



The Center Page

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Empirically Supported Treatments for Behavioral Health Problems

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The Center for Behavioral Health's strong commitment to offering high-quality, effective treatments is made evident by its longstanding *Policy on Treatment Efficacy*, which states the Center "shall operate only those mental health treatments, services, and programs for which there exists *evidence in the professional literature of their efficacy*." In a continuing effort to provide only the best possible treatment services, the Center strives to identify, effectively implement, and routinely monitor the effectiveness of *empirically supported treatments* (also known as *research-based treatments*, *evidence-based treatments*, and *scientifically supported treatments*).

What are empirically supported treatments (ESTs)? Empirically supported treatments are specific interventions (i.e., therapy techniques or psychiatric medications) that have been scientifically tested and determined to meet rigorous scientific criteria for effectiveness for particular behavioral health problems.

Why is it necessary to identify ESTs? More and more studies now conclude that there are treatments of choice for particular mental health problems, just as there are best treatment practices for specific physical health problems such as diabetic and cardiac disorders.

How do ESTs differ from other mental health treatments?

Whereas ESTs have been scientifically tested and have objective evidence indicating they work, the effectiveness of other mental health treatments tends to be unreliably determined by the subjective impressions of the therapist and client. ESTs are also unique in that they tend to be short-term treatments that are delivered by using a highly structured treatment protocol, usually detailing the specific treatment goals, content (such as cognitive and behavioral skills), and client assignments to be covered during each session. Unlike most conventional mental health treatments, ESTs emphasize the importance of monitoring the effectiveness of these treatments with each client and in each treatment setting.

From a scientific perspective, what are reliable indicators that a client is getting better, or that treatment appears to be working? To be diagnosed with a mental health disorder, a client has to meet specific symptom criteria (e.g., panic attack frequency, duration, and severity) and has to be experiencing significant emotional distress (e.g., anxiety, depression, or anger), and/or impairment in social or occupational functioning (e.g., poor work or school performance, incompetent parenting, marital discord). Therefore reliable indicators of client change or improvement are substantial, measurable reductions in symptoms, distress, or functional impairment.

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Behavioral Medicine—A Partnership



Leslie Robison, Ph.D.

Many people are familiar with the term “behavioral medicine” but are unsure of what it actually is and how it is of relevance to CBH. The following is my overview of what behavioral medicine is and how it contributes to the mosaic of mental health services.

In general, behavioral medicine is a field of study that encompasses physical medicine and psychology. Traditionally, the two areas have been viewed as mutually exclusive. Many of us learned about the mind-body dilemma and the antiquated idea that the mind and body are two separate entities within a person that have little interaction. Although few people today believe that the mind and body are independent of one another, providers are still trained to treat either physical illness or mental illness separately—with the possible exception of psychiatry. A dilemma arises for many providers when confronted with a person who has a physical illness that creates problems in their life, or when mental illness prevents them from being able to care for their physical illness.

Behavioral medicine tries to address this dilemma by focusing primarily on the psychological and behavioral factors that adversely affect the course of a medical condition. Extensive research has found that psychological and behavioral factors may significantly impact many medical conditions including diabetes, dermatological disorders, gastrointestinal disorders, cardiovascular disease, renal disease, oncological disease, neurological conditions, and pulmonary and rheumatologic disorders. There are numerous ways in which psychological and behavioral factors can impact physical illness:

Psychiatric disorders may complicate a physical illness. For example, major depression leads to decreased motivation and self-care. Thus, a person with major depression and diabetes may be less likely to monitor their blood-sugar levels and/or put forth the effort needed to maintain a healthy diet. Major depression has been found to be a leading culprit in the complication of many illnesses including heart disease, multiple sclerosis, and Parkinson’s disease.

Personality styles may influence the onset and course of a disease. There are personality traits that can impact the course of an illness. For example, research has found that hostility, a component of the well-known Type A personality, is a good behavioral predictor for cardiovascular disease. Personality styles can also impact physical illness by affecting the patient’s relationship with their health care provider. Certain personality characteristics can interfere with the relationship making it difficult for the person to obtain and/or work with a medical provider. One such characteristic is known as *pathologic denial*—when a person denies the presence or seriousness of a physical problem to the degree that it prevents them from seeking needed medical services. Conversely, some personality traits aid treatment, such as *healthy denial*—when a person may deny the

Behavioral Health, continued...

full extent of their physical illness but is still motivated to seek treatment so he or she can “recover” completely.

