2004).

In a review of literature on e-mail interviewing as a qualitative method, Meho (2006) asserts that since 2003, the use of in-depth e-mail interviewing is on the rise. Findings of Meho's (2006) review of studies using qualitative e-mail interviewing show benefits of lower cost, ability to obtain samples from diverse geographical areas, minimal editing or formatting of responses, no need to coordinate schedules for the interview, the ability to interview more than one respondent at a time, and provision of a format by which shy respondents can contribute. However, weaknesses of e-mail interviewing include varying data collection periods which may be due in part to an unlimited number of exchanges between researcher and respondent, inability of the researcher to read body cues of respondents, exclusion of participants with limited writing skills, and the loss of valuable data due to lack of direct probing (Meho, 2006).

The interview format preference of this researcher was in-person, but only one

subject opted for this arrangement. The in-person interview allowed for this researcher to respond to nuances in behaviors such as facial expressions and body language, and, in doing so, the interviewee's comfort level and openness could be determined more quickly. Considering the nature of the phone interview masks nonverbal communication, this researcher listened carefully and responded to speech hesitations and word underlining with the remaining eight subjects to increase subject response. The one in-person interview was conducted in a study room in the Van Pelt Library of the University of Pennsylvania; the study room allowed for privacy and possibly contributed to this subject's ability to become tearful during the interview. Four subjects outside of Pennsylvania preferred to interview over the phone while at work, and they indicated they were speaking from private offices. This researcher offered to meet the remaining four subjects who were outside of Philadelphia, yet they preferred interviewing over the phone. The subjects near Philadelphia interviewed from their homes or offices. All subjects were interviewed during the day, and none of the subjects wished to be interviewed via Skype. The e-mail option was not needed.

Interview guide description

This study's substantive frame is a combination of topics from the literature review and theoretical approach, both of which directed the interview guides (see below) (Charmaz, 2006; Morgan, 1997). While this researcher used many open-ended questions phrased in a manner to avoid restriction of subject responses into confined categories (Charmaz, 2006), probes were used to elicit detailed responses (Charmaz, 2006; Morgan, 1997).

Interview Guide

We are here to understand your views on how you and other staff dealt with and perceived the impact of high- challenge encounters, a term based on Freuh, et al. (2000) definition of sanctuary harm. In high-challenge moments, escalated moments between staff and clients lead to potential emotional and/or physical client harm.

- How have you dealt with situations in which clients were emotionally or physically harmed by staff? Were you involved in that moment? If so, how? If not, how did you approach the situation with the client and/or the staff member?
- How did the high-challenge encounter come about? How did you deal with your hurt, humiliation, or fright? How do you think the client dealt with those feelings? Did you approach the client later about negative feelings brought up in yourself or the client with respect to the encounter?
- What feelings do clients bring up in you? How do you deal with those feelings on the job?
- How do you feel clients get better? What do you feel is client progress? How do you think clients will make progress?
- How do you feel a client's trauma and/or psychiatric background relates to treatment? Is it important? If so, how? If not, how? Does it come up during a high-challenge encounter?
- How do you feel about having a similar background to clients? Describe ways

you relate. How does that play out in a high-challenge encounter? Does having a similar background help? Does it not help?

- How do you feel about having a different background than clients? Describe ways you differ. How do those differences come up while working with clients? Are those differences particularly relevant during a high-challenge encounter?
- How does your training and supervision help/hinder the way clients are treated? Does training help mediate high-challenge encounters?
- Are there any personal factors among staff members that help high-challenge encounters?
- What do you feel would make those situations better?
- How does the residential setting affect how you deal with clients, particularly during high-challenge encounters?

Coding and data analysis

To generate the five themes discussed in this dissertation, this researcher engaged coding and category formation. The first step involved this researcher's transcription of audio recordings for each interview verbatim. This researcher then engaged in two levels of coding. Initial coding was done line-by-line in which this researcher examined each line or set of lines of the transcript for salient ideas, processes, segments of data from the transcripts, or *in vivo* quotes from subjects. Subjects' ideas, processes, and direct segments and quotes were then recorded as initial codes. Initial coding requires "staying close" to the data (Charmaz, 2006, p. 47), and line-by-line coding allows for new ways of looking at the data, diminishing researcher transference (Charmaz, 2006).

A second level of codes was generated from a re-examination of transcripts and initial codes; this is known as focused coding. Focused coding involves organizing and synthesizing large amounts of data by looking at the most significant or frequent initial codes (Charmaz, 2006). Gerunds were used to emphasize codes' "enacted processes," preventing analyses from remaining at a general, descriptive level (Charmaz, 2006, pgs. 136-137). Subjects' language and terms were also included to provide *in vivo* codes (Charmaz, 2006).

Focused codes were then grouped into 28 categories. Categories were generated by *in vivo* codes characterized by embedded meanings, active and brief codes, and the themes and patterns of many codes (Charmaz, 2006). Overall, categories were determined by both the content of the interviews and the literature review (Padgett, 2008) in the most relevant manner to the data (Charmaz, 2006).

Finally, categories were grouped to form the five themes discussed in this dissertation. Saturation for the categories was not reached as subject responses often contained varying properties that did not always overlap (Charmaz, 2006). Thus, the themes for which the categories were collected also did not reach saturation.

This researcher documented the codes and categories to contribute to an audit trail (Padgett, 2008). In writing the findings, transferability was aided by thick descriptors and anonymous quotes that did not include any identifying information. Detailed description ensures credibility, and interpretation of the description resulted in stronger concept formation. Debriefing with the dissertation committee occurred after interviews, adding to credibility of the study (Padgett, 2008).

Reflexivity

As a former therapist in residential substance abuse treatment settings, this researcher has witnessed beneficial and harmful interactions between both paraprofessionals and professionals and their clients. Thus, in interviewing clinicians and paraprofessionals, this researcher considered her potential biases and made efforts to remain balanced with interview questions in that this researcher did not offer her opinions on subject responses and maintained neutral body language. This researcher also consulted her dissertation chair at routine points throughout the analysis to check for bias.

CHAPTER 8: RESULTS AND DISCUSSION

For this study, nine subjects responded. They consisted of two paraprofessionals and seven professionals. Of the seven professionals, four were practicing master's level therapists and three were residential treatment setting supervisors with clinical treatment experience. The two paraprofessionals were a paraprofessional supervisor and a group leader. The paraprofessional respondents, as well as two master's level therapists, were male and worked in a faith-based male 90-day adolescent residential substance abuse treatment facility. Two of the master's level supervisors were female and worked in a women's residential substance abuse treatment facility. The other master's level supervisor was male working in a co-ed substance abuse treatment facility. There were two female master's level therapists in inpatient substance abuse treatment facilities, one of whom worked in the same facility as the male master's level supervisor. The other female therapist worked in a co-ed substance abuse treatment facility in which clients received treatment from a few days to less than two months, differing from the other eight respondents who worked in long-term substance abuse treatment facilities in which clients received treatment for at least three months. Many respondents were seasoned in the mental health and addiction field with at least a year in their settings upon interview. One master's level therapist was in her mid-twenties, while the other respondents were between thirty to seventy years old. One paraprofessional respondent was African American while the remaining eight participants were Caucasian.

Table 1. Subject Characteristics		
Gender	Female	4
	Male	5
Race	African American	1
	Caucasian	8
Educational level	Non-degreed	2
	Master's level	7
Position	Paraprofessional group leader	1
	Paraprofessional supervisor	1
	Therapist	4
	Clinical Supervisor	3
Residential facility type	90-day, faith-based adolescent male	4
	Long-term, adult co-ed	2
	Long-term, women	2
	Short-term, adult co-ed	1

The responses of participants are organized into five themes. Theme one addresses the significant history of client trauma and client exploitation by staff as reported by subjects. The second theme evaluates the pros and cons of residential

treatment settings as they relate to high-challenge moments, and theme three examines shame as a form of client re-traumatization. Theme four describes the ways in which staff-client boundary violations occur, oftentimes from staff overidentification with client issues, and, finally, the fifth theme focuses on how training is necessary for staff to deal most effectively with client trauma and escalated moments regardless of staff educational level. Next is a presentation of these themes to include subjects' quotes with associated commentary and discussion by this researcher.

Theme 1: Significant client trauma histories

Prevalence of client trauma

There is a significant prevalence of trauma history in substance abuse treatment facilities. A master's level supervisor reported "probably 90% of women in recovery have some type of trauma," and all subjects discussed co-occurrence of substance abuse and psychological trauma.

None of the subjects reported working in a fully trauma-informed facility despite having clients with co-occurring substance abuse and trauma. Subjects indicated that working in a trauma-informed facility would entail assessing clients for trauma prior to treatment, addressing client trauma histories with increased sensitivity, ensuring clients are validated and heard, and providing clients with appropriate aftercare. SAMHSA (2013) states,

When a human service program takes the step to become trauma-informed, every part of its organization, management, and service delivery system is assessed and potentially modified to include a basic understanding of how trauma affects the life of an individual seeking services. Trauma-informed organizations, programs, and services are based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization (pgs. 1-2).

The need for trauma-informed facilities

A paraprofessional group leader describes a sense of helplessness and a lack of understanding of trauma when dealing with client sexual abuse:

...I have a lot of compassion for them. I feel it's terrible. I've got some that's physically abused. There's some that I've not had personal contact ... but I believe there's some that have had sexual abuse in their lives... I don't have the professional training. I really defer that to the ones with the clinical training...I don't wanna use the phrase it's above my pay grade, but it probably is. All I can do is try to show 'em kindness...I'm not trained professionally enough to deal with that... struggle with that. But I think it's terrible.

