Adolescents in Crisis: Client Factors for Effective Coping and Follow-up

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The Need for a Model

• Dominance of third party payers who define stability based on lack of symptoms of acuity

• The trend of shortened hospitalizations has been identified as dangerous to clients due to the “revolving door” and “patch and dismiss” approach to psychiatric care (Rinsley, 1990, p. 9).

• The flaw in this has been that no process of stabilization has been identified.
A Goal Attainment Model of Stabilization

• Is a positive model requiring client behavior beyond a lack of symptoms of acuity
• Acknowledges the role of therapeutic intervention as a critical element in attaining stability
• Based on problem solving theory consistent with Cognitive-behavioral, Reality, and Adlerian theories (Nystul, 1995).
Elements of the Proposed Model

• (a) The client is committed to safety;
• (b) The client identified the problem(s) that resulted in the crisis;
• (c) The client processed relevant coping skills to the identified problem(s);
• (d) The client committed to follow-up.
How do we know if clients meet their goals?

**Goal attainment scaling** may be done in the framework of setting individualized goals on a measurable scale and transforming overall goal attainment into a standardized T score. This method, together with random assignment of patients to treatment modes, was devised to evaluate client outcomes, permit comparison of treatment modes within a program, and provide a basis for a judgmental evaluation of the total program (Kiresuk & Sherman, 1968).
Goal Attainment Scale of Stabilization: Some Research

- Researcher developed
- Pilot study
- Psychometric qualities
- Revised throughout research
  - Commitment to safety
  - Problem identification
  - Coping skills
  - Coping skills
  - Commitment to Follow-up
Goal Attainment Scale of Stabilization

Directions: For the following items/goals, please circle the number on the scale by each item that most clearly describes the extent to which the client accomplished the goal. The numerical values signify the following:

-2: denotes the least favorable outcome
-1: outcome is less than desired or expected
0: attained desired or expected outcome
+1: outcome is more than desired or expected
+2: denotes the most favorable outcome

1. The client is no longer a danger to self or others. -2 -1 0 1 2
2. Thoughts and behaviors that were previously considered as a danger to self or others are now manageable. -2 -1 0 1 2
3. The client has demonstrated stable behaviors. -2 -1 0 1 2
4. The client has verbalized a plan if he/she begins to feel unsafe. -2 -1 0 1 2
5. The client does not verbalize or glorify dangerous acts. -2 -1 0 1 2
6. The client is able to identify problems that led to being referred for services. -2 -1 0 1 2
7. The client understands how his/her behavior may have contributed to the problem. -2 -1 0 1 2
8. The client expresses motivation to address the problem(s) and change behavior. -2 -1 0 1 2
9. The client is able to identify potential issues and events that could contribute to regressing back to previous high-risk behaviors. -2 -1 0 1 2
10. The client is open to hearing feedback related to problems in his/her life. -2 -1 0 1 2
11. The client understands how his/her behaviors were dangerous. -2 -1 0 1 2
12. The client does not accept blame for problems considered out of his/her control (e.g., abuse). -2 -1 0 1 2
13. The client worked toward identifying personal strengths to encourage coping and decrease stress. -2 -1 0 1 2
14. The client worked toward identifying weaknesses that discourage coping and increase stress. -2 -1 0 1 2
15. The client is willing to increase his or her social support. -2 -1 0 1 2
16. The client has verbalized healthy behaviors that he/she needs to demonstrate. -2 -1 0 1 2
17. The client has demonstrated ability toward healthy problem-solving and decision-making. -2 -1 0 1 2
18. The client was willing to explore alternatives that led to unhealthy/dangerous behaviors. -2 -1 0 1 2
19. The client agrees to attend follow-up services. -2 -1 0 1 2
20. The parent(s)/guardian(s) are willing to comply with follow-up recommendations. -2 -1 0 1 2
21. The client and family have identified adequate resources (financial, transportation, etc) to follow recommendations. -2 -1 0 1 2
22. The client has access to support outside the immediate home environment. -2 -1 0 1 2
23. The parent(s)/guardian(s) have access to support outside the immediate home environment. -2 -1 0 1 2
24. Appropriate services/resources were identified by the client. -2 -1 0 1 2
25. Parent(s)/guardian(s) believe the client can benefit from further counseling. -2 -1 0 1 2
GASS--Reliability & Validity

• Reliability for the subscales with the current sample using Cronbach’s alpha:
  – Coping: .97
  – Follow-up: .96

• Strong content, convergent, and discriminant evidence (Balkin & Roland, 2007)
Goal Attainment Scale of Stabilization-Validity

- Evidence based on test content—Index of Item-Objective Congruence (Hambleton, 1984)

- Evidence based on internal structure—Modified Multitrait-Multimethod Matrix (Balkin & Roland, 2007) and EFA
  - Two-factor solution with factor loadings > .60 and accounting for 70% of the variance in the model.
Evidence-based Assessment of the Goal Attainment Model

• Evidence based on relations to other variables—
  – *Clinician Problem Scale-Revised* (Balkin & Roland, 2007) and
  
  – *Target Symptom Rating* (Balkin, Leicht, Sartor, & Powell, 2010).
Implications

• When adolescent clients were better able to clearly express the problems that related to their crisis, the more likely they were to be relieved of symptoms and to be more stabilized.

• Clients should have a commitment to follow-up. That decision should not be made sometime later.
Implications

• Client diagnosis might not be very relevant to acute care treatment.
• Symptoms are relevant!
• Interventions may be more general and goal oriented rather than focused specifically on a client’s diagnosis.
• Undue emphasis on gearing treatment to diagnosis would seem to have little value in an acute care psychiatric program.
Implications

• Awareness of gender differences and how they affect treatment goals is also important (Balkin & Roland, 2005; Heflingier et al., 2002; Faurie, 1990).

• Understanding that connectedness is a necessary component in female development (Jordan et al., 1991) and may be linked to commitment to follow-up.
Implications

• Theory related to male development has emphasized separation, autonomy, and individuation (Gilligan, 1993).

• Coping skills seem to be a component to these processes (Balkin & Roland, 2005).
Implications

• The goal attainment model may help provide a basis and structure for delivering counseling services that are both helpful to the client and brief in nature.

• Coping and commitment to follow-up lead the client to present with fewer symptoms associated with high-risk behavior.
Questions