Psychosocial factors may influence medical and psychiatric outcome. Limited social support, social isolation, and limited socioeconomic resources can lead to increased stress levels. In turn, as many of us know, increased stress can adversely affect a person’s health and/or their ability to connect with needed services. An example: research has shown a very interesting relationship between relaxation and the response to cancer treatments. A study was conducted comparing two groups of cancer patients. One group received chemotherapy and the second group was taught relaxation in conjunction with chemotherapy. In comparison to the group who received chemotherapy alone, the relaxation group appeared to have a better response, a lower mortality rate, and fewer recurrences of the cancer.



Other psychosocial factors affecting health treatment outcomes include *maladaptive health behaviors*. These are behaviors that we know are unhealthy but we still do regardless of “knowing better.” These include cigarette smoking, alcohol and/or drug use, overeating, and a sedentary lifestyle to name a few.

Mental health providers who practice within the field of behavioral medicine are presented with the challenge of determining the relationship between the physical and the psychological. The nature of this relationship can determine the type of intervention needed. Interventions vary widely and include:

- a. treatment for a co-morbid (co-existing) psychological disorder(s),
- b. facilitating adjustment to a chronic illness,
- c. teaching behavioral management of symptoms, and
- d. assisting in treatment planning in order to enhance adherence to a treatment regimen.

Challenges for Providers

Collaboration. Regardless of the exact nature of an intervention, one key factor in successful management and treatment of physical and psychological illnesses is the *collaboration of all providers*. When the physician and mental health provider are working together with the person towards a common goal, a positive outcome is more likely. In addition, this collaboration may decrease the impact of a person’s problematic personality traits (if present) on treatment.

Time. Another challenge for behavioral medicine is *time*. In contrast to many medical interventions, behavioral interventions typically take more time to become effective. Clients and providers need to be persistent and patient with respect to symptom improvement. Many techniques and skills require time and practice to become effective. Given appropriate time, these interventions can lead to improved quality of life for the individual and decrease over-utilization of medical services. Thus, these treatments can be more cost effective for both clients and providers.

We may need to expand our thinking about treatment so we (mental health providers and physicians) become even more collaborative in our work. As the fields of physical medicine and mental health become increasingly focused on treating the whole person, behavioral medicine will continue to grow as a field.

David Spiegel, M.D. (1995) summed up the field of behavioral medicine perfectly with the following statement, “...a sound body may be, in part, the product if not the home of the sound mind.”

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*Principles of Effective Drug Addiction Treatment**



Drug addiction is a complex illness. It is characterized by compulsive, at times uncontrollable, drug craving, seeking, and use that persists even in the face of extremely negative consequences. Drug seeking becomes compulsive, in large part as a result of the effects of prolonged drug use on brain functioning and, thus, on behavior.

Because addiction has so many dimensions and disrupts so many aspects of an individual's life, treatment for this illness is never simple. Effective treatment programs typically incorporate many components, each directed to a particular aspect of the illness and its consequences. Not all drug abuse treatment is equally effective. Research has revealed a set of overarching principles that characterize the most effective drug abuse and addiction treatments and their implementation. The following

summarizes the overarching principles that characterize effective treatment:

1. **No single treatment is appropriate for all individuals.** Matching treatment settings, interventions, and services to each person's particular problems is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.
2. **Treatment needs to be readily available.** Because individuals who are addicted to drugs may be uncertain about entering treatment, taking advantage of opportunities when they are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not immediately available or accessible.
3. **Effective treatment attends to multiple needs of the individual, not just his or her drug use.** Treatment must address drug use and any associated medical, psychological, social, vocational, and legal problems.
4. **An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.** It is also critical that the treatment approach be appropriate to the individual's age, gender, ethnicity, and culture.
5. **Remaining in treatment for an adequate period of time is critical for treatment effectiveness.** Research indicates that for most patients, the threshold of significant improvement is reached in about three months of treatment.
6. **Counseling (individual or group) and other behavioral therapies are critical components of effective treatment for addiction.** In therapy, patients address issues of motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding non-drug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relations and the individual's ability to function in the family and community.
7. **Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.** For patients with mental disorders, both behavioral treatments and medications can be critically important.
8. **Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.** Patients presenting either condition should be assessed and treated for the co-occurrence of the other type of disorder.
9. **Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.** Medication detoxification safely manages the acute physical symptoms of withdrawal associated with stopping drug use. While detoxification alone is rarely sufficient to help addicts achieve long-term abstinence, for some individuals it is a strongly indicated precursor to effective drug addiction treatment.
10. **Treatment does not need to be voluntary to be effective.** Strong

Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.