Avoidance of client trauma content

When asked if client histories depress this paraprofessional group leader, he stated,

No, I'm gonna tell you this...I eat, sleep, and drink this. But I've been doing this long enough that it- I've learned a long time ago, I can't fix 'em... I mean, everyday, I go home with it. I'll wake up in the middle of the night. I've got a pretty good prayer life. And I'll wake up in the middle of the night. God'll put something in my heart. I'll pray for 'em for an hour or two... You know, and call 'em out by name to Lord. So, I'm taking 'em home with me, yes. But I'm not bearing their burdens. I'm releasing 'em to the Lord.

This subject's prayer is a very personal way of addressing and attempting to alleviate his clients' distress. Praying for his clients at home may be an effective way for this subject to cope. Feminist theory would support this approach in that it recognizes knowledge people have of each other may be inarticulated and intuitive, and people hold individualized beliefs about common phenomena (Anderson, 2012).

However, not understanding how to address client trauma can engender powerlessness in staff. The amount of time spent spontaneously awakening in the middle of the night to address client trauma histories may reflect a possible susceptibility and helplessness in this subject to vicarious traumatization (Trippany, Kress & Wilcoxon, 2004). Increasing the chances for vicarious traumatization include working with large numbers of traumatized individuals (Bloom, 2003; Edmund & Bland, 2011), especially

sexually abused children (Bloom, 2003). When staff see clients struggle with barriers and when staff have difficulty eliciting trust from clients, they are at risk (Edmund & Bland, 2011). Those who develop vicarious traumatization have difficulty upholding a sense of optimism and trust in human integrity, and, as a result, the paraprofessional respondent's ability to contain his clients' emotional states diminishes (Bloom, 2003). Feeling overwhelmed and unable to address client concerns can lead to high-challenge moments.

Traumatized clients lack trust

A trauma-informed facility could help staff identify client PTSD symptoms. Clients who have a history of trauma have trust issues that can impede or impact the therapeutic relationship, which has implications for why staff need to be trauma-informed and equipped. One master's level supervisor expressed partial understanding of the behavioral manifestation of PTSD symptoms. She described clients in her facility with both trauma and substance abuse backgrounds as "slow to trust people," stating:

Trauma stuff comes up a little differently. I find sometimes people have a trauma history...they tend to not speak up when they feel like they're hurt by a staff person, emotionally hurt by a staff person. Sometimes they tend to internalize it-they tend to just not have a voice...get a little passive with it, get resentful, and, but they tend to take it to an internal place as opposed to having an outburst.

This subject's characterization of those with co-morbidity may stem from the emphasis on treating pathological anxiety and addressing the internalizing subtype of PTSD (Miller, Kaloupek, Dillon & Keane, 2004). However, those suffering with PTSD display both internalized and externalized symptoms with externalization strongly associated with substance abuse (Miller & Resick, 2007; Miller et al., 2004). Clients with the externalizing PTSD subtype can have the following reactions when engaging in treatment for PTSD: anger, impulsivity and aggression (Miller & Resick, 2007).

However, externalized symptoms may be overlooked, misunderstood, and responded to inappropriately leading to high-challenge moments.

In another instance, a master's level therapist in an adolescent treatment facility recalls a week in which his client was dealing with past trauma and that client's mother having been admitted to the hospital. The client described was "fragile" and a "complete anxious wreck", and he had difficulty dealing with any staff member who was very direct. In their study of incarcerated youths, Ulzen & Hamilton (2003) found a high prevalence of PTSD with a strong co-morbidity to internalizing disorders, particularly past depression. Stressful life events are associated with heightened anxiety (McLaughlin & Hatzenbuehler, 2009). This client may have been predisposed to an internalizing disorder given the trauma in his background, and his anxiety was worsened by the stressful life event of his mother's hospital admission. The staff member's directness could have exacerbated the client's state, possibly reinforcing the client's negative beliefs. In this instance, a staff member's inappropriate approach potentially decreased the client's ability to trust him leading to probable client harm.

Minimization of trauma

A master's level supervisor illustrates an instance in which she was insensitive toward a client. As a seasoned clinician and supervisor, this respondent stated she had accidentally minimized a client's sexual abuse history. When this client presented her sexual abuse history, she said the abuse occurred numerous times versus the one time she originally reported. The subject responded to this client's change in her account by stating, "Well, it only happened one time." The outcomes of this encounter were an

immediate apology from the subject and a grievance filed by the client. After the incident, the interactions between this subject and client were “polite” and “guarded at a distance.” While an admitted mistake, the subject had minimized the client’s sexual abuse history. It is unknown whether this subject was working in a trauma-informed facility, raising the question whether staff, regardless of credentials or experience, are consistently attuned to the sensitivities of traumatized clients. A significant number of adult psychiatric inpatients report past childhood sexual abuse or incest, and diminishing the abuse in any manner could reinforce negative self-beliefs; the minimization could also suppress appropriate reactions through the victim’s acceptance of blame and dismissal of the abuse in hopes of maintaining a familial or societal norm (Doob, 1992).

Considering the client’s abuse may have occurred in a hierarchical relationship, any future attempts at a therapeutic alliance with staff are hindered (Doob, 1992; Jacobson & Herald, 1990). Unfortunately, client harm may not stem from staff mistakes or oversight but may be executed purposefully as discussed in the next two sections.

Client sexual exploitation

A more insidious form of a high-challenge encounter is client exploitation. A master’s level therapist in a residential treatment setting discusses instances of client exploitation based on their trauma history and general vulnerability in an inpatient unit:

...I’ve have encountered or know of ... many staff members, not necessarily therapists, but were in inpatient settings and either a clinical assistant or nursing assistant who was fired, either for putting their hands on them [patients] in inappropriate manner or restraining them in inappropriate manner, and things like that... I actually was involved in one particular situation where a patient of mine ... this lady was in her, probably, 40s, very nice, very sweet, extremely limited and had one of the worst abuse histories I ever possibly heard of. ..Incest, things like that... we had a particular NA on our unit this client had told me ... was sexually propositioning her...Because this patient needed money out of her account and our facility only does certain bank runs on certain days, this particular NA offered to withdraw money from her account for exchange for some

kind of sexual act, and I, with permission from this client in front of me, she gave me the information to access her online account. I printed out the receipts to confirm that withdrawals were made from her account while she was in inpatient facility and she was accounted for being on the unit. Before he got fired... he just didn't show up the next day... so that's one.. of many that I know of... I don't think you would even see the emotional part in her because she's just so used to it... by adults...just being taken advantage of Obviously, it just completely disgusted all of us, especially myself because I was her primary therapist. I had no problems whatsoever about contacting my supervisor and my supervisor's director, and writing the documentation and doing the- we have to do online incident report... he's no longer there, but he just basically proved his guilt by not showing up to work because he knew he would have gotten fired.

She describes another instance:

...I know of an incident where, again, it wasn't a therapist per se... someone who is new to recovery and new to working ... you're young and you're on a unit with young people and there was definitely inappropriate interactions... everything this patient reported was in order was depicted on that tape...Everything. Everything. Down to who was in the hallway, who exchanged who, who walked by what, what the bathroom it happened in... You know, everything...so that's kind of one of the better scenarios. Sometimes, you can't catch it because... we don't have the best... videotapes.

In the aforementioned instances, the subject described the sexual exploitation of clients by staff. Considering the existence of trauma in patients, it is important to consider the effect of the power differential between staff and clients in instances of sexual exploitation. In her discussion on doctor-patient boundaries, Galletly (2004) points out the authority doctors hold make their sexual transgressions with patients akin to incest or a parent abusing a child. Also, clients exploited by staff may have a difficult time developing trust as the trauma background of these clients may entail having been victimized by key figures whom these clients depended upon for safety (Center for Substance Abuse Treatment, 2000); these clients may depend on staff members for safety in a similar manner they entrusted past abusive figures and cannot risk further betrayal (Jacobson & Herald, 1990). Staff can further debase clients through the misuse of their power as discussed in the next section.

Misuse of staff power

The misuse of staff power in residential settings exacerbates their victims' emotional aftermath. One subject illustrates and explains an example of client mistreatment:

...I know of other situations where, again it's not a therapist, it was a CA or NA who... a lot of them use their power and, while I very much appreciate a lot of people who work in this field who're recovering addicts, it doesn't necessarily mean they're extremely healthy either... I think the power of being a staff person sometimes goes to their head. Just the simple thing of a patient exchanging a note with another patient, and just grabbing this patient's wrist to prevent it from happening. I mean, just ridiculously extreme...he got a slap on the wrist... he's still there and he's been there for umpteen years. It's one of the biggest issues I have with the field that I've honestly contemplated getting out of it... Is just how frequent this mistreatment is- emotionally, physically –it disgusts me, quite honestly, and it happens all the time. It happens all the time. You have people who blatantly...pride themselves on admonishing patients.

This subject discusses her total frustration with mistreatment of vulnerable clients by direct care staff. Her infuriation is not only with the staff members themselves but with the larger workplace system that does not address the consequences of client mistreatment by direct care staff and the subsequent contribution to inpatient abuse. Considering the emotionally compromised state of clients, it seems possible more instances have occurred without repercussion. It is also of great concern that staff members engaging in mistreatment and predatory activities may not be punished based on their longevity with a facility. Inpatients often experience trauma, fright, and humiliation in hospital settings (Cusack et al., 2003). Thus, it is almost an expectation clients will be victimized in treatment. Aspects of the residential setting in which these high-challenge moments occurred need to be examined for their possible contribution to harm.

Theme 2: Residential setting pros and cons and factors of high-challenge encounters

Pros

Subjects generally felt residential settings allowed clients to get away from “people, places, and things.” Clients are given support in a residential substance abuse treatment facility and are separated from drug-infested settings (Brunette, Mueser, & Drake, 2004). One master’s level therapist in a shorter-term detoxification program described the pros of a residential facility:

I mean it certainly gives...people an opportunity to get away from their environment that they weren’t able to stop using substances...I think that aspect is obviously beneficial because it gives people [the] opportunity to detox, to get the substances out of their system, and... learn a baseline of skills where they kind of [have]no choice...but to be there. And do it without the distractions of knowing that you can just pick up the phone and call your dealer, or the distractions of day-to-day life...Employment, children, family or whatever. So that way, it is a benefit, and it has helped.

