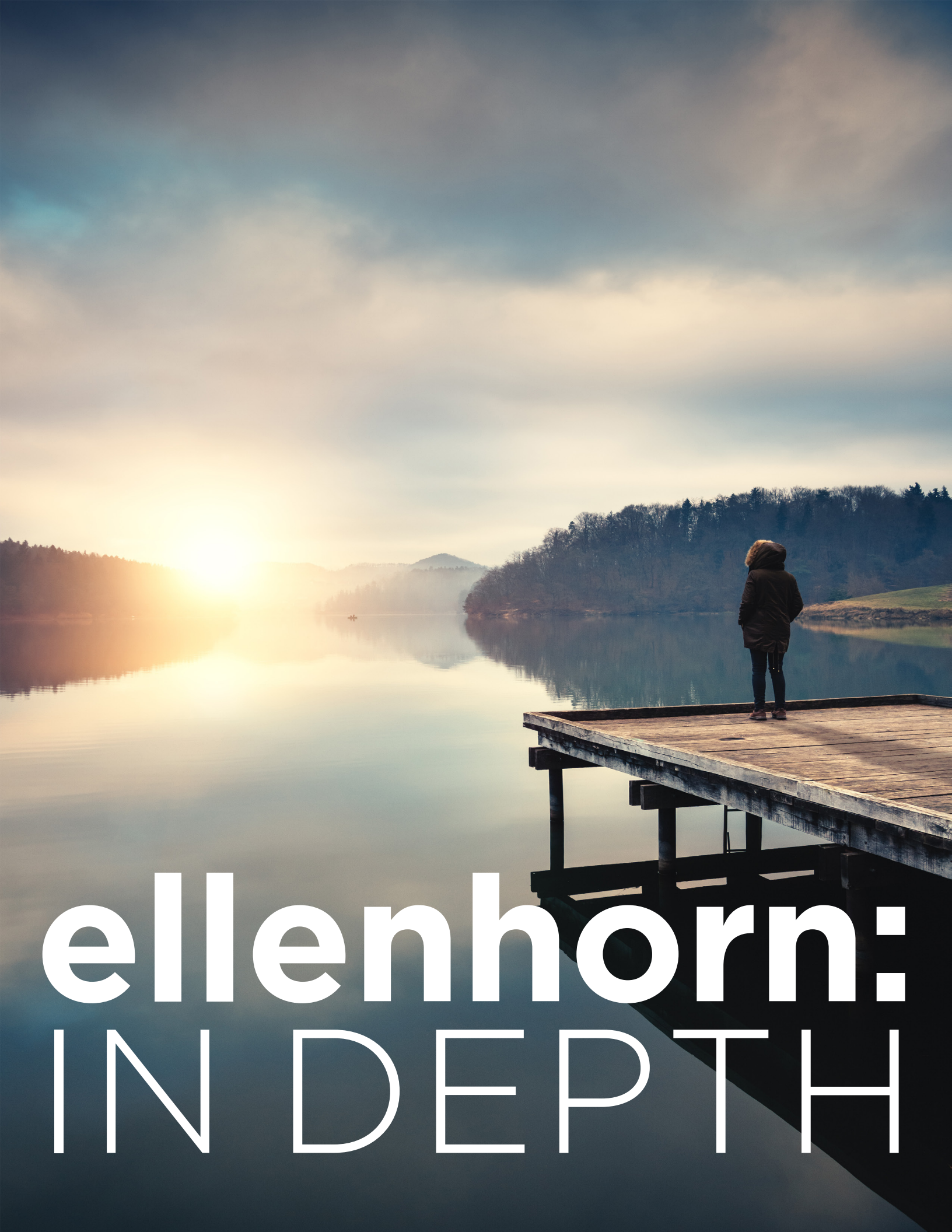

ellenhorn: IN DEPTH

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ellenhorn

REBUILDING PURPOSEFUL LIVES

A MESSAGE FROM THE OWNER

I know from my own experiences that the choice of treatment providers is one of the most important decisions a person ever has to make. When seeking help for yourself or a loved one, I believe you deserve to be well-informed about your treatment options. Only by fully understanding the therapeutic approach of a provider can you make the right choice. That is why I wanted to provide additional information on our program in this special section of our web site, called "Ellenhorn In Depth." Written specifically for you, I hope these pages give you and your family a deeper understanding of what we do at Ellenhorn and why and how we do it.

Ross Ellenhorn, LICSW, Ph.D.
Owner/CEO Ellenhorn

The Roots of our Model

Founded by a clinically-trained sociologist and a psychiatrist, Ellenhorn blends intensive hands-on work helping individuals remain integrated in the larger community, with the most robust psychiatric care provided by a private community-based program in the United States. We are as oriented to preventing and treating the serious social damage often endured by individuals identified and treated for psychiatric issues, as we are on alleviating the suffering and potential dysfunction that psychiatric symptoms can cause.

We see that balancing the two seemingly disparate goals of helping people regain their rightful place in the world *and* alleviating difficult psychiatric experiences are actually mutually beneficial. Helping people stay on path with their family, vocational and educational goals often requires thoughtful and coordinated pharmacological care (medication) that addresses the ways symptoms and medication side effects can impede a person's ability to achieve these goals.

At the same time, the very best pharmacological care occurs when a doctor is part of a team of treaters (clinicians, therapists and others) that supports each client in regaining or maintaining their role in the community. When psychiatrists are members of such a closely-knit team, they are able to make better, more finely-tuned treatment decisions that lead to precisely-targeted care, the avoidance of overmedication or improper medication, and care that can safely help some clients become medication-free.

Our model is based on one important premise: *Social experiences and psychiatric recovery are intertwined.* Humans are the most social of all the animals, none of us an island. The largest and most human part of our brains (and also the newest invention in the animal kingdom) is vested mostly with the complex task of cooperating, collaborating and interacting in all manner of social situations. Other animals have nervous systems that warn them with pain, keep their hearts pumping, and keep their lungs breathing; and other animals know to flee when they see a predator and how to find food. Many animals also survive by working in groups, and some animals can be altruistic, looking out for the betterment of their small band. But no animal is as fully dependent as humans on thoughtful cooperation with others for its survival, having to deal daily with strangers of its own kind and with the constant change in social situations required of this particularly innovative and inventive species. We are not ants. Every day is novel for us, presenting us with a stream of unique social situations.