Drug Treatment, continued...

motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can significantly increase both treatment entry and retention rates and the success of drug treatment interventions.

11. **Possible drug use during treatment must be monitored continuously.** Lapses to drug use can occur during treatment. The objective monitoring of a patient's drug and alcohol use during treatment, such as through urinalysis or other tests, can help the patient withstand urges to use drugs. Such monitoring can also provide early evidence of drug use so the individual's treatment plan can be adjusted. Feedback to patients who test positive for illicit drug use is an important element of monitoring.
12. **Treatment programs should provide assessment for HIV/AIDS, Hepatitis B and C, Tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place themselves or others at risk of infection.** Counseling can help patients avoid high-risk behavior. Counseling can also help people who are already infected manage their illness.
13. **Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.** As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. Participation in self-help support programs during and following treatment often is helpful in maintaining abstinence.

According to several studies, drug treatment reduces drug use by 40–60 percent and significantly decreases criminal activity during and after treatment. However, individual treatment outcomes depend on the extent and nature of the patient's presenting problems, the appropriateness of the treatment components and related services used to address those problems, and the degree of the patient's active engagement in the treatment process.

*Excerpted from the National Institutes of Health (NIH)'s Research-based Publication No. 99-4180; printed October 1999.



Center Profile



Gregory Sidell, M.D.

Gregory Sidell, new Center psychiatrist and native Hoosier, attended Indiana University, graduating with a BA in French and a BS in Biochemistry in 1982. He soon added an MD (from IU-Indianapolis in 1998) to his credentials; married Carol, his Bloomington sweetheart; and began a practice (and a family) in Ann Arbor, Michigan. The Sidells relocated to Waterville, Maine and welcomed a second child into the family before Bloomington's allure (and the nearness, here, to relatives) called them back.

Licensed to practice psychiatry and geriatric psychiatry in both Maine and Indiana, Sidell joined the CBH staff in October 2000. "It's good to be back...these days my priorities are to keep everything balanced, with a life outside work, and I can do that here."

Greg enjoys the friendly work environment at CBH and hopes to increase team camaraderie by broadening psychiatric discussion group opportunities. "If I have a tough patient, I have the option of referring to another psychiatrist to get a second opinion. I've worked with three other mental health centers, and this is, by far, the most comprehensive and clinically adept. They do have a clinical load to deal with and financial concerns must be met, but I'd say within those constraints, this is a very humane place!"

Welcome Greg.



What's New in Schizophrenia Treatment?



Mark Hickman, Ph.D. & Linda Groce, BSN, RNC

In 1998, *Schizophrenia Bulletin* published a critical study of schizophrenia treatment. The report indicated that over half of the two million Americans with schizophrenia fail to receive adequate care. In addition:

1. Schizophrenics received inappropriate dosages of antipsychotic medications in about two-thirds of the cases studied.
2. Despite the fact that 15% of schizophrenics commit suicide, fewer than half of depressed schizophrenics received antidepressant medications.
3. While 75 to 80 percent of schizophrenics studied had significant side effects, only half of these received medications to address the side effects.
4. Blacks with schizophrenia were overmedicated twice as often as were whites.
5. Less than 10 percent of families of persons with schizophrenia received education and supportive services, despite the fact that research has shown that education improves clinical outcomes.
6. Vocational rehabilitation was available to only 22.6 percent of adults with schizophrenia.
7. Fewer than 10 percent of persons with schizophrenia were involved in assertive community treatment programs, despite the fact that such programs are effective in preventing relapse and hospital recidivism.