A master’s level supervisor or a women’s unit also describes her residential setting positives:

..It’s [a] very home-like environment and I think we treat people like that...When we’re having someone here for 3-6 months, we see these women every day for months and months...I think it definitely does affect how they’re treated and impacted positively.

The prospective comfort provided by a residential facility may allow clients a chance to separate from and work through past or ongoing trauma. Also, as Courtois and Bloom (2009) point out, a therapeutic community can allow for acceptance, normalization of trauma with others of similar backgrounds, positive coping, and healthy relationship skills.

The subjects indicated that they and other staff gained more information about their clients through daily interactions and everyday activities than once-weekly outpatient therapy. Subjects felt outpatient treatment may allow a client to not return to

therapy whereas residential treatment requires staff and clients to work through conflict, a skill clients can use upon discharge at home with their families.

Staff members state they benefit from the residential setting in that they can work together within a system to decrease escalated situations or crises such as suicidality in the moment. In doing so, clients can avoid being forced into psychiatric care via a court order. The residential setting also allows for immediate staff collaboration and support to address client needs. However, the residential setting also has treatment drawbacks as discussed in the next section.

Cons

The residential aspect of inpatient substance abuse treatment settings can provide several protective factors. However, subjects also responded on the residential system factors that can escalate situations between clients and staff. Cons of the residential treatment setting include inability to sufficiently address client abuse, little motivation to change by client, lack of appropriate staff coping skills, artificial protection from substance use triggers, and stress between residents surrounding daily living activities.

Subjects relayed an inpatient setting cannot adequately address extensive client abuse histories, especially as insurance companies may shorten client stays. In an investigation of outcomes of a 6-week inpatient program for adults abused as children, the mean scores for the treatment group on measures of PTSD at six- and twelve months were significantly better than scores upon admission. However, at twelve months, improvement had deteriorated substantially, and subjects covered by government insurance displayed a considerable amount more PTSD symptoms than those with private

insurance. The authors found treatment covered by insurance or government assistance had a negative association with improvement (Stalker, Palmer, Wright & Gebotys, 2005).

Another negative aspect of the residential setting is the lack of motivation to change by clients who were court-ordered; subjects felt these clients' low motivation could affect the remainder of the residential community. Participants also conveyed high-challenge moments can arise in this intensified setting when clients and staff do not have "great coping skills." Subjects communicate that issues can continue from day to day, and staff may have difficulty in resetting a positive dynamic with a resident involved in prior negative interactions.

Another negative aspect to the residential substance abuse treatment setting is the client's lack of exposure to substance use triggers. A therapist expressed:

It is an artificial environment, and people, although there are drugs in the facility..., at times, it kind of comes and goes in waves...people are kind of in a bubble and they're protected. That's why...in a lot of cases, intensive outpatient or partial hospital is a better option for people...because they get exposed to...to their triggers...on a daily basis..., whereas, for the most part in, in an inpatient environment you're insulated from that.

While the residential facility affords a potential break from drug use triggers, it can permit or in some cases incite other triggers, such as interpersonal conflict arising from living in close quarters with people who may lack strong interpersonal coping skills and mood regulation skills.

A supervisor of a women's unit discusses conflict between residents around daily living:

...When they get into it with each other...then we have to intervene... you know- who took my laundry out, set it on top of the dryer, and... it's usually residential issues. She keeps the light on too late and I want to go to sleep... stuff that seems like a crisis to them. You know the residential setting becomes their whole world...My family, my friends, my- day in day out- it's everything.

This subject discusses staff response to resident conflict:

...they're probably is more concern about safety ...I would say that's a reasonable forefront issue that someone will have in their mind. How is this gonna affect the rest of

the community... They [Staff] may be quicker to try to get somebody to comply than in an outpatient setting where it doesn't matter as much. Here... it's gonna affect the whole community and it spreads like wildfire. People get that hysteria where something's going on, and, then, something's going on everywhere...

In summary, subjects expressed the substance abuse residential setting itself allows clients to focus on their treatment goals without the triggers and responsibilities clients experienced within their home environments, and the setting allowed for staff and clients to foster relationships that reveal more about the clients than in an outpatient setting. The residential setting also allows for staff to collaborate in the moment regarding client needs and emergencies. However, inpatient treatment may not adequately address underlying client trauma and psychiatric issues that may relate to their needs and trigger emergencies. The residential setting “insulates” clients from triggers and responsibilities, and the daily living of the residential setting can become clients’ entire focus. While staff members have a close relationship with clients, it may be difficult for staff members to prevent staff-client conflicts or client reputations to color their view of clients and react to clients accordingly. Also, staff members may not tailor their responses to the individual needs of those residents experiencing conflict and/or relapse but, instead, respond in a way that prevents disruption amongst the remainder of the residential community. The restorative functions of the residential substance abuse treatment setting can be weakened by tension between staff and clients giving rise to high-challenge encounters. The next section discusses high-challenge moments surrounding residential rule enforcement.

Rule-enforcement versus healing

Rule-enforcement is an integral part of the operations of a residential setting. Disruptions and general tension within the setting, however, elicit a range of staff

reactions, and the manner in which rules are enforced has caused high-challenge encounters for which reconciliation may or may not occur. What follows are several examples of rule enforcement in the residential setting.

Perceived reconciliation from high-challenge moments

A residential director describes a situation in which a staff person had crossed physical boundaries while attempting to enforce the rules. The subject also describes staff-client reconciliation for this occurrence:

Yeah, can think of one where the person was doing something -she was- it was, like, lights out and she was supposed to be in bed and she was downstairs making food. And I remember the staff person...snatched the food and threw it away...So that was probably taking it a little too far. I don't think the client was emotionally scarred or anything, but I don't think that the staff person handled it as well as she could have...we had the client ... put it in writing... She had said that the staff person actually scratched her which wasn't the case...she did snatch the food out of her hand and throw it. But she certainly didn't grab a hold of her and scratch her like she said because there was other people there... then, we sat down with her [client], myself and the executive director...then we sat down with the staff person, who was also very distraught by that point. She [staff person] was crying when it all was over because she was like, it's just went much further than it needed to... we ended up, then, sitting down with the client and the staff member because the client was still gonna be in treatment for a period of time and she had said...she was wrong in the first place with what she was doing and the staff person said she was wrong for how she reacted...and then they hugged it out... so that turned out in a positive way ...And then we ended up having had her [staff person] go to trainings instead. One of them...kind of bombed ...I think it was just called conflict resolution ...The one that she did go to that was helpful and had a couple of people go to was De-escalation training ... she came out of with a lot of good information and handouts that we ended up giving to all the staff ...

The client saw the psychiatrist the following week.

Seeing a psychiatrist may be part of the regular client schedules or check-ups, but it is of concern whether seeing the psychiatrist was related to tempering the client's behavior. Moreover, a chemical restraint is indicated in the use of a drug to manage behavior versus an agent in treatment. Although psychiatric emergency services are ill-defined, caution is warranted in the use of chemical restraints due to inherent safety risks,

and it is advised that the least constricting restraints or seclusion must be enacted (Currier & Allen, 2000).

A master's level therapist in an adolescent treatment setting describes another high-challenge moment stemming from rule enforcement:

The direct care staff member who is not a licensed therapist... There's three 8 hour shifts. So they're [direct care staff members] the ones that are with the residents, 8- 8 residents at a time- with each direct care staff member...he was new to the program. He was learning some of the policies...there were two clients that were kind of picking at each other. One of them was my client. He went over to kind of break it up, and, I think he said something like, 'you two break it up or I'm gonna come take care of you both'. Basically, I'm gonna get physical with both of you... which is something that's certainly a staff member does not need to be saying. I think that that just instilled a little bit of fear in my client. Both of the other guys were a little bigger than he was, so I think that there was a right to be fearful. But when he found out that the direct care staff member was just trying to settle things down..., it all blew over eventually... again, I think very much in the moment, he [client] was very upset... I approached him [client], and said, look, the direct care staff has my number. Don't hesitate to have him call me if he needs me to come out... He was very nervous about going back, but, when we said... we're gonna move you over to another dorm under another person's watch, I think he was a lot more comfortable with that.

Regarding the direct-care staff member involved in the above high-challenge moment, this subject stated, "Really, in my mind, that member should have been dismissed, but, looking back, I certainly don't think that was the case, I just think some training needed to be done." Reconciliation of the high-challenge instance between the client and the offending staff member was not carried out directly, but the client received comfort through the enforcement of the institutional safety protocol that met the approval of the client's family.

Reconciliation was recognized in varying degrees between staff and clients post high-challenge moments. However, it is concerning that the staff members in both instances had to be reported by either the client or nearby staff for reprimand. Staff may not be apprehended after high-challenge moments, and, if they are, extensive damage

may have been done. The following section will discuss the lack of reconciliation for the clients after high-challenge moments.

Lack of reconciliation from high-challenge moments

High-challenge moments related to staff rule enforcement may possibly be allowed to continue at the clients' expense without reconciliation. Subjects describe such high-challenge instances in examples of over-enforcement of rules in an adult residential setting, the tendency for newer staff in adolescent residential settings to overemphasize rules, and escalated situations occurring as a result of staff in adolescent treatment settings not asking for help in a timely manner.