Aware of this powerful *social* element in all of us, we at Ellenhorn are sensitive to how even the best psychiatric treatments can actually harm people. Psychiatric treatment potentially stigmatizes individuals, causing painful experiences of ostracism and the corrosion of their social support. When these treatments are provided in settings that are apart from the rest of the world — hospitals and residential facilities, but also 9-to-5 treatment, such as partial hospitalizations, intensive outpatient and day treatment programs — people are removed from the resources that give them a sense of purpose, a social role and community connection. Psychiatric treatment, too, can be disempowering, with experts holding sway over how to understand a person's behaviors and experiences, leaving individuals voiceless in controlling their identity and fate.

At Ellenhorn, we think a lack of purpose and meaning, and experiences of isolation and ostracism, cause serious problems for people diagnosed and treated as mentally ill. *That's why we view a person's social inclusion as a powerful medicine.* We see that re-engaging with family in a functional way is medicine, going to school is medicine, working is medicine; volunteering, going to religious services, having a romantic relationship, joining a club, hanging out with friends: all medicine. Mental health providers think a lot about how to get their clients to take medications, often labeling client who refuse to take medications, "non-compliant." But when treatment is provided in a manner that removes a person from his or her sense of purpose and social role, the responsibility for "medication non-compliance" in regards to such medicines as meaning, purpose and community inclusion rests on the shoulders of clinicians, not clients.

We at Ellenhorn have great respect for many psychiatric programs, and believe that taking time out from life-stresses and focusing solely on one's psychiatric well-being can be helpful for some people. At the same time, we do take seriously the harm often caused by the current ways mental health care is delivered and the way people experiencing psychiatric disruptions are treated in our society. In large part, our confidence in our alternative model comes from what our clients tell us.

Listening Closely to the Chief Complaint

Clinicians are taught to look for the "chief complaint" when they first meet a client. This is the client's statement regarding his or her reason for seeking help. If you listen closely to what people say when they come for intensive treatment, and you bracket your own preconceptions about their psychiatric condition, you will find a pattern in many of these complaints. People complain less about actual symptoms related to psychiatric diagnoses than they do about *what has happened to their lives* since being labeled mentally ill and treated for this illness: whether they will be able to fulfill their dreams; about their status in relationship to their peers; and whether they will ever be able to lead an independent life. Their chief complaints might be expressed as "My friends are moving on, and I'm standing still;" "I used to have so many friends, and now I'm alone most of the time;" "I feel uncomfortable around my family, now that I'm the black sheep;" "I'm so upset that I can't get myself to find work, and ashamed about the enormous gap on my resumé." They often locate these complaints at the forefront of their anxieties. In fact, they frequently feel them to be more distressing than their psychiatric issues.

Hearing such complaints, clinicians can feel helpless in addressing them, since most clinicians don't have access to resources that can remedy or prevent the debilitating *social* injuries regularly affecting consumers of mental health services. Faced with seemingly unanswerable concerns, many clinicians will often force the round peg of a social complaint into the square hole of psychiatric diagnosis. The client who is upset at seeing her friends moving on suffers from "poor self-esteem and depression;" the client without friends suffers from "social anxiety;" the one who is uncomfortable around his family "lacks social skills" and "comes from a dysfunctional family system;" the one who is afraid of a job interview has "low motivation."

At Ellenhorn, we take these social chief complaints very seriously. In fact, we've coined a term for the social damage often endured by people who are diagnosed, labeled and treated for mental illness: *psychosocial trauma.* While we expertly treat a diverse array of psychiatric complaints, and treat each client as a unique individual, we believe psychosocial trauma is the common thread among most of our clients — the issue most have experienced.

Treating Psychosocial Trauma. The basic meaning of the word "trauma" is an injury to an organism caused by an external event. In the realm of mental health, "trauma" usually refers to psychological trauma. This is an injury to a person's psychological well-being caused by an external event, that can last long after the initial hurt. While you might immediately think of a trauma to our psychological well-being as caused by some disastrous event that is out of the norm of our daily life, *psychosocial* trauma is different. It is often caused by events that happen as a matter of standard practice in the current way we treat psychiatric symptoms. These events include involuntary ones, such as being forced to go to a psychiatric hospital, or being restrained by hospital personnel or police; but also events that are more subtle, such as leaving work or school for psychiatric treatment; feeling disconnected from family and friends because of the label of mental illness; or being diverted from one's life-plans because of treatment.

While psychosocial trauma may not always be as entrenched as the psychological trauma sustained by children, victims of violence, or veterans, it does cause similar results. The trauma of being identified and treated as a psychiatric patient disturbs a person's sense of security in the world, her capacity to act independently in her life, and her willingness to trust her perceptions. Most importantly, we at Ellenhorn see that psychosocial trauma negatively affects a person's motivation to change, and their ability to carry on strong and supportive relationships.

When other clinicians describe someone as “lethargic” or “demotivated,” we at Ellenhorn first look for deeply painful social losses, ones proven to negatively influence a person’s motivation. Likewise, when other clinicians assume that a client has become “isolative” and “disengaged” because of psychiatric problems, we see social losses as one likely cause.

We also see in our work that psychosocial trauma leads individuals to resist engaging in treatment. People who have experienced psychosocial trauma, just like those suffering from psychological trauma, aim to stay as far away as possible from the source of the trauma. For the majority of our clients, the source of trauma is previous treatment experiences. Thus, when we see behaviors other clinicians often describe as evidence that a client is “difficult to engage,” “treatment-resistant,” “non-compliant,” or engaging in “treatment-interfering behavior,” *we* most often see damage caused by psychosocial trauma and the client’s natural desire to not suffer any more damage.