Everyone from behavioral scientists to cognitive scientists, from psychosocial theorists to rehabilitation specialists, and from the National Alliance of the Mentally Ill to medical journals, is writing about schizophrenia. New treatments all focus on empowering the client as an active part of the treatment team. Specifically, groups like the National Alliance for the Mentally Ill (NAMI), in cooperation with a growing number of social scientists, assert that:

- Our carefully designed treatment goals are of little value unless the client wants to achieve those goals.
- All people are more invested in plans that they, themselves, helped to build.
- Clients who go for prolonged periods of time without feeling better will lose hope, and treatment compliance declines.

This focus on treatment goals as plans that are embraced by the client, with the therapist having responsibility for increasing motivation, is not unlike the innovative approaches of William R. Miller (1992) to the treatment of addictions. Miller proposed that our rigidity in defining goals for clients (e.g. insisting on a goal of full sobriety) may block our opportunity to help many people—like those with less severe alcohol problems who might be able to achieve controlled drinking, as well as those who need a goal of sobriety, but won't be able to accept that until they have experienced failure in a controlled drinking plan.

Similarly, E. Fuller Torrey (1983), a leader in modern schizophrenia treatment, used the example of alcohol to illustrate the importance of client endorsement of treatment goals. Torrey challenged the way clinicians approach the issue of alcohol use in people with schizophrenia. He noted that some schizophrenics who are able to achieve controlled amounts of drinking may actually experience beneficial effects, and that we only undermine our own credibility with the client when we make dire predictions about alcohol use that don't turn out to be true for the specific client. With the focus on treatment goals endorsed by the client, Torrey also observed that it is likely that different mentally ill abusers will need different treatment goals, especially if the alcohol abuse is limited in scope and effect. He advocated for such different treatment goals for the mentally ill, noting that abstinence may be neither achievable nor essential for some mentally ill clients.

Carlo Perris (1989), in exploring the benefits of cognitive therapy for people with schizophrenia, emphasizes that goal-setting is a collaborative task for the therapist and patient. Again, the usefulness of the goals depends on the client's endorsement of those goals.

We will review several treatment areas:

Medication Therapies—Today, there is scientific evidence for all drug therapies of schizophrenia, which has led to more successful treatment for many severely ill people. This has also led to more effective and predictable drug effects, fewer side effects, and better medication compliance. Research has identified drugs that will help *many* of the people with a specific mental disorder, but this same research has also demonstrated that *some* people are not particularly helped by these same medications. For many people with severe mental disorders, the most successful outcomes follow comprehensive treatment that combines psychiatric/medication with behavioral/psychosocial approaches.

Psychodynamic Therapies—Research on various psychodynamic therapies in the treatment of schizophrenia has usually shown these therapies to be ineffective, and sometimes detrimental, to persons with schizophrenia. Incidentally, the first person to observe that insight-oriented therapies would not be effective for people with schizophrenia was Sigmund Freud himself.

Low-Structure Therapies—Clients with schizophrenia have not done well in unstructured treatments such as therapies that expect the client to assume responsibility for the direction of treatment. While it is useful to engage the schizophrenic client in therapeutic decisions with the clinician, loosely-organized approaches have been unhelpful, and sometimes detrimental.

Confrontational Approaches—Studies have shown an *increase* in symptoms among schizophrenic and schizotypal clients who are placed in traditional addictions treatment programs. The confrontation, expressed emotion, and social/communicative demands of these programs are inconsistent with the vulnerability to stress and social deficits of most clients with severe mental disorders.

Post Traumatic Stress Treatment Protocols—Schizophrenics, like any other person, can have the effects of prior trauma. Research indicates that in such cases, symptoms relating to the trauma may be helped with PTSD treatment protocols. However, such treatment does *not* help with the person's symptoms of schizophrenia.

Psychosocial Interventions—Much success in improving the schizophrenic's life skill functioning and adaptation to community living has been achieved through psychosocial interventions, such as assertive case management, life skills training, partial hospitalization programs, and assertive community treatment (ACT) models.

Cognitive Therapy—Aaron Beck, along with The Beck Institute for Cognitive Therapy and Research, is investigating the effects of cognitive therapy in the symptoms of schizophrenia.