Adult residential substance abuse treatment setting

A master's level therapist describes an instance in which residential setting rules were overemphasized:

It had something to do with a particular client's behavior... I think it involved... you know just verbally disrespectful and the other staff member who was her primary counselor was instructed to put this person on a... behavioral contract for... having been disrespectful. I came to observe this because I share an office with other clinicians...it was towards the end of the day and I was just in my office finishing my paperwork and my colleague...brought the other person [client] into the office and she had the contract written up. She explained why she was placing her on contract and the terms of that, but, then, beyond that, wanted to get the client to understand just how disrespectful she was and to verbally admit it. And I don't [think] the client was really...ready to admit that? ...One of the aspects of the contract is to do a homework assignment...where you do reflect upon that behavior. So...chances are, the behavior change or the attitude change could have come about as a result of doing that....homework? So I kind of felt like the contract would take care of itself. Why do you need to have a 15 minute conversation about...the behavior? I kind of felt like it was overkill and a waste of energy on the part of this other clinician...I could sense that she [the client] probably felt attacked...judged...maybe shamed a little bit? Because, you know, hearing it, I kind of felt a little bit of that myself, like, ooh, I'm glad I'm not on the receiving end of that....and it's funny because at the beginning of the interaction, she [the client] was not happy about being placed on contract but she was much more pleasant. But as the other clinician kind of kept beating a dead horse, she became more and more defensive. I felt kind of awkward. I did kind of want to step in and say something, but I knew it wasn't my place to say something. And I am close with the other clinician who did that...she talked to me after... she actually expressed to me that she thought that she didn't handle

it very well...she [the clinician] had actually asked me if I would be willing to kind of stay behind... knowing I was there would kind of keep her from getting escalated...the other clinician kind of knew that this area was like a trigger for her in some capacity.

This subject feels the client might have had residual feelings but “got over it” in a day or so. However, the perception that the client “got over it” does not speak to the possibility of this client having complex trauma. A multiply-traumatized person may hide her reactions in response to further abuse as a way of coping. A client struggling to regulate emotions may respond to harmful situations with depression, sadness, difficulty controlling anger, emotional numbing, anxiety, guilt, shame, and suicidality. Thus, the excessive rule enforcement could have triggered this client’s potentially dysregulated response. Due to difficulties in developing close relationships, those with complex trauma are often susceptible to caregiver re-traumatization. This client’s therapist was a possible caregiving figure expected to build rapport with the client, and her inability to do so worsened this high challenge moment. A lack of response by those in authority can also negatively intensify existing trauma (Edmund & Bland, 2011). In this case, the lack of follow-up with the client and the assumption the client was not significantly harmed may have impaired the client’s existing issues.

Adolescent residential substance abuse treatment settings

In this section, high-challenge moments related to rule-enforcement are described by subjects in adolescent substance abuse treatment settings. One paraprofessional respondent describes how new staff members enforce rules with adolescent clients: “We see some guys in the beginning are real strict, and, you know, just real hammering ‘em and trying to beat, you know, verbally beat it into them.”

In the same adolescent treatment facility, another paraprofessional

respondent in a supervisory role describes a situation of rule enforcement:

Mainly a kid don't wanna go to his room, and staff directed him to go to his room and the kid refused to go to the room, so, staff insisted on...the kid follow the rules, trying to give a reason to go to his room... they go back and forth...that happens frequently because you got kids coming from homes, and they're coming down off the drugs, and they're not ... enforcing the rules...a lot of times the kids upset...they're on substances...they're not meeting with their authority figures ...It's just that the staff's [got] to have support in the system...so their kids won't get escalated.

This paraprofessional supervisor describes how staff vulnerabilities increase their reactivity to adolescent clients, leading to high-challenge moments:

A lot of times... I feel that the staff take it personal.. The kid might say, 'you're momma'... 'your wife look good'... They're [the staff] not reaching the kids... 'cause they now take it personal...I would say they...annoy the kids. What I mean by that- they [the staff] try to protect themselves...where they [the staff] do something they regret...- in other words, the kids done won. Because they done pushed a button of the staff. They [adolescent clients] done won because now they [staff] done said something...to them [adolescent clients]...some staff... they don't have the experience... they're doing a job... they don't fully know the program...When you take it personal, it can lead to the improper language...it go to the extreme... if you're not careful, you can be verbal with the kids, and verbal aggressive...You can curse, you can say a lot of different things... It can be a lot of undertone... I have seen staff say things that they regret they said it. Name calling... 'you weak'...And that's not cool."

This subject describes how failure to make a call for help by the staff can lead to escalated moments with clients:

...they [adolescent clients] not gonna run because they might be.. locked [up] so they decide not to comply to the norms of the rules...They ain't gonna run, but they don't wanna be there. So, they're gonna turn their attention on the staff. Negative attention...the kid say, well, I'm just gonna start [to] pour water [on] the floor, going from room to room slamming doors open...the kid done got some other folks involved...all because he didn't want to be there...So, the staff begin to talk to him. And the staff took it personal. So [the client] have a chair. The staff try to get the chair instead of just calling for somebody, he wanna try to get the chair out of the kid's hands...it escalates. So, the other kids, 'we ain't doing this, we ain't doing that', cussing the staff...they'll go back and forth... The kids- they got worser. They want [to] punch holes in the wall and then the staff called for back-up ...to deescalate the situation. But I think the point was he should've just let the kids alone and called for help immediately...I think it [this escalated situation] happens **a lot** when you deal with kids... A lot of times, personalities don't match...They [staff] go through a process... they call it Crisis Intervention...they talk to the kids, process, and, consequence...there's a role play and gets them [adolescent clients] back in to the routine.... they have to process the incident to allow the kid to understand that 1. You not there for punishment. 2. I want to help you 3. We going do this together...We'll see you through this program.

When asked if he has been in situations with adolescents that escalated, this

paraprofessional supervisor states,

...I believe that's part of the job... by escalation on my part is maybe I got to a point where I felt that I wasn't reaching the kids... I'm 6'5", 300 lbs, got a deep voice... to really get their attention...sign of weakness...I have to raise my voice to get their attention. Let 'em know that it's serious... my size helps me out a whole lot...I don't have to do this as much as the other, [staff]

He also stated "So, when you [are] dealing with, you know, young male, or women, the more passive you [the staff] are, the more they're [clients] gonna take over...They gonna do what they wanna do."

The paraprofessional supervisor supported his staff in utilizing crisis training and calling other staff for help to avert client escalation. He and another respondent also pointed out that newer staff members are more likely to engage in the aggressive rule-enforcement. This subject indicates that not using his physical attributes, including height and a deep voice, would be a "sign of weakness." Furthermore, he states the adolescent clients would take advantage of "passive" staff. However, the same physical characteristics that this respondent uses to emphasize his seriousness with adolescent clients in escalated moments could also be used to intimidate and emotionally harm the clients. As noted in an earlier example, an adolescent client in the same treatment setting as this paraprofessional supervisor reacted with fear when a paraprofessional physically threatened him while enforcing rules. Considering the paraprofessional supervisor oversees the paraprofessionals in this treatment setting, it brings in to question whether the paraprofessional supervisor is promoting a culture of physical intimidation of clients.

In each high-challenge instance related to the enforcement of rules in residential substance abuse treatment settings, the staff reacted to clients' violence by translating this behavior as intentional and disrespectful rather than a skill limitation, and this may have

further inflamed staff. In a study looking at stress in 143 male New Jersey correction officers, these officers reported inmate interactions as the source of their highest level of stress, particularly when violence was involved (Cheek & Miller, 1983). The instances in residential substance abuse treatment settings with adolescent and adult clients did require immediate staff attention and response, yet the staff responses to these situations were strict and forceful, without any room for discussion or understanding of the clients, resulting in high-challenge moments. Bloom (2003) relayed that within an organization, authoritarian versus democratic decision-making may develop a “culture of shaming, blaming, and judgmentalism,” which can become a “culture of toughness and meanness or actual violence” (p. 467). Thus, staff adhering to rigid rule-setting may engage in shaming, such as name calling of clients or physical threats.

In an adolescent treatment setting, it is expected that many of the staff members have backgrounds of recovery from substance abuse, and part of their job duties is to act as role models and provide hope for clients dealing with substance abuse issues. The developmental stage of adolescents must be considered, and rule enforcement should be tailored accordingly. Rule-enforcement requires sensitivity and firmness, not authoritarianism. The goal is to help clients gain relief from anxiety, not add to it. Importantly, staff supervision should involve identification of transference and countertransference (SAMHSA, 1999). As outlined in this section, punitive enforcement of rules can bring about many negative emotions in clients, including shame. The next section will discuss other ways staff elicited shame in clients.

Theme 3: Shaming as re-traumatization

Utilizing shame in a high-challenge moment can result in harm to the client. In the section below, one subject describes an instance in which a client is shamed based on her substance abuse background, and another subject describes a staff member shaming clients through excessive confrontation. The second section discusses the subjects' views and the potential client harm that can result from labeling.

Shaming clients based on their addiction background

Shaming of clients by staff can lead to high-challenge moments. For instance, a residential supervisor has witnessed firsthand these harmful interactions and labeled them as “inappropriate use of their authority as ... a staff member” and relays an incident:

I can recall ... there was the monitor just outright yelling at some of the clients... didn't have any therapeutic value, but ... they were having a difficult day and...there was a lot going on in the unit and they just lost it...on the client...the staff member was yelling at the client and saying, 'you people'... addressing an individual like they were responsible for the other things that had gone on... saying that they were an addict, and, that they lied about things and just, kind of shutting a person down...it was at one person in a room... There were other residents around.

In response to this incident, this subject describes his reaction:

... I'm actually the director here...I felt angry and sad ...I remember talking to the individual [client] at a later point...they hadn't felt heard or believed or valued... And that reminded them of other life experiences that they had had... where people had treated them poorly because... a lot of our people end up, unfortunately, as a result of addiction... getting into... prostitution and things like that. They're very ashamed when they come in to our unit of some of the things that have occurred in their lives... I ended up talking to both the staff member and the client at different points and separate from each other...and the staff member was...embarrassed and they had ... regretted it...I really tried to make a point in working with the individual and the resident, and through their primary counselor to make sure that they did get a sense they were valued in what had occurred was not how we as a team or facility viewed them...unfortunately, this happened here, but that's not how you need to define yourself... I think that they were able to get through that in a way that they were able to cope with it appropriately.