Trusting the clinician one sees for treatment, and having the motivation to change, are the prerequisites for using treatment in an effective manner. Ellenhorn’s understanding of the large impact of psychosocial injuries on a client’s feelings, behavior and ultimate recovery, coupled with our wish to compassionately respond to our clients’ *social* chief complaints, lead us to a model of care that blends psychiatry with a psychosocial orientation.

Ellenhorn: The Leader in Community Integration

Ellenhorn is the most robust community integration program in the nation. Community integration programs help those who are receiving psychiatric services maintain their social roles in the real world and remain connected to nourishing social networks and communities. Rather than separating people from vibrant community resources, such programs support clients in staying focused on their future — in *believing* in their own productive, fulfilling futures — while receiving help.

Providing an effective alternative to care that removes people from the community, Ellenhorn uses the most researched and evidence-based best-practice model for people who experience psychiatric events. The model we use is called Program for Assertive Community Treatment (PACT) (please click here for Dr. Ellenhorn's article on PACT, which is also called ACT). The success of the PACT model was a driving force in the development of community integration programs, and it remains the gold standard in this kind of care.

The Program for Assertive Community Treatment Model (PACT)

PACT is endorsed by both the National Alliance on Mental Illness (NAMI) and the National Institute of Mental Health as a highly effective treatment. Research on PACT programs shows that they decrease hospital rates, improve employment outcomes, stabilize and reduce psychiatric symptoms, and increase sobriety.

The PACT approach has four unique linked components. These are: (a) a single-source, multidisciplinary team approach to providing treatment services; (b) highly flexible and personalized treatment planning; (c) mobile treatment services delivered to clients outside the office and in the community; and (d) assertive help that guides people to use community resources to assist in their recovery.

A Single-Source Multidisciplinary Team Approach. Rarely does a serious psychiatric issue spring from just one source. And rarely can one specialist, alone, effectively address a major mental health issue. That is why mental health care provided by a multidisciplinary team achieves the best outcomes.

Besides the enormous therapeutic value of a team consisting of specialists in a wide range of areas, another benefit of a multidisciplinary team is their close and continual communication with one another about each client. To varying degrees, psychiatric hospitals and other residential settings provide multidisciplinary care through regular communication among different specialists, for example, during clinical rounds and treatment planning meetings. Some private outpatient mental health treaters attempt such communication, but typically it is sporadic at best. As an outpatient, a person might see more than one provider during the week — for example, a therapist, a psychiatrist, and someone for vocational help — and may attend a day treatment program, clubhouse, or partial hospitalization program. All too often, these providers communicate only minimally with one another, or not at all.

The result of this fractured outpatient care is that any effectiveness depends entirely on the client's ability to manage his or her symptoms on their own, and to faithfully attend treatment appointments despite the disabling intensity of their psychiatric experiences or the results of social injuries they've incurred. Yet when clients in an outpatient program exhibit symptoms beyond what appears manageable to family and clinicians, those around them often begin to make decisions for them — a slippery slope that can lead to the extremes of hospital stays or other 24-hour arrangements. In this light, *many psychiatric hospitalizations are not the logical result of a crisis that leads to a hospital stay. They are the result of a mental health system that has failed.* And one of many points of failure has to do with lack of communication and coordination among outpatient treaters.

Against this backdrop, PACT fills a huge gap between outpatient treatment and sequestered care. Central to the PACT philosophy is a belief that good communication among treaters is the same as good clinical care. *PACT blends the regular multidisciplinary communication of a psychiatric hospital or residential setting with all the multiple, proven advantages of being treated while living in the community and leading a real life.* It is a single-source model of treatment in which all treatment is provided by the team.

That makes PACT very different from the way most community-based programs attempt to fill the gap between the hospital and community. These programs typically provide paraprofessionals, such as case managers or coaches, who link clients with different treaters in the community, but don't provide treatment themselves.

In sharp contrast to these programs, our PACT program doesn't link clients to treaters; *we are the treaters.* That is why Ellenhorn is staffed by licensed clinicians who are well-educated in their therapy specialties. Our PACT teams include psychiatrists, nurses, personal trainers, therapists with an array of expertise in different therapeutic approaches, addictions specialists, and both vocational and educational specialists. Unlike most community integration programs, our psychiatrists are fully part of their teams. Holding small caseloads, they spend a large part of their time working with their teams and communicating about treatment for each client.

A person's psychiatric experiences don't end at the end of a shift. Thus connection with treatment should be available at all hours. Ellenhorn provides around-the-clock, on-call services by our PACT team staff. When appropriate, this staff is ready to meet with clients face-to-face at any hour.

Highly Flexible and Attuned Treatment. Our multidisciplinary team approach makes possible highly personalized care based on a nuanced view of each client as a unique individual with unique needs, and gives us the ability to be infinitely flexible in meeting their needs.

We see our clients as constantly changing — often improving, sometimes getting worse, then progressing again. The best treatment responds to the reality of constant change in a client, shifting in intensity and approach whenever necessary. Revisions in treatment should be made as simultaneously as possible with a client's changes. Meeting multiple times each week about every client, our team is able to quickly make these revisions — in the type of treatment, how it's provided, and its level of intensity — depending on what is happening for our clients.

Mobility and Outreach. In general, clinicians acknowledge a cause-and-effect relationship between the severity of a person's psychiatric symptoms and their ability to function in life. But for all too many clinicians, concerns about functioning often end when it comes to a client's ability to complete such tasks as keeping office therapy appointments, or sitting through a day of group treatment. They expect clients to function well enough to do these tasks, often despite evidence to the contrary.

PACT, on the other hand, sees office-based therapy as only one option for treatment. *More than 75 percent of Ellenhorn's PACT services are delivered to clients outside the office.* Our teams provide support to clients in diverse community and vocational situations — for example, at school, on the job, or at the client's apartment. Because we work flexibly and intensively with individuals in their own environments, the Ellenhorn program is an effective alternative to residential or hospital care as well as such 9-to-five programs as partial hospitalization, and intensive outpatient and day treatment. As a PACT program, we function as a hospital or residential program "without walls," providing up to thirty hours a week of personalized care management to a given client, including intensive psychiatric services. As a result, we are often able to effectively serve individuals experiencing acute psychiatric symptoms without placing them in an institutional setting.