In cognitive behavioral therapy applied to psychosis, the therapist teaches the individual to recognize and modify false beliefs and distortions in processing information, which can reduce distress and enhance coping. Clients are taught to regard their beliefs as hypotheses to be tested. Cognitive behavioral therapy of psychosis aims to help the individual with an understanding of psychosis, improved coping, self belief, and motivation to regulate behaviors. To accomplish this, the therapist teaches coping strategies (e.g. questioning voices or distracting techniques), setting reasonable and achievable next-step goals, modifying delusional beliefs by considering alternative explanations, and modifying dysfunctional assumptions about self which would otherwise lead to self-defeating behaviors.

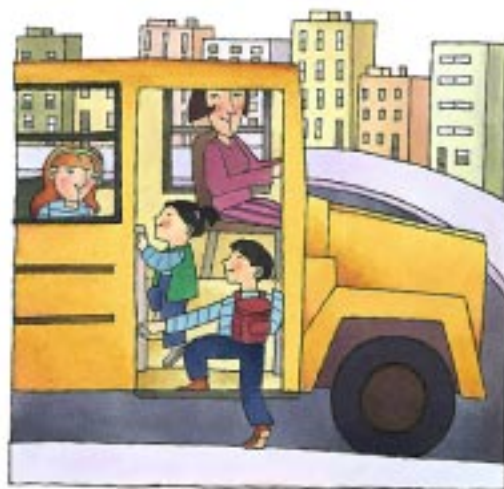
Reasonable Next-Step Goals

If we start with the premise that no one wants to offer unsuccessful treatment, it behooves the clinician to be sure to set achievable goals. To harness the reinforcing power of success in treatment, we must be sure that we have a plan with which the client can succeed. If the client presents a goal that is too big (i.e., the client is likely to fail instead of succeeding), part of your expert clinical services will be to help the client break that bigger goal into steps that can be accomplished.

Grandiose-Therapist Goals

Pam will have no auditory hallucinations.

Note: Are you magic?



(See "SMI," page 8)

SMI, continued...

Reasonable Goals

Pam will use relaxation strategies to calm herself during hallucinations, without prompting.

Is Treatment Working?—Outcome Evidence

Fuzzy Goals

John will have improved self-esteem.

Note: This goal is fuzzy because two people could disagree about whether the goal was achieved.

Clearer Goal

John will have improved self-esteem as evidenced by him verbalizing three things that he likes about himself at each session.

Note: This goal is clearer than the fuzzy goal because two people can agree about whether the “as evidenced by” part of the goal was achieved, even if they disagree about how to define a concept like self-esteem.



This is an exciting time; research continues to progress in medical and behavioral treatments of schizophrenia. Clinicians who stay abreast of new findings can offer the best treatment to severely disabled clients.

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ESTs, continued from page 1

What is the most objective and reliable way to track change that occurs over the course of treatment? The most accurate method is to administer a psychological instrument, or outcome measure, before treatment begins and after the client completes treatment. Such an instrument must be appropriate—relevant to the particular treatment, and psychometrically sound—research-based with high reliability and validity. These instruments ask clients to report the type, frequency, and severity of the symptoms they are experiencing.

How is the significance of a client's clinical change determined? To judge the significance of a client's change over the course of treatment, both the statistical and clinical significance of the improvement are examined. A clinical change is determined to be *statistically significant* when statistical analysis indicates the change is very unlikely to have happened by chance alone. An improvement is considered to be *clinically significant* when it is determined to be a meaningful amount of change. One method of determining clinical significance is to examine how a client's post-treatment functioning (such as the frequency and severity of panic attacks) compares to that of a person with normal functioning (no or very few panic attacks).

How do researchers determine whether a treatment works in a real-life setting? It is first essential to test it in a *treatment efficacy study*. Treatment needs to be scientifically tested under ideal, controlled conditions to determine whether there is any possibility of it working, and to rule out possible causes of improvement other than the treatment. Once it has been determined that a treatment will work under ideal conditions, the next step is to test it in a *treatment effectiveness study* to see if this treatment will also work with real-world clients in a real-world setting. In treatment effectiveness studies, the treatment is offered in a typical treatment setting, by typical providers (unlikely to be highly trained or closely supervised), to typical clients (a greater number of low-functioning clients with multiple problems and diagnoses). Researchers use a benchmarking strategy to gauge the treatment group's level of improvement. That is, the average improvement of the treatment group can be compared to the average score of the control group in the treatment efficacy study.