This subject surmises that staff members present during the incident may have been upset, but he hopes that some value was derived from the incident.

In another use of shame by staff members, a master's level therapist in a residential adolescent treatment facility recalls instances that he was made aware of through resident reports in which a paraprofessional group leader, who has a recovery but not a clinical background, told adolescent clients that they are "full of, you know" and asked them if they were "blowing smoke up our butts." According to this subject, the group leader's past experience was with adults with whom, this subject states, he could be more confrontational "without having to worry about the harm." The adults with whom the group leader worked with had substance abuse disorders, and, given the prevalence of trauma with substance abuse in adults, the group leader's highly confrontational technique is questionable despite the subject's stance that the group leader did not need to worry about the harm. Confrontational techniques are not appropriate for those traumatized with domestic violence as they can be interpreted as an extension of the perpetrator's abuse (IDHS, 2005). Thus, it is possible that both the adults and the adolescents could have been shamed and, ultimately, re-traumatized by the strong confrontational approach of the group leader.

The residential treatment director recognized, addressed, and followed-up on the potential for eliciting a response based on past trauma or shameful circumstances in adults. However, the staff member involved in making generalized statements about "addicts" seems to hold similar beliefs as other treatment providers who believe those dependent on alcohol or drugs can stop if they make a greater effort (Edmund & Bland, 2011). Shaming sanctioned by staff members in residential substance abuse treatment settings harms clients and can result in negative generalization of client character traits, which will be discussed in the following section.

Negative client descriptors

Facility staff may utilize negative terms to label clients. This could, inadvertently, create a disparaging view of those the staff members treat. Such terms may create a culture that primes staff to engage in high-challenge moments.

A master's level therapist in an adult residential facility recognizes an overuse of the term "manipulation":

... you need to know the difference between symptoms and behavior, you need to be able to differentiate when someone's abusing your time or if somebody's really needs your time more than what you've been giving. And, there're a lot of therapists who're just not capable of doing ...they feel like ...because they're addicts, they're [the clients are] manipulating all the time and they're lying all the time...they're trying to manipulate me into using my phone or...it's been testing the limits as in pushing the boundaries is what they're used to doing... We implemented the appropriate boundaries to decrease that behavior... if you're dealing with a borderline patient, it's just 'manipulation' is thrown around all the time...It's not being able to look at someone's behavior. It's just automatically labeling the behavior...is this patient pushing ... limits or boundaries or is this patient only needed my time right now? And sometimes that's yes, and sometimes you need to stop what you're doing and work a little bit later so that you can tend to what's going on because if they were capable of dealing with it on their own they wouldn't need an inpatient setting. They'd be in IOP or OP.

While manipulation was seen as a negative term to describe client behavior, a master's level supervisor of a women's unit uses comparable negative terms to actually describe her clients. She points out that staff members will respond "similarly" to the "neediness" as well as the "demanding," "impatient," and "impulsive" nature of the co-occurring population. This supervisor states that clients have a "laundry list of needs they want fixed now" making it difficult for the staff to differentiate between "legitimate" client concerns or a client's desire for "someone to talk to or listen to them," and the female clients on this subject's unit may use their mental health diagnoses as an excuse or "crutch."

These respondents express differing views on the utilization of negative terms to describe clients. Although the master's level supervisor expressed support for her clients,

the use of negative descriptors and a discouraging view of their mental health diagnoses may contribute to a tone within the staff culture to reject resident requests, subsequently leading to high-challenge moments. As clients traumatized multiple times seek help for their issues in a system of care, they receive numerous labels by potential service providers that dehumanize them; they are thus re-traumatized, worsening their attempts to address their issues (Edmund & Bland, 2011).

Clients in high-challenge moments can be vastly distressed by the use of shame and negative labeling, as described by the subjects, with both having the potential to re-traumatize clients. The next theme discusses boundary violations, another way clients can be harmed by staff.

Theme 4: Client harm through boundary violations

One subject states, “...the most therapeutic tool is your relationship with these clients.” When these relationships are damaged, clients can experience emotional harm. This theme looks at high-challenge moments in the form of relationship boundary violations between staff and clients. Strong emotions elicited in staff by clients and difficulty in maintaining boundaries with clients can lead to boundary violations that may cause client harm.

Clients elicit staff emotions

Clients can elicit a range of positive and negative emotions from staff members. In this section, the subjects discuss the emotions that connect them with their clients. Regarding his work with adolescents, one paraprofessional subject states that he has a “passion” for working with teenagers, claiming:

...If you don't care about 'em, don't show up...Emotionally, it's probably too hard a job if you don't care about the kids...You see the hurt in their life, I don't know how you walk away from this.

However, this same subject also describes how clients can elicit negative feelings:

...You get negative feelings when you think the kids are playing it...they're smiling at you and telling you everything you wanna hear. You have a gut feeling that they're just gonna go back to their same life with no intention of changing...and they don't understand that they're gonna live in this hell 'til they get, 'til they wake up and say, I don't believe in using anymore, I don't believe in that lifestyle anymore... and that kinda hurts, but it's their choice...we're responsible for our own choices and our own actions.

One master's level therapist in the same adolescent treatment facility describes his newly found respect for his adolescent clients once he meets their parents.

My clients bring up a lot of compassion. Now, my clients' parents bring up a lot of detest...I get pretty disappointed and frustrated with them...dealing a lot with some of these parents- it's like, are you kidding me, you need to step up to the plate to be the right kind of parent...on the job, usually I can maintain a pretty critical, clinical mindset and realize that it's not the same background as what I've had and come to an understanding that there's not always the same educational status or even a financial status which, all of those things, of course, impact a family upbringing.

He attempts to deal with these feelings by talking to his colleagues and/or his wife without the clients' identifying information.

A master's level supervisor of a women's unit states, "I love our clients," and she describes them as "smart," "funny," and "passionate." However, she also states,

I feel, sometimes, really hopeless. We get people that they have more and more barriers and are more and more indigent every year. So, sometimes, they're kind of hopeless...when they're not acting how I think they should act... then I get a little frustrated and angry. And deal with that by reminding myself that they're doing what they're supposed to be doing which is being early in recovery and a little crazy. So, they're being exactly how they should be. I'm the one who feels like they should be either further than they are or more grateful than they are, or more proactive than they are.

In dealing with these feelings, she states,

I just remember that they're a sick person and if they... had cancer, and were that despondent or not as proactive – I probably wouldn't down them as much for it and as hard.

One master's level therapist describes a range of emotions in dealing with his adolescent clients:

A lot of times, you just feel sorry for them. That empathy- just the situations they've been in, you just can't believe it. But then also, too, when you have maybe a kid with conduct disorder or something, preys on the weak. I definitely get angry about that. I don't have a lot of patience for that. There's definitely anger there too, but, I mean, I guess even at times, you have that fear 'cause you get in a confrontational session with a kid and he gets in anger mode and starts pacing around the room, I mean. Yeah, I guess pretty much every emotion possible. I've felt it.

One paraprofessional supervisor in an adolescent treatment facility responds to feelings elicited from clients with a plan of action:

I believe the feelings in me is... it depends on your make up, your character, your way you view things...I'm very nontolerant on certain cases. A lot of mine's not feelings. A lot of mine is how we gonna do it...the way I feel is if a kid knows to do right and have the potential... when I feel that I believe I can't reach him... something I need to change to reach the kid or I need to stay the same...that's my whole dynamic because I learned early that your feelings... they'll have you crying and have you going home in a rocking chair...you got to have a level of thinking as a young adult...The level of thinking is that... friend is the last relationship. The last. First, you have to initiate this is why I'm here...And I'm gonna help you on time...the level of thinking is pro-active.

Clients in all residential facilities produce a range of powerful emotions in staff respondents. That emotional intensity can fuel a potentially negative interaction between the staff and clients that could escalate into a high-challenge moment. The respondents described several ways of recognizing and coping with their emotions. A master's level therapist deals with his anger regarding his client's parents by trying to understand the differences in the parent's situation versus his own. A master's level supervisor deals with her negative feelings by reminding herself of her clients' stage in recovery and comparing addiction to cancer. While most of these respondents discussed recognition and coping mechanisms, staff members who do not engage in these processes could be at risk for intensified moments with clients that unleash their accrued emotions, leading to high-challenge encounters.

Challenges in maintaining appropriate boundaries

Appropriate boundaries are necessary for good client-staff relationships, and the lack of appropriate boundaries can lead to client harm. One master's level therapist revealed that she has heard of clinicians having "run off" with clients who have relapsed on crack or other drugs. Another master's level therapist comments on the management of her personal issues:

...I've recently been so triggered and I think just my brain is just so not where it should be to the point where any training just kinda goes out the ...window...and I kinda go into survival moment.

This subject recalls an instance in which a client screamed at her, called her a "racist bitch", and made suicidal gestures. She states that she had "quasi-dissociated" and did not call a necessary code for such escalated client actions. Considering the difficulty in managing such triggers, the subject is contemplating leaving the counseling field.

To maintain healthy boundaries, management of personal issues is vital. The emotionally demanding nature of a psychologist's work includes "distress, burnout, vicarious traumatization, and eventually impaired professional competence," and requires a second look at how these professionals care for themselves. These stressors can lead to negative coping strategies such as addictions or the use of clients for emotional support or fulfillment (Barnett, Baker, Elman, & Schoener, 2007, p. 603). On an individual level, some subjects reported consciously keeping their emotional issues and personal lives outside of their jobs as well as maintaining "very rich lives outside of work." One master's level therapist stated, "Therapists have therapists," adding that she goes to her own therapist when her "stuff's getting triggered." Also, treatment facilities have built-in policies preventing staff and clients who are familiar with one another outside of

treatment to be placed on the same unit, and those staff members cannot sponsor clients post discharge.