This combination of flexibility and mobility is key to supporting clients not only when they might be doing poorly but also when they make positive change. For example, imagine that a client in an outpatient program has finally gotten the nine-to-five job she always wanted. But these hours conflict with her attendance in a day treatment program, or her ability to see her outpatient therapists.

There's a good chance her treaters will tell her that she's not ready for the job since she's not "finished with treatment."

Our PACT program would view the situation very differently. We would not see the client's return to work as potentially interfering with treatment, but *as a form of treatment* that we support with all our combined team resources. Therefore we would work out a plan in which we visited her during her lunch breaks, or before or after her work. Turning the idea of "readiness" on its head, we would make sure that office-based treatment didn't interfere with the powerful medicine of feeling integrated in one's community and engaged in purposeful activity.

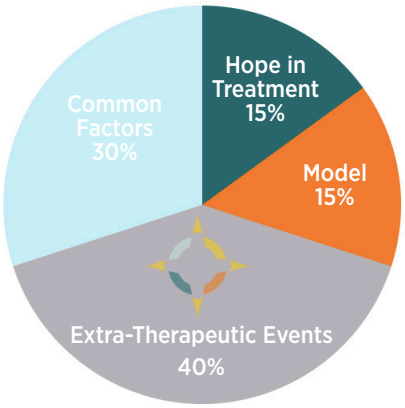
Using Community Resources. At Ellenhorn, we believe that the standard bar of "readiness" to re-start one's life pursuits is really a reflection of the lack of support for real-life activities in the current way we provide psychiatric care. While we at Ellenhorn know that certain people might not be ready to live on their own, we also know that most people can live independently with the right supports, and that they need to be integrated in real-life settings in order to recover. Remember that for all us humans, social role, purpose and being connected to others are necessary; when these social functions are lacking, providing them is like giving a person the medicine they need to recover — and making them whole. When we deem someone "not ready" to be part of the community around him or her, we are removing them from the very important medicine of being part of the social world in order to treat them. It's like trying to cure a fish by removing it for too long from the water it needs to live.

PACT is an innovative form of providing services. The effectiveness of a PACT program, however, depends on its teams' ability to make connections with clients, and to create truly collaborative relationships with them. Collaboration, recognizing and respecting "client voice," and empowerment, are all facets of Ellenhorn's central mission.

Partnering with Clients and the Ingredients of Change

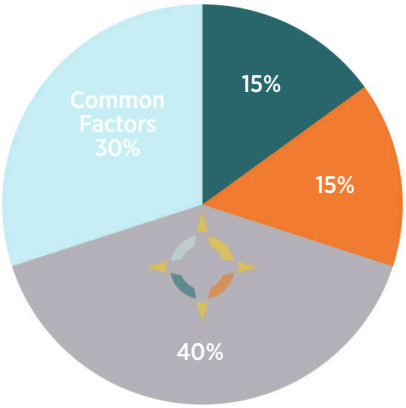
Mindful of the psychosocial injuries often caused by being diagnosed and treated for a psychiatric issue, we at Ellenhorn seek to re-empower our clients, helping them regain a sense of voice and control in their lives. This focus stems from our knowledge that *the styles of treatment proven most effective put the client in the driver's seat.* Again and again, research shows that collaborative relationships are the most effective therapeutic relationships.

Based on extensive research on the effectiveness of different therapies, the pie chart you see here captures a surprising fact about what helps promote positive change in people: A hefty 30 percent of client change results from "common factors" in the relationship between client and therapist. The term "common factors" refers to behaviors and attitudes exhibited by therapists, *independent of the therapeutic approach they use,* that promote change in clients.



Partnering Relationships: The Secret Sauce of Therapy

Common factors include the therapist's ability to inspire belief in the client that the therapist shares their goals, understands them and is interested in them; and that they are respected and accepted by their therapist. It turns out that these feelings have a great deal to do with the therapist's ability to build a trusting and collaborative relationship with the client, which in turn, empowers the client to navigate change.



Research into the effectiveness of common factors validates the old "light bulb" joke about therapy: *How many therapists does it take to change a light bulb? One. But the bulb has to really want to change.* Research reveals that the best individual therapies are those in which the therapist creates a strong partnership with clients, so they feel supported to make change. That is why the Ellenhorn approach is so strongly focused on collaboration. The focus is rooted as much in our wish to be humane, as it is in our knowledge of what produces the best outcomes.

The documented power of common factors to influence positive change should make all of us a little hesitant when we hear clinicians use the word "intervention." That word is used a lot in the psychological and psychiatric professions.

We often ask, “How should we intervene in the patient’s behavior?” But the word *intervention* means to come between two things and disrupt their connection. When we use the word *intervention* in the behavioral health professions, we are describing our attempt to cleave some sort of sickness from the patient. We intervene to remove the symptoms, to split a person from his or her pathological behavior. It’s important to note that, in an intervention, the clinician is the one in charge of “changing the light bulb.” He or she is the agent of change, and the client is seen as quite passive, if not resistant.

“Intervention” suggests something almost surgical: an expert with a scalpel removing something diseased from someone who is passive. But research into the effectiveness of common factors yields a different image: *the clinician as more of a gardener or farmer; someone working vigorously, thoughtfully, and with a good dose of wisdom, to nurture an environment that allows for each individual’s natural tendency to grow.*

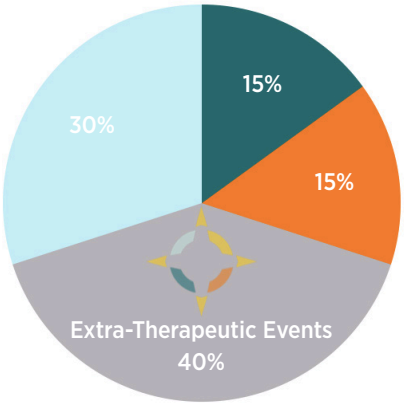
From time to time, we at Ellenhorn need to take a more interventionist approach, acting without full coordination with our client. We always do so if we feel a person is at imminent physical risk. We might also intervene if a client’s psychiatric experiences are so seriously impeding progress that a more assertive approach might help. Yet partnership and collaboration are our most basic and defining principles. Our job is to help our clients figure out where they want to go, what can get them there, and what gets in the way. Having a partner by their side gives them *faith* in their ability to face obstacles in their path. We see again and again that this faith translates into empowerment, and that empowerment translates into a willingness to change.