Many researchers and research-informed mental health professionals would argue that we have a professional and ethical obligation to provide treatments of known efficacy, and that the most objective and reliable way to determine treatment efficacy is by testing treatments in controlled research studies. Providing ESTs greatly increases the likelihood that clients will be effectively and efficiently treated. As a result, clients are more apt to be satisfied customers and insurance companies are more likely to reimburse for services. Finally, providing ESTs is rewarding for the therapist because they see first-hand what an incredible difference these treatments make in clients' lives.

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Computer SITES

Society for a Science of Clinical Psychology
<http://pantheon.yale.edu/~tat22>

APA's Society of Clinical Psychology
www.apa.org/divisions/div12/rev_est/index.shtml

Psychological Corporation's *Therapy Works*:
www.psychcorp.com/sub0300/twrk.html

Society of Behavioral Medicine
www.sbmweb.org

National Institute of Mental Health (Fact Sheets):
<http://www.nimh.nih.gov/publicat/schizoph.htm> and
www.nimh.nih.gov/publicat/schizsoms.cfm

National Institute on Substance Abuse
www.nida.nih.gov

Information on the National Alcohol & Drug Addiction Recovery Month (September 01):
www.health.org/recoverymonth/2001



Aboriginal South Central Indiana Culture

Mark Hickman, Ph.D.



When I first heard that the Center's Cultural Diversity Committee was targeting "aboriginal Hoosiers" as a culture to understand, we had some laughs as Sandy Pate and I defended our local roots and speculated about just what all of you immigrants to our four-county area were implying. But, I have concluded that the Committee has a sound plan. We *do* have local cultural factors that are important considerations in accurate communication, therapy, and cooperative work.

First, some disclaimers: (1) Bloomington is a transient city, with people living here from every country on the planet. Aboriginal Hoosiers living within Bloomington city limits are quite accustomed to cultural differences, even if the aboriginal values remain at the core of our personalities. (2) Because Bloomington is so transient, don't presume that everyone living there is a dyed-in-the-wool Hoosier. (3) There are multiple Hoosier cultures, relating to European migration paths in Indiana during the early 1800's. (4) Although the current south central Indiana culture is of interest, we should always remember that the true aboriginal Hoosiers are the Native Americans who lived here for centuries before Euro-Americans arrived.

Regarding the specific Hoosier culture in our catchment area, we are talking about a group of people, mostly from Great Britain and Germany, more recently from the Carolinas, who braved the dangerous wilderness in the 1770's to 1790's to seek new opportunities in Kentucky. There were many casualties among these pioneers, with dangers ranging from bears to fighting coalitions of British Soldiers and Native Americans that the British incited to violence against the settlers *after* the conclusion of the Revolutionary War. Many pioneers were victims of the Kentucky Fort Massacres of the 1780's and some of the survivors of the massacres were marched northward by their captors and held captive in Detroit.

However, most of these sturdy settlers eventually found their way back to Kentucky and began a steady migration into southern Indiana, even before the Indiana Territory was formally open for settlement by Euro-Americans. This group of explorers entered Indiana through Clark, Jefferson, and Harrison Counties (including what is now Floyd County), and fanned out into what is now Crawford, Washington, Lawrence, Jackson, Orange, Brown, Monroe, Greene, Owen, and Morgan Counties. Southern Indiana was a hilly, deciduous forest in those days (the rolling hills preserved because the last glacier stopped just south of Indianapolis), so establishing farms was grueling work. Those of us whose families have been in these counties for several generations descend directly from those stalwart Kentuckiana pioneers. Our ancestors were at the same forts and stations as Daniel Boone. Understanding this history makes sense of some cultural values that are prominent among us locals. These prominent (to a fault!) values include (1) privacy, (2) egalitarianism, and (3) work ethic.



PRIVACY—Our ancestors lived in a world where death was always just around the corner. Every one of the pioneer families experienced untimely deaths in the Indiana wilderness. But, being a determined people, our ancestors staked their claims to 160-acre parcels of land and depended immensely on the resources within the immediate family. The hard-earned homes and farms were something to be cherished and respected.