To foster client-staff relationships, a master's level therapist in an adult residential treatment facility states, "...sometimes, I'll advocate to a fault" in an attempt to empower clients and let them know that they have staff support. She also attempts to develop mutual respect with clients by engaging with them throughout the day, e.g. playing cards. She is also keenly aware of avoiding clinical "jargon" as it is perceived to be condescending. This subject feels that she has to be "direct" and "real" with clients, stating, "...if you don't talk to them like this, they will eat you alive."

Other respondents also feel that the way one communicates with a client factors into the client-staff relationship, and they convey that setting limits are necessary within that relationship. A master's level supervisor for a women's unit attempts to set limits by becoming "parental" and using her "mom voice" at times; however, as she states, she does so without disrespecting the clients. Another master's level supervisor of the same women's residential setting discusses setting limits:

I was that second shift. I was that evening counselor for 5 years at one point... you kind of have to get on top of 'em... sometimes they're not gonna listen unless you kind of speak their language... when we do treatment plans, they say... don't go above an eighth grade education... use the client's language. Well, I don't think it's any different for conflict... I don't know if this is gonna make me sound terrible or not but sometimes you have to say, if you don't knock it off, go pack your shit... they're not gonna hear you otherwise when it's in the heat of the moment... if the clients can read that where they know they can push boundaries. I mean, if you're a drug addict, chances are you're pretty manipulative and know how to read people.

This master's level supervisor points out that it may be equally effective to separate out and talk with clients privately. Thus, she acknowledges two approaches in setting limits, and her personal approach would be to "speak their language." While other subjects have discussed boundary setting as a way to foster relationships, this subject's

response and client descriptor, “manipulative,” may be her justification of past staff-client power struggles. In rejecting the needs of clients with abuse histories, health care professionals engage in boundary violations (Adshead, 1998). Thus, in mirroring the clients’ aggressive language and behaviors as a way to reach clients, the master’s level supervisor may be expressing an intolerance and rejection of client distress. High-challenge moments can stem from the challenge of setting appropriate staff-client boundaries. As the subjects discussed, the challenges may result from lack of awareness staff may have of their emotions elicited by clients, lack of personal awareness, not setting appropriate boundaries within the staff-client relationship, and the manner staff approach clients in escalated moments. Another boundary violation leading to client harm is overidentification discussed next.

Overidentification as a boundary violation

“Perception of another as an extension of oneself” is one definition of overidentification (“Overidentification”, n.d.). A master’s level supervisor comments on staff overidentification with their clients:

I have two staff members where they run everything past their own rules- they’re like, ‘well, I didn’t do this’ or ‘I did that’. Well, that doesn’t matter because that client isn’t you. So, I think with some, I’ve seen that be a hindrance.

Another master’s level supervisor recalls a staff member telling a client what he needed to do for his recovery. This staff member and the client knew each other from a recovery fellowship outside of the treatment setting. This shared experience may have led to the staff member overstepping professional boundaries to direct the client’s recovery.

A master’s level therapist in an adolescent treatment facility discusses overidentification as a tendency seen in newer staff members:

I find that a lot in, maybe, staff members that haven't worked there very long. They start out with that, and they quickly learn...this doesn't really help the cause any. So, I see that kind of dissipate perhaps when we're getting ready to open up another dorm, and so we've hired on a lot of new people... we're seeing some of the adjustment, the cycle that you go through, just learning how the program works... You know, this is my story and my story's worse than your story...

A master's level therapist discusses the possible damaging effects of staff overidentification when dealing with clients in relation to the 12-Steps:

...I do see clinicians and other staff members that do have that [recovery] background where it is very helpful...But I've also seen where it can be kinda damaging...depending on the way that the other staff member utilizes it that it could be damaging because they could have biases based on what worked for them in their own recovery. I've seen this a lot with people...that are not completely receptive to 12 step meetings. I've seen that kind of pushed down people's throats by staff members that are in recovery...versus the staff members that come from more of a clinical background. And that could be very off-putting for the client not only for the therapeutic relationship but it could potentially color their whole perspective of 12 step type of things...

One master's level supervisor discusses how the good intentions of staff members can go beyond the limits of self-disclosure in recovery:

Occasionally, we have had staff people who have kind of used their job as their recovery program, which is inappropriate. So, they'll... come in here and tell their story all the time and talk about themselves all the time... We're not here to talk about us, we're here to have the patients talk about themselves... there's limits to what's appropriate to self-disclose, even about recovery...I had a staff person who works... the weekends. Lovely woman... I'd known her for a real long time and every Monday, I would come in, and the patients basically tell me that she told her story every Saturday and Sunday in group...I think her motive was to inspire...However, the method was inappropriate. And I had to sit down and meet with her and say, you need to stop doing that...I think she thought she was doing a good thing, but... the patients wanted to talk about their own issues.

In the same well-intentioned vein, one paraprofessional respondent relays his extensive recovery background to clients to let them know, "I've been where you're at. It's gonna get better." He states,

... I'm not a trained professional. I just know that I went to a party at the age of 9 and I left it at the age of 44... I'm clean almost 15 years now...My thinking is this. If I can change one young man out of 8 to stop using now...it's a success story...they know that I'm ...not shootin' crap at 'em and tellin' 'em stuff out of a book. I've lived it... I understand what it's like to do three to five thousand dollars a week in drugs. I understand what it's like to have everything and lose everything. I understand what it's like to...call up the electric company and say, what's it take to keep the lights on? I share these stories with 'em, you know...I'm real... I'm not blowin' smoke at 'em. They know that I've been there and done it...I think that they can relate to that...Now, sometimes

they get tired of hearing it 'cause we're here a lot... for 90 days, I probably get 50 groups with any one individually.

The subjects point out that a recovery background is not always necessary to build rapport with clients. Asking about a staff member's recovery status may serve as a "smokescreen" or "avoidance technique" for clients, and inexperienced staff members with or staff members without a recovery background may feel undermined. One subject states that having a similar background is "inconsequential," and, of clients who ask about a similar background in staff, a master's level therapist states, "...Once they get over the denial stage, the different background does not come up a lot." According to White (2000), a history of addiction does not necessarily serve as the only qualification in aiding another's recovery. Imparting experiences of addiction to clients by staff in recovery is only appropriate when the intent is to help clients move toward sobriety.

While the recovery background is a way for staff to model sobriety and provides a way for clients to relate, it is not completely necessary to build rapport. Caregiving by professionals can be maladaptive if the staff is over-involved with the patient, hindering the patient's efforts toward independence (Adshead, 1998). Thus, overwhelming clients with personal methods and stories supersedes individualized treatment, decreasing a client's motivation to recover and leading to emotional harm. In looking at ways to prevent high-challenge moments, staff training will be discussed.

Theme 5: Staff training

Many residential staff members report they lack the necessary training to help them deal with trauma and manage high challenge clients and situations. One subject states, "Some of our best staff have a high school diploma," and others relay that inherent

qualities are only enhanced by education. What is relevant is training. Training leads to increased awareness, and specific trainings in “conflict resolution” and “crisis intervention” have been referenced as useful in high-challenge encounters. Training can prevent staff from yelling at clients and aid in discerning the clients’ sensitive points. However, while training has been described as necessary by most respondents, the appropriate and necessary training may not be offered to the staff members who could benefit the most with respect to client care.

A master’s level therapist describes nursing assistants’ (NAs) lack of knowledge in identifying client clinical symptomatology and subsequent reactivity:

...they’re not clinical... there is not enough training as to how to deal with the population that we have cause even though it’s the forensic unit that’s for drug and alcohol, we also have many cases who’re dually diagnosed... a lot of people who do not understand how to differentiate between behaviors that are symptom related and behaviors that are just behavioral. And a lot [of] patients get punished for symptoms that they’re experiencing... I remember we had a client who was very mentally ill and... shouldn’t have been on our unit, but...on pretty heavy doses of antipsychotics, and was exhausted...our program is you need to be up in the dining hall at 7 at 8:10 for count ... this person is on umpteen milligrams of thorazine. This person’s not choosing not to get up, they can’t get up...you’re expecting him to do something they can’t do and, not only that, you’re punishing them for it...if you’re not at count, you can’t go to the kitchen at night. You can’t have visitors on weekends...they don’t get symptomology, and it’s just all behavioral, they’re all aggressive, they’re all assholes, they’re all this... I remember we just had this guy. He was so nice ...he had very odd social skills and if you didn’t have a connection with him, he kind of make ... looks at you- he’s schizophrenic...odd affects... you guys [NAs] have any idea-why’re you describing symptoms of this... what is it that you want him to do?...if you’re gonna work in the field, you need to be trained.

She describes how the staff members in need of training are not receiving it:

You have NAs on our unit... they have daily interactions with the same population we [master’s level therapists] have daily interactions with. Explain to me why they are not mandated to go to the same training we’re mandated to go to ... customer service training ...the complaints the organization gets about things like this - the majority is coming from the CAs, the NAs, staff who just aren’t trained. Kitchen staff, maintenance staff...

She describes how lack of training can cause problems:

I expect patients to test and to push boundaries and stuff like that- that’s what they’re supposed to do. There is a significant gap between how therapists are trained, clinicians are trained ... as compared to the training that clinical assistants get, nursing assistants get, techs get. And it causes a lot of issues because it causes us more problems cause then we have to put out a lot more fires...I start to wonder if because there’s a lack of training

and a crisis happens, you know, because they're uncomfortable or scared is when they overreact inappropriately. Because they don't want things to get out of control ... if there's a cell phone on the unit... that's not a crisis, but, they'll make it into a crisis ... And I'm sure they're bored out of their minds. So, let's create something to do... They're insecure, and that comes off with trying to be over clinical... wanting to be more involved than [they] really should, sometimes. Or because they have umpteen years clean... I think they misconstrue that as being clinical...