Partnering with our clients to build good, sustainable lives means that our focus is often on reducing obstructive psychiatric experiences. That is why we offer robust psychiatric care. Unlike the majority of programs in the U.S. that serve clients experiencing psychiatric distress while they remain in the community, Ellenhorn psychiatrists are active participants in treatment planning, in strategizing the minutiae of treatment, and in working with families and other providers, such as primary care physicians and sleep specialists. Our aim in providing such intensive psychiatric care is to decrease one likely hindrance in a person’s quest to take hold of his or her life: severe psychiatric symptoms. This collaborative approach to treating psychiatric symptoms contrasts subtly yet importantly with programs in which symptom reduction is the *only* goal, regardless of whether a reduction in symptoms in and of itself, leads to a better quality of life.

The path to a better quality of life is not as clear as simply reducing symptoms. Many people enjoy lives of significant quality without treatment, even though they have experiences that professionals would classify as psychiatric symptoms. Other people engage in treatments that reduce their symptoms, but lead lives of minimal quality, never reaching a state of fulfillment and purpose. Still others must reduce their symptoms in order to reach such states. If professionals believe their jobs are to reduce symptoms, they see only one road, their success measured by the amelioration of psychiatric experiences. But if, as we do at Ellenhorn, professionals believe their job is to help clients reach a better quality of life, they see not one path, not even three paths, but as many paths to fulfillment as there are clients.

Focused on the quality of our clients' lives, rather than solely the quantity of their symptoms, we work with them collaboratively on remaining integrated in the community, helping them locate, attain, and retain those activities that give each of us a sense of purpose and fulfillment. In this way, our work is in sync with another surprising fact from the pie chart: Forty percent of the issues that either produce or block change occur *outside* the therapy office. These are called extra-therapeutic events.

Assertively Working on Extra-Therapeutic Events. Lifestyle, social experiences, experience of community connection, financial factors, daily stress, intimate relationships, family cohesiveness — the list of extra-therapeutic issues that encourage or hinder personal change is infinite. Together, these issues exert the greatest influence on a person's ability to develop a life they like.

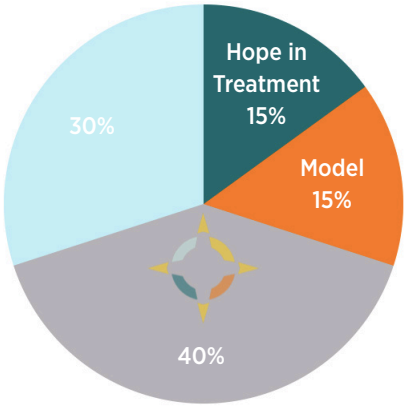


As the most robust community integration program in the United States, we clearly focus on these outside-the-office issues. That means we put a lot of energy into issues other than a client's purely psychiatric symptoms, working with clients in the community and with their families, attempting to strengthen social connections and to enhance our clients' integration in the world.

Hope in Therapy and Therapeutic Models

As the chart indicates, the two remaining factors contributing to a client's ability to make positive changes are: (1) the amount of hope she feels about whether her treatment can help her; and (2) the specific clinical approaches used by the clinicians serving her. At Ellenhorn, we view these two change-promoters as intricately entwined.

Hope in Therapy. We know that a person is more willing to change when she feels a clinician is willing to work collaboratively with her to reach agreed-upon goals. The pursuit of these goals, however, is not a mechanical one in which client and therapist simply follow a plan step by step. Instead, the client's ability to move toward a goal depends to a large extent on her belief that the clinician has hopes for her future and has faith that she can take the right steps to get there. There is a simple algebra here: Collaborative relationships = the client's hope in the partnering endeavor + faith that it will bring her to a better future. Yet for many people, achieving hope, in general, is not as easy as reaching for a calculator. That's especially true for people who have experienced the *social damages* that often result from being diagnosed and possibly treated for psychiatric experiences.

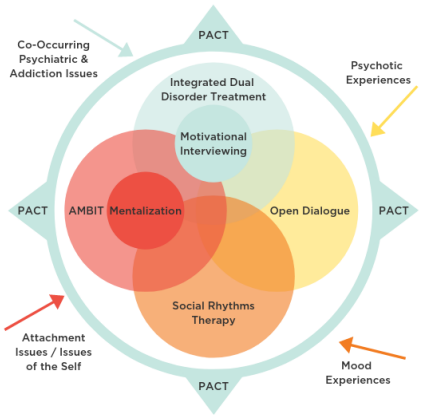


We see that many of the people we work with at Ellenhorn have a disturbed relationship with hope. Having experienced significant disappointments in their lives, they approach hopefulness as dangerous, the harbinger of more disappointment. Frequently, they have been in and out of treatment for years, and often — and often rightly — don't have much confidence that clinicians can help them. These clients are therefore resistant to building the kind of partnering relationships with professionals proven to be so central to therapeutic change.

With psychosocial trauma at the forefront of our thinking, we often say at Ellenhorn that we work with all kinds of psychiatric diagnoses, but that all our clients deal with a single dilemma: a sense that something has failed in their lives, and a subsequent loss of faith and hope in themselves, in treaters and in the malleability of the world around them. Our clients' loss of hope that they can create change is a central hindrance in their lives. That is why we need every possible collaborative arrow in our quiver. While Ellenhorn provides all manner of therapies, our staff has spent many hours being trained in what we think of as "collaborative therapeutic models."