A culture of respecting home evolved. An illustration of this can even be seen in close family relationships. My 80-year old father and I are very close, but he always calls me before he visits, to see if it's a good time. It's not that I wouldn't welcome him anytime—it's his way of conveying his respect for me, given the local cultural privacy value. Perhaps the biggest culture shock we locals feel regarding this privacy value occurs when we are

Indiana Culture, continued...

dealing with people from the east coast big cities. Don't be surprised if our eyebrows rise in disbelief when you ask us about our surgery, about our relatives, or about our political beliefs. Personal talk about oneself happens after a trusting close friendship develops over time. Otherwise, local culture would dictate that, "if I want you to know, I'll tell you." And, out of loyalty (because once that gradual friendship develops, it's solid), that applies doubly to your questions about our relatives and friends.

What does this prominent privacy value imply for a health clinic? Conveying respect for privacy is going to be important in collegial and therapeutic relationships. If appropriate therapeutic boundaries are clarified, the formal relationship will be a context in which personal details can be discussed as needed. If you respect the fact that it is your local clients' decision what they want to share with you, they are likely to respond to your respect of their privacy by being more open with you.

EGALITARIANISM—There is no greater indicator in south-central Indiana culture that someone is unworthy of our time and attention than for that person to act as if he/she is entitled to special privileges based on wealth, position, heredity, education, class, accomplishment, physical appearance, etc. It took intense cooperation for people to survive in the early Hoosier farm communities. They were living in a world of having to clear dense forests in order to farm (with the other option being starvation), death by wild animals being all too common, and massacres that continued long after the revolutionary war was formally ended. Having a person around who thought he or she was above the grueling tasks was, in fact, a dangerous liability. This doesn't mean that locals don't respect accomplishment. Accomplishment is great, but a sense of entitlement is seen as arrogant and uncivilized. Accordingly, the most respected people in local societies are those who complete great accomplishments, but minimize them, with their modesty demonstrating that they understand their good fortune doesn't make them better than anyone else.

Implications for a health clinic? Approach your local clients by respecting the expertise that they bring to the appointment. You are the expert on therapeutic technique, while your clients are the experts on what they feel, what they believe, what they want, and what they know. They are also the experts in determining whether or not your treatment is working for them.

WORK ETHIC—Arising out of the same survival realities that made self-important people a dangerous liability in early local communities, lazy people were also a threat to the survival of the group. Although the dangers from bears and massacres from Native Americans incited by British soldiers is past, it was not very long ago that hard work on the farm was the only way to eat. There remains entrenched in the local culture a strong work ethic value. The value of one's work is central to the value of the individual—whether that be work on a job, or work in the home. Many of our seriously disabled clients feel shame about accepting "welfare," such as Medicaid or Social Security. Such clients need reassurance that their eligibility for disability does not reflect any decisions that they made. And, they need for you to understand how very painful this dilemma may be for them as they have been reared in a culture where their work was going to define their value. For some of them, the solution may be in vocational services. For others, the answer may lie in helping them find a non-vocational way to feel a sense of contributing value to the community.

Regarding co-worker relationships: workers who embrace responsibility for their own jobs, and seek opportunities to help or support others in their work, are highly-valued colleagues. The values of the survivors—such as privacy, egalitarianism and work ethic—have been passed down through the generations.

Your understanding and respect of these core values will enhance your relationship with your "aboriginal south to south-central Hoosier" clients and colleagues.



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CBH Breakfast Learning Series

The Center for Behavioral Health continues to offer its free monthly “Breakfast Learning Series”—informative sessions on a variety of mental health topics. Each session is held on a Friday morning from 8:00–9:30 a.m., at the First United Methodist Church, 219 E. Fourth St. (Bloomington), Rm. 318. Attendees may be eligible for 1.5 CEU credits (both Category I and II) and no reservations are required. Breakfast is free. For more information, contact Cathi Norton (812-330-2887; cnorton@the-center.org). Upcoming topics include:

Sept. 21, 2001	“Oppositional Defiant Disorder in Children”	Deb Mishler, MSW Center for Behavioral Health
October 19, 2001	“Adolescent Addictions Treatment: Problems When Parents Use”	Cindy Houston, LCSW, LMFT
Nov. 16, 2001	“Behavior Management for Parents of Preschoolers”	Cindi Winegardner, MSW
Dec. 14, 2001	“Depression in the Elderly”	Gregory Sidell, M.D.