This subject describes how the training required for clinical staff could actually benefit non-degreed staff more, particularly in avoiding high-challenge encounters. This subject also proposes that high-challenge moments also arise when direct-care staff attempt to control crises. In Cheek & Miller's (1983) study, police officers attributed higher stress levels more to inadequate training, lack of communication and problems with supervision than to crisis situations, as they fear doing something wrong. Thus, paraprofessionals may experience high stress levels when they attempt to control crisis situations they are unsure of to compensate for that lack of training, supervision, and appropriate communication.

A master's level supervisor describes a relevant training and approaches that are provided to clinical staff:

Like the Sanctuary Model we're trying to do things, mindful of the impact of all this on a staff so that they stay energized and focused... if we can't see the positive in the people we're working with, we can't bring that out in them. Sometimes that can be difficult. I try to get people to bring different things that they're doing, try to keep them energized, so that people here on the staff can work through it. And I try to do the same. Actually that's a model in my readings that really kind of struck me as something that you could do, and we're not a sanctuary model program...

He also states,

...I don't think that the schools [MSW programs] do a great job in treating or in training people about drug and alcohol addiction, so, there's more on the job kind of training in working with people, and understand what they're seeing in essence to kind of separate out the person from the behavior

In response to whether monitors (non-degreed staff) were included in the incorporation of the Sanctuary Model principles, this subject replied:

It's mostly clinical staff. It would be ideal if it were more than that. We're a smaller facility, and most of the monitors are part-time...it's much more difficult to get them in the same place as a- it's actually almost impossible to get the entire staff in one place at the same time. So that's a real drawback.

From both subjects' accounts, master's level therapists are given training that is supportive and relevant, but possibly redundant. However, both subjects report that relevant training is not provided to non-degreed staff working with the same clients with whom master's level professionals work. Training and information sources are more relevant to treatment interventions than staff educational level (Herbeck, Hser, Yih-Ing, & Teruya, 2008; Knudsen et al., 2003).

Subjects described the potential results of training. A paraprofessional respondent shares his thoughts on the subject:

Emotionally, we have a training that we use to get 'em to try to calm 'em down, talk to them. You know, we give them the option, do you want to talk? ...what we're trained to do- if they don't want to cooperate right now, we leave them alone.

A master's level supervisor describes the beneficial effects of training:

I would say the majority of our clients have fairly significant co-existing mental health disorders coming in of higher acuity as well. And so ... we've had ...our better-trained staff spending time with the lower trained, kind of work on deescalating techniques...And the lower trained staff are not as good at deescalating situations...it's a halfway house, and people have chores and the residents have things that they need to do. So, if somebody is refusing to do their chore...and it's a Saturday morning and the person that I had working is not ...they're highest training would be a high school diploma...a more trained individual may walk in the situation and try to find out why, what's going on that the person who doesn't know what the problem is... and I've seen lesser trained staff just get down to -you need to do this task, and ...then have the situation escalate because they're not understanding what the person's coping with.

Even escalated client behaviors can be seen as a "therapeutic opportunity" to address deeper issues and lead to client change. A master's level therapist explains:

Overall, though, if a client gets escalated, has those emotions get involved, probably, you're gonna have some real issues come out there. I'm sure, sometimes, clients try to manipulate it, pretend like nothing's wrong, but overall, if the client gets emotionally involved, they're the true emotions might come out in that situations and you might actually have therapeutic opportunity.

It is significant that training versus education is emphasized as the needed component in deescalating and preventing high-challenge moments. Training for the direct-care staff that has the most contact with clients is overlooked, making residential substance abuse treatment settings rife with potential for staff-client escalation and harm. Higher levels of training can allow staff to look beyond client behaviors with empathy and understanding. Without training, staff of any educational level will not be able to “separate out the person from the behavior” which can lead to high-challenge encounters.

CHAPTER 9: LIMITATIONS

This study is limited by a number of factors. The majority of the subjects wished to be interviewed over phone which may have limited interview depth by the inability of this researcher to probe upon visual cues (Sturges & Hanrahan, 2004). Saturation of data was not reached which was partly due to the small sample size of nine subjects, and time constraints that did not permit further sampling. Having an uneven number of paraprofessionals and professionals factored into the lack of comparisons between these groups, and subjects reporting on adolescent and adult residential substance abuse treatment settings were included together. Almost half of the respondents were from the adolescent treatment setting in which both paraprofessional respondents were employed, and the remainder of the respondents worked with adults as either therapists or supervisors. Four respondents were from an adolescent residential treatment facility in Tennessee whereas the remaining five were from adult residential facilities in Pennsylvania. Thus, this sample is not representative of all paraprofessionals and professionals in residential substance abuse treatment facilities with respect to the location and the populations they serve. Also, it is unknown what the subjects' motivations were in responding to and participating in this study.

Future Research

Recommendations for future research include a larger sampling size to reach data saturation and to elicit any potential within-group differences, such as gender, training, educational status, or history of addiction. A larger scale study replicating this one would be useful to guide treatment practices and staff training in residential substance abuse

treatment settings. The findings and literature review of this study support a need for additional research in implementing trauma-informed services in residential substance abuse treatment settings and uniform staff training in crisis intervention and conflict resolution. Studies on supervision to help staff of all educational backgrounds feel supported and manage their responses to clients is essential, and examination of the identification, expulsion, and legal consequences of predatory staff members is vital for conducive and safe client treatment.

CHAPTER 10: CONCLUSIONS

This study reveals instances of harm and re-traumatization of clients by staff in residential substance abuse treatment settings, and subjects confirmed the existence of high-challenge moments in residential substance abuse treatment settings. Respondents discussed the pervasiveness of trauma histories amongst clients, but sensitivity to those histories is questionable. None of the respondents reported working in a trauma-informed facility, a cause for alarm as the high-challenge moments involving client trauma content avoidance, minimization of trauma, and misinterpretations of PTSD symptoms may have been circumvented. The absence of trauma-informed facilities in this sample is consistent with the assertion of Courtois & Bloom (2009) of general limited trauma training amongst providers. Staff reports of sexual exploitation of clients and misuse of power has some similarities to Shaw's (1998) description of sadistic abusers in nursing homes. Unfortunately, subjects report some of these abusive staff members having longevity in their treatment settings.

The definition of high-challenge moments presented to subjects emphasized escalated moments resulting in client psychological and/or physical harm. Subjects' responses to witnessing or engaging in high-challenge moments encompassed descriptions of escalated moments and psychological constructs of countertransference, overidentification, exploitation, re-traumatization and boundary violations. Subjects also described potential contributors to high-challenge moments in their discussion of client trauma history, aspects of the residential treatment setting, and staff training. Thus, the scope of responses on the instances defined in high-challenge encounters was broadened.

Results were consistent with the literature that paraprofessionals do not receive enough standardized training or supervision (Giangreco et al., 2001; Nittoli & Giloth, 1997). As discussed in Theme 5, respondents revealed training, particularly for paraprofessionals, is remiss. They are overlooked for needed trainings, and master's level staff who are already trained receive more trainings and supervisory support. This is a regrettable situation as subjects also described paraprofessionals who do receive trainings such as crisis intervention and de-escalation on the job utilize such trainings adeptly. Subjects highlighted paraprofessionals who were untrained or new on their jobs as engaging in high-challenge encounters. These findings echo conclusions of Walter & Petr's (2006) literature review of paraprofessionals assisting children and families in mental health and education in which they conclude training is not sufficiently provided but is necessary for worker confidence and quality of work.

The literature shows paraprofessionals struggle to maintain role clarity (Nittoli & Giloth, 1997). As described in Theme 5, paraprofessionals may overcompensate and respond to unit aberrations in the rules with a need to control. Described in the rule enforcement of adolescent substance abuse treatment settings in Theme 2, a paraprofessional staff threatened adolescent clients who were fighting, and another paraprofessional affirmed his imposing physical characteristics are useful in directing clients. Also, in Theme 5, paraprofessionals were described as not understanding client symptomatology and enforcing rules clients could not meet. This instance may also speak to staff intolerance of the expression of client symptomatology and authoritarianism in residential settings. Authoritarianism can also be seen in an overemphasis of rules as discussed in Theme 2. Respondents described overemphasis of rules in instances such as

a staff member who snatched a resident's food or a therapist's excessive focus on a client's insult to another staff member. In doing so, the staff members involved maintained order, but they emotionally harmed their clients.

The literature denotes harmful countertransference includes negative labeling (White, 2003) and inappropriate maintenance of boundaries (Nittoli & Giloth, 1997; Walter & Petr, 2006). While clients present with many challenges (Courtois & Bloom, 2009; Hanrahan, 2010; Serper et al., 2005), staff may respond to them with shameful labeling (White, 2003). Staff in adult treatment settings often termed clients as "manipulative" referred to in Theme 4. In Theme 2, staff members working with adolescents were described as taking client insults personally, responding with insults, and attempting to deescalate heightened situations without calling for other staff members help.

Many staff working in residential substance abuse treatment are recovering from past substance abuse. While attempting to use their personal experiences of recovery to help, wounded healers may be inclined to overidentify (White, 2003). Reminiscent of the shame tactics of Synanon (White & Miller, 2007), staff in Theme 4 were described as forcing the 12-step program, indicating their stories were 'worse' than their clients,' and sharing a disproportionate amount of their recovery experiences; all of these acts eclipse their clients' needs and lead to harm.

Re-traumatization, threats, and shame are similar to some of the types of abuse elders experience in nursing homes, and nursing home abuse is rising. This is of concern given the similar staff structure to nursing homes. Thus, the confirmation of high-

challenge moments by subjects from this study implores the need for staff training and, consequently, the protection of clients in residential substance abuse treatment.

CHAPTER 11: IMPLICATIONS

Momentum to address the traumatic histories of the majority of children, adolescents and adults receiving services in public mental health and substance abuse treatment systems increased in the early 1990's. As a part of their mission to address women's issues and gender-specific treatment, SAMHSA's Center for Mental Health Services (CMHS) held a conference, Dare to Vision, in 1994 with 350 consumers, practitioners, and policy makers that drove national testing and development of approaches to address trauma and violence. In 1998, The National Association of State Mental Health Program Directors (NASMHPD) held the first national trauma experts meeting and established its position in maintaining trauma as a focus in national mental health policies. The NASMHPD has been involved in several trauma-related documents and in the reduction of seclusion and restraint practices.