Collaborative Models of Care. It is clear from research on the factors that promote therapeutic change that the collaborative aspect in therapy is a far more powerful agent of change than any particular therapeutic approach. At the same time, the choice of specific models of treatment (i.e., approaches) for a given client is very important, guiding clinicians in how they respond and interact with their clients.

At Ellenhorn, we continually increase our range of therapeutic approaches, supporting our clinicians in attending multiple trainings, and providing extensive ongoing in-service trainings for our clinical staff. We are selective in the treatment models we learn about and use, identifying ones that match our culture of collaboration, thus reflecting the very good outcomes shown by research into common factors.



While Ellenhorn therapists and clinicians use many collaborative therapies, we especially focus on the following four powerful treatment styles, using them not only as tools for promoting change in clients, but also using one or the other as a productive *treatment path* for a given client. Here's what that means: since we view each client as a unique individual with her own needs, we don't believe any client fits within a cookie-cutter treatment "track" or "protocol." At Ellenhorn, a client's treatment path is completely personalized and always-evolving. At the same time, we find that making one or more of the following four powerful therapies a central part of how we design treatment for a client can be an effective guide for a personalized blend of services. These four therapies are: Motivational Interviewing, Open Dialogue, Mentalization-Based Treatment, and Interpersonal and Social Rhythms Therapy.

Motivational Interviewing. Motivational interviewing was developed for counseling people with problematic substance use, and is based on a non-confrontational partnering relationship between counselor and client, in which the client is respected as the agent of change. It is a therapeutic model that differs from traditional approaches used with people problematically using substances. The longstanding foundation of most treatment for problematic substance use is the concept of "denial." This is the idea that, because a person problematically using substances is behaving self-destructively, the only way they are able to continue the self-abuse is by denying they have a problem.

Motivational interviewers see things differently. For them, problematic substance use is less about denial, and more about ambivalence. People who problematically use substances often see there is a problem, yet at the same time, don't want to give up something that serves a desperately-needed purpose(s) for them. In contrast to denial-based treatment, our goal at Ellenhorn is to build a partnering relationship with people with problematic substance use, psychiatric and psychosocial problems, using this relationship to work through the ambivalence, with the goal of a sober, psychiatric and psychosocial recovery.

We use motivational interviewing as part of our Integrated Dual Disorder Treatment Most clients who come to us suffering from the co-occurring issues of problematic substance use and psychiatric complaints work with us within the IDDT model. Please click here for more information on IDDT.

Open Dialogue is both an organizational model and a therapeutic approach. In a sense, it is like PACT, in that it defines how a program delivers services as well as the therapeutic nature of those services. Open Dialogue is shown to significantly benefit people having, what is described, in professional terms, as "psychotic" experiences. Perhaps they hear voices, see things we can't see, or have thoughts that don't match what others around them believe. When this approach is used as a framework, psychotic experiences are understood as something for

which there is no language.
To foster communication, Open Dialogue involves regular "network meetings" attended by the client and the client's clinicians, therapists, family, and important others in their network. Through a process of dialogue among all those at the meeting, a shared meaning and vocabulary is developed that facilitates communication and a sense of connection among all participants. We at Ellenhorn often use this approach at the very start of our relationship with a client, as a way of involving the client in designing their own course of treatment and life-goals. For more information on Open Dialogue, please click here.

Mentalization-Based Treatment can be a highly effective therapeutic approach with people who struggle with their attachments to and relationships with others (syndromes often called "personality disorders").

The term *mentalization* refers to our ability to accurately understand the intent and mental experiences of others, and to correctly perceive our own intentions and thoughts. We all mentalize — feeling in-sync when we interact smoothly and successfully with someone. And we all sometimes fail at mentalizing when we lose track of the meaning behind our feelings and behavior, and/or distort and misunderstand what's in the minds of the people with whom we interact. When we get ourselves in trouble with other people, it's often because of poor mentalizing: a lack of curiosity about the workings of our own mind and those of others.

People with significant attachment issues tend to mentalize poorly in a chronic manner, and this inability to perceive the intent and experiences of others, or to grasp what's happening in their own minds, is a dominant force in their lives that often leads to persistent conflict and hurt. The goal of Mentalization-Based Treatment is to increase the client's curiosity about their own mind and that of others, helping them discover the cause of misunderstandings and be less certain they know exactly what someone else is thinking or feeling.

Mentalization-based treatment, with its focus on accurately grasping the thoughts and emotions of others, is a valuable tool for our clients as we support them in re-integrating into the community. For example, a client who goes back to work now has techniques for dealing better with a boss. Similarly, a client who returns to school can more easily connect with fellow-students or professors. At Ellenhorn, we often use mentalization-based therapy with clients outside the office, helping them — in the very moment of distress — rethink and become curious about real-life incidents with others. Typically, when we approach a client from a mentalization stance, we also use a model of organizing care, called Adaptive Mentalization-Based Integrative Therapy (AMBIT). This is a way of delivering mentalization treatment often outside the setting of an office, with a high level of sensitive both to the client's attachment needs, and the key clinician's well-being in working with the client.

Interpersonal and Social Rhythms Therapy (IPSRT) is a collaborative form of care, placing the tools for recovery in the hands of our clients. We work alongside them as they navigate their recovery. IPSRT also matches our whole-person approach, considering a person's physical, mental and social experiences, while recognizing that bipolar and other mood experiences cannot be treated with medication alone.

The foundation of IPSRT centers around the belief that problems in the circadian rhythm and sleep deprivation exacerbate manic depressive and major depressive symptoms. This specific type of psychotherapy focuses on helping a person to identify and maintain the regular routines of everyday life, including sleep patterns. Additional attention is given to helping a person learn to solve interpersonal problems and social issues that interfere with the daily routine. These practices teach skills that allow a person to guard themselves against future episodes.

IPSRT is designed to reduce the frequency of relapses that are caused by stress, social difficulties and inconsistency in circadian rhythm. IPSRT therapists work with clients to help them understand the importance of circadian rhythm and daily routines - eating, sleeping, etc.