Current policies have been influenced by significant studies to include the Adverse Childhood Experiences (ACE) Study and the Women, Co-Occurring Disorders and Violence Study (WCDVS). The ACE Study connected various categories of childhood trauma with mental health issues, social well-being, significant health issues, disability, and death later in life with substance abuse included as a significant risk factor. Findings from this ten year epidemiological study conducted with 17,000 patients continues to influence scientific articles and to impress upon mental health and health professionals the importance of screening clients for adverse childhood experiences. *Crossing the Quality Chasm* Report by the Institute of Medicine in 2001 and the President's New Freedom Commission on Mental Health Report (2003) addressed a

complete change in the delivery of mental health care with the latter focusing on the need to address child traumatic stress. Begun in 1998, the WCDVS conducted by SAMHSA was the first federally supported study to focus on the lack of appropriate services for women with trauma histories experiencing co-occurring mental health and substance abuse disorders, and their children. This study showed interventions are cost-effective, and it influenced evidence-based models with the potential of replication in the public service settings. Several centers addressing trauma emerged.

Individuals involved in the WCDVS study formed the National Trauma Consortium (NTC) in 2003 to help integrate research and practice, disseminate information about trauma to the public and influence policy, and help implement effective approaches for trauma treatment. The National Child Traumatic Stress Network (NCTSN) was created by Congress in 2000 to improve care and access by children and families in the United States to better trauma treatment and to distribute knowledge of evidence-based practices and trauma-informed services to professionals and the public. SAMHSA and the Center for Mental Health Services (CMHS) formed the Center on Women, Violence and Trauma (CWVT) in 2005 to advance state initiatives in developing trauma-informed services and support the leadership of those with trauma backgrounds. Also funded by CMHS/ SAMHSA, the National Center for Trauma-Informed Care (NCTIC) provides free or low-cost trauma training and consultation to publicly-funded systems. Several have been developed to create trauma-informed service systems and organizations, and numerous best-practice trauma-informed and trauma-specific models have been established to help clients (SAMHSA, 2006).

In light of the movement to create trauma-informed care, the occurrence of high-challenge moments in residential substance abuse treatment settings gives rise to discussion of several areas for improvement. The high prevalence of trauma with substance abuse calls for an examination of policies implementing trauma-informed treatment in substance abuse treatment settings. Doing so may allow for standardized and increased staff awareness, sensitivity, and treatment of trauma symptomatology in clients. Staff may discern internalizing versus externalizing PTSD manifestations and guide their responses accordingly. There are several facets to which staff members respond to client trauma symptomatology: level of staff directness; understanding of client impulsivity, anger and aggression; and ability to draw out appropriate responses in clients who minimize their emotions. An understanding of symptomatology can reduce a staff member's sense of helplessness and avoidance in dealing with client trauma and may even prevent vicarious staff traumatization.

Looking at uniform staff training such as conflict resolution and crisis intervention can allow for new and seasoned staff to have the same tools to deal with challenging situations with clients, and it may limit the possible tendency toward overcompensation of missing credentials. Checks on authoritarianism in residential treatment can prevent the over-enforcement of setting rules particularly as they relate to diminishing client crises to maintain order. Instead, an emphasis on individual staff supervision is needed to provide support to overwhelmed staff and encourage them to discuss issues surrounding transference and countertransference. Supervision can help a staff member conceptualize a client's drug and alcohol issues without shaming labels, and it can encourage the use of staff skills versus a reliance on their potentially imposing

physical characteristics to manage clients. Supervision may also ward against staff-client boundary violations in monitoring the intensity of staff-client relationships and overidentification.

Increased dependence on client reports and security cameras is needed to ensure the emotional and physical safety of clients while in treatment. However, predatory staff are found in facilities aiming to heal, and they re-traumatize vulnerable clients already agonizing from past trauma and shame from addiction. Once caught, the outcome of their violations is unclear. While better hiring practices may prevent such staff from entering residential substance abuse treatment settings, it is also absolutely vital to have in place a staff protocol that efficiently identifies signs of client abuse and results in consequences that include legal prosecution. Ongoing research into the existence of, prevention and treatment of trauma and re-traumatization of drug and alcohol patients is an essential next step.

The potential for client harm can impact social work practice for residential substance abuse treatment on micro, mezzo, and macro levels. Direct care practitioners may tailor the treatment planning of clients with abuse histories to include ways to maintain emotional and physical safety while in treatment. Social workers in supervisory roles may hone in more closely on harmful countertransference and power struggles their supervisees may have with clients. Lastly, macro level social work practitioners can enact policies and laws to prevent client re-traumatization specific to such settings. If utilized effectively, the range of roles accessible to social workers and their collaboration can significantly enhance the quality of residential substance abuse treatment upon which vulnerable clients are so reliant.

APPENDIX A

Consent Form Intensive Semi-structured Interview

Research Project Title

Comparing and understanding paraprofessional and professional approaches to and interpretations of high-challenge moments with clients in residential substance abuse treatment settings.

Introduction

The researcher is a graduate student in the DSW Program at the University of Pennsylvania School of Social Policy and Practice.

Purpose

The study intends to look at paraprofessional and professional responses to and interpretations of high-challenge moments with clients in residential substance abuse treatment settings.

Involvement

The interview is expected to last approximately 60 minutes. The researcher will make an audio recording of the interview and will take written notes. The researcher will be asking how the participant has responded to and interprets the impact of challenging moments with clients in residential substance abuse treatment settings.

Confidentiality

The information you share will be kept strictly confidential. The researcher will not share information about whether or not you participate in this project with anyone. The researcher will never use your name, personal information or information about where you live or work in the write-up of the interview.

Nothing with your name or other identifying information (names and places mentioned in the interview) will be turned in to my Dissertation Committee. The researcher will be the only one to listen to the audio recording. A transcriptionist will hear the audio recording should a transcription service be used. Once the researcher has analyzed the interview and written her dissertation, the audio recording, interview, notes, and interview transcript will be destroyed. Identifying information including geographic locations and names of particular individuals you might mention in the interview for the dissertation will be removed. Any documents you sign, where you can be identified by

name will be kept in a locked drawer in Annapoorna Ayyagari's home and will be kept confidential.

The research team will make every effort to keep all the information you tell us during the study strictly confidential, as required by law. The Institutional Review Board (IRB) at the University of Pennsylvania is responsible for protecting the rights and welfare of research volunteers like you. The IRB has access to study information. All the documents will be destroyed when the study is over.

Risks of participating:

The risks of participating are minimal. The ways that confidentiality will be protected have already been described. In the unlikely event that you find what you discussed in the interview is upsetting to you after it is over, please let the researcher know so that she can provide names and numbers of resources that may be of further assistance.

In the event you are injured, the care needed to treat injuries directly resulting from taking part in this research will be covered. If appropriate, your insurance company or other third parties may be billed for the costs of the care for your injury, but you may also be responsible for some of them.

There are no plans for the University of Pennsylvania to pay you or give you other compensation for the injury. You do not give up your legal rights by signing this form.

If you think you have been injured as a result of taking part in this research study, tell the person in charge of the research study as soon as possible. The researcher's name and phone number are listed in the consent form.

Benefits of participating:

Although being a part of this interview will not help you directly, it is possible your sharing on the study's topic may be rewarding.

Compensation:

If you decide to participate, you will be given a **\$10 gift card** upon the completion of the interview. There are no costs associated with participating in this study.

If you have questions about the project after the interview is over, please feel free to contact me:

Annapoorna Ayyagari
Cell: (856) 630-1592
E-mail: aavyag@sp2.upenn.edu

Your participation is completely voluntary.

You do not have to participate in this project. There will be no negative consequences if you decide not to participate. Any program or agency that you work with will not know

whether you participate or not. If you do not participate, it will not affect your job or anything else.

If you do decide to participate in the intensive interview today, you can decide leave at any time. You can also refuse to answer questions you would not like to answer.

The study may be stopped without your consent for the following reasons:

- The PI feels it is best for your safety and/or health-you will be informed of the reasons why.
- You have not followed the study instructions.
- The PI, the sponsor or the Office of Regulatory Affairs at the University of Pennsylvania can stop the study anytime.

Your consent for this study is confirmed by your actual participation in the interview. Thus, signatures from you or the researcher have been waived for all interview formats: in-person, phone and Skype. However, the researcher is available prior to the interview to answer all of your questions to your satisfaction. Please ask the researcher to explain anything you do not understand, including any language contained in this document. You may ask to have this document read to you.

APPENDIX B

Letter of Contact

Dear Potential Participant,

This letter is to invite you to participate in a study that will contribute to a dissertation. I am a doctoral candidate in the Doctorate in Clinical Social Work Program at University of Pennsylvania School of Social Policy and Practice, and I am interested in gaining a better understanding of how paraprofessionals and professionals approach challenges clients present in residential substance abuse treatment settings.

Your expertise as a clinical staff member in such settings is sought as there is not much known in this area. If you decide to participate, you will take part in a one-hour individual interview which will remain completely confidential. Participation can take place in person, over the phone, via Skype, and via e-mail. Upon completion, you will receive a \$10 gift card. Please remember that both counselors and paraprofessionals (psych techs, peer counselors, etc.) are invited to this study.

Please feel free to ask any questions that you have about participating at any time as I would like for you to have the information you need to make a decision best for you. Please note that although I will be available to answer questions via e-mail, your confidentiality cannot be ensured if you use a work e-mail address as most work environments save e-mails independently. I look forward to hearing from you soon!

Sincerely,

Annapoorna Ayyagari

Cell #: (856) 630-1592
aayyag@sp2.upenn.edu

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