Clients learn to consistently track their daily activities and moods. Doing so enables the them to focus on better interpersonal relationships.

When combined with psychiatric medicine, IPSRT has been proven to reduce both manic and depressive experiences; to make essential gains in achieving a person's targeted life-goals; and to assist in the person's ability to be consistent in maintaining daily routines.

Again, IPSRT in another big step in our quest to provide effective targeted treatments, placing our clients in the driver's seat of their care, as we collaborate together to help them navigate their road to recovery.

Collaborating with Families. We at Ellenhorn see isolation, a sense of rootlessness, and disconnection as central factors in the experiences of our clients. We also believe that their families are often impeded by these same factors. Just as many programs treat the person of concern as a passive recipient of mental health services, so family members are often viewed by clinicians as outsiders to treatment decisions, their input and insights placed on the sidelines of planning, or — worse yet — their behavior judged by clinicians as pathological. It is not uncommon, for example, for treaters to label parents and other family members as "treatment-interfering" or "enabling" (the latter term referring to their over-involvement in their child's life, and their participation in generating problem behavior). Families of people with psychiatric distress can also experience a significant disconnection from their communities due to stigma. They can become traumatically disoriented, their input on their loved one discounted, and their connection to their community frayed, as they face an unclear future alone, with no map, no way to chart a course.

A bit tongue and cheek, we say at Ellenhorn that we've invented a new word for the term "enabling." Half-seriously, we say our new term for "enabling" is "love." Even under the best of circumstances, no parental love is uncolored by pain, anxiety and worry. But when a child suffers from difficult psychiatric experiences, these painful parts of a parent's love often come to dominate, powerfully influencing the parents' behavior. In the grip of those emotions, parents can act against their best judgment; even, at times, doing and saying things that, to clinicians, appear destructive to treatment. Yet when clinicians blame parents for this love-based behavior, they only increase their suffering. The clinicians' critical attitude deepens the parents' sense of isolation and loss of control with respect to their child.

We at Ellenhorn — many of us, parents — are sensitive to this awful marriage between parental anxiety and therapeutic processes that can isolate the parents of people diagnosed with a psychiatric condition. Instead, we take a collaborative approach to parents and other family members, making sure to include their important voices in our work. While Ellenhorn's main focus is on our clients — on giving them voice and nurturing their ability to become autonomous individuals, and even though this focus sometimes conflicts with the wishes of parents — parents and other members of our clients' intimate networks remain an integral part of our care. Their insights provide important guides to effective treatment. In addition, helping parents learn new ways of working with their loved one translates into a better prognosis for him or her. When a person leaves our program, they will often return to family as their central network of support. Our goal is to make that network as strong and nurturing as possible.

Ellenhorn provides many kinds of collaborative family therapies, including Open Dialogue. With our client's permission and collaboration, we also incorporate into treatment regular (often weekly) contact with parents and other family members. Ellenhorn also offers regular family weekends. These events bring families together, helping them connect with others who are going through or who have had similar experiences, and helping them combat their sense of isolation. Some weekends are for families whose person of concern is experiencing psychosis. These educational weekends are also designed to create helpful bonds among participants. Other family weekends are more focused on this bond, and on helping families learn how to care for themselves while they help their loved one recover.

Whether working with clients or family members, we can proudly say, without hesitation, that Ellenhorn's staff are trained in the most current and researched treatments that are, at root, collaborative approaches. *In fact, our collaborative approach starts on a person's first phone call with our admissions staff, then continues the moment a client walks through Ellenhorn's doors, as we immediately begin working with the client (and often, with their family and network) on developing a completely individualized plan for recovery called the Roadmap to Recovery.*

Beginning with Us: The Roadmap to Recovery

While the typical relationship between assessment and treatment in mental health care is a two-step process, in which treatment follows assessment, we begin treatment at Ellenhorn immediately. We have two reasons for this simultaneous approach. First, we don't want our clients to wait for treatment. That's why we conduct an extensive review of each client before they arrive at Ellenhorn, and are confident we can match treatments to their needs from the start. Second, and more importantly, we believe that the best way for clinicians to fully understand a person is within a therapeutic relationship.

Many kinds of information can be gathered when a client meets a virtual stranger in order to complete a psychiatric assessment, as occurs in a traditional assessment. But this information typically lacks nuance and a full understanding of the whole person. The best

way to build an assessment that leads to a person-centered plan is through a combination of formal and classic assessment techniques — psychological testing, medical record review, and life history, to name just a few — coupled with the important insights that can only come through a partnering relationship between a clinical team and their client.

While Ellenhorn clinicians have significant expertise in helping people, we also know that our clients are the experts on their own experience, what best helps them, and what they want to achieve in their lives. Accordingly, our beginning assessment process is not the traditional static report of symptoms and diagnoses. It is an endeavor developed in partnership and in conversation with our clients that combines in-depth investigation of a person's psychiatric issues with serious assessment of other aspects of their life, including their physical wellness, social experiences and context, and spiritual posture. Our aim is to build a tool that can help our clients navigate their growth with us, as they pursue their dreams. That tool is called the Roadmap to Recovery.

The Roadmap to Recovery

We begin working on the Roadmap to Recovery as soon as a client enters our program. We typically complete the Roadmap within the first month of care, although it can take slightly longer.

To acquire the necessary information about a client, we typically conduct an in-depth holistic (whole-person) assessment. In reality, this consists of many assessments, each addressing one facet of a complex individual. Included are neuropsychological and psychological tests; psychiatric and neurological examinations; and assessments of physical wellness, family dynamics, substance use and other addictions, spirituality, social/developmental issues, mind/body wellness issues, and educational and vocational experiences. When necessary, a client consults with Ellenhorn specialists in particular areas.

Too often, consumers of mental health care receive varied and even conflicting diagnoses. Typically, these diagnoses are formulated from a purely brain-bound stance, one that exclusively reflects the person's psychological status, as if their suffering has little or nothing to do with their social experiences and the life they lead. In contrast, our multi-faceted assessment provides a thoughtful and holistic picture of a person's situation that gives equal weight to their social being. Partnering with our clients, we are curious to know how they connect with others, where they feel most at home, which community experiences give them a sense of meaning and belonging, and how they see their role in the world. We also want to know when and where they have felt most isolated, if they've had experiences of being estranged from or ostracized by others, and if they've experienced significant periods of purposelessness, and/or a general sense of being an outsider.

Our assessments are *living* documents, focused not on a diagnostic snapshot that represents one moment in time, but designed for use in developing a highly personalized and ever-evolving plan for recovery. Once the plan is complete, the client's team meets — typically with the client present — to develop the comprehensive, multidisciplinary treatment plan (our Roadmap to Recovery). The plan targets life-goals desired by the client that both client and team agree are achievable.

We see each client as having certain dreams for the future, yet facing barriers to realizing these dreams. They come to us living in a sort of "field" between dreams and barriers. Our job is to help them lift the barriers and use their skills to turn their dreams into realities. Ellenhorn's Whole-Person Assessment process helps us gain an essential understanding of the strengths a client can call upon to reach their dreams, as well as the barriers they face.

The Open Dialogue-Informed Process. Sometimes clients come to us not able to articulate what they need in the present or want for the future. Often this is because they are struggling with psychotic experiences. For such individuals, our Whole-Person Assessment might feel too intrusive-feeling or demanding. When someone is struggling to articulate their experience, we typically offer our Open Dialogue-informed process as a means to develop their Roadmap to Recovery.

While our Whole-Person Assessment relies on the clinical assessment and input of Ellenhorn clinicians, the Open Dialogue process is, for some clients, an effective alternative to formal assessments. Over several weeks, as a new client participates in weekly discussions with their team — which often include family — everyone gains an understanding together about the client's dreams and challenges. Ultimately, this collective understanding enables a client to design his or her own treatment plan for recovery. Thus, through Open Dialogue, the client has a large and empowering role in determining the nature of their treatment and establishing life-goals, based on their particular way of articulating their needs. A client participating in Open Dialogue at this initial stage can choose to also participate in any assessment(s) given as part of our Whole-Person Assessment Process.

The Real Deal: A Truly Integrative, Whole-Person, Person-Centered Approach

We at Ellenhorn take seriously our mission to provide *whole-person* and *person-centered* care. Whole-person care is based on the recognition that a person's psychological suffering has multiple roots. Whole-person care thus depends on a multidisciplinary approach, one in which a client's suffering is addressed through multiple means.
Viewing a person in their entirety also means identifying and understanding their strengths. Thus whole-person care is also inherently "strength-based," viewing clients as people who are rich in personal resources and doing the best they can, while facing difficult odds. In a whole-person approach, enhancing and bolstering a person's strengths is as important as — often more important than — addressing where they might have deficits.

Person-centered care is grounded in a view of each client as a distinct individual who is best served when treatment is molded to her unique needs and strengths. In person-centered care, clinicians might follow preexisting treatment protocols designed for particular complaints or symptoms, but their main goal is to develop a specific treatment for

every client that matches each of their unique needs. Person-centered care is always about invention and innovation on a granular scale, fashioning treatment to the one-of-a-kind qualities of every person. It is impossible to fashion these person-centered treatments without listening closely to clients and without partnering with them. Thus person-centered care is inherently collaborative, and focused on finding ways to enhance and support each client's voice in treatment. In person-centered care, the *person* is at the center of how the treatment is designed.

Whole-person and person-centered are warm and appealing terms, and many mental health treatment programs use them prominently in their promotional efforts. However most programs using these terms are, in reality, simply adding holistic and personalized modifications to the existing ways they provide care. Whether they are a hospital, residential program or outpatient counseling agency, they continue to *deliver care in the usual way, within the traditional structure of the organization, while tweaking treatment to be more personalized and offering clients more therapeutic options to choose from.*

But real whole-person and person-centered care doesn't really happen through new therapies: it require an entirely new way of doing things — a profound change in what happens during the workday of clinicians, both in their interactions with clients and with one another. These changes include the organization of treatment, such as where and when it occurs, and how the team communicates.

True whole-person and person-centered psychiatric care depend on a treatment team that is both multidisciplinary, so it can address the many factors contributing to a client's issue(s); and nimble, so team members can quickly change course in treatment as these factors change. That is why Ellenhorn teams meet regularly every week — often daily — about each client they serve. In addition, as so many of a person's experiences, so much of what makes a person unique, and thus so much of what can either obstruct or liberate a person's movement towards change, happens in the real world, truly whole-person and person-centered programs must also provide services where clients lead their lives. That is why most of our work at Ellenhorn is conducted right in the community, in people's homes, near their workplace or school; just about anywhere.

What's more, for an approach to truly address the whole person as well as provide person-centered care contoured to each individual's unique needs, care must be provided beyond the 9-5 hours of an office. That is why Ellenhorn offers 24-hour support, often meeting with clients face-to-face at points of crisis. And real whole-person and person-centered care is always collaborative, seeking a partnering relationship between clients and clinicians. That is why the clinicians at Ellenhorn spend a significant amount of time working together with clients to design a plan for change.

Lastly, addressing the sum of a person, and creating treatment well-matched to their unique tastes, aptitudes and experiences, always involves understanding this person as a social being who often needs help re-integrating into the world around them. That is why Ellenhorn sees work, school and family involvement as *forms of treatment,* not simply the treatment goals a person reaches once they have been "cured," and why so much of our work involves helping people return to their vocational, family or educational pursuits.

At Ellenhorn, the terms *whole-person care* and *person-centered care* are much more than slogans. Providing these forms of care in the truest sense is fundamental to our values, part of our DNA, influencing everything we do. They are central to the pledge we make to every client:

Our treatment is formed around each client's unique experiences, personality and pace of change. No treatment is the same, and all treatment evolves according to the client's needs. We see a direct relationship between getting better, becoming empowered and re-integrating into the world. That's why our clients are leaders in their own care and why so much of our work is conducted outside our office, in the community. We help people re-enter the world, return to their social role and resume their pursuit of a purposeful life.