Kris Kelsang Lipman

SW 431-Case Presentation

03/09/14

Case Presentation Outline

**Client introduction and context**

Client: Celia Rider A&D Clinician: Kris Kelsang Lipman

Agency: Project Network Mental Health Clinician: Francesca Barnett

Celia Rider is a 34 year-old woman who is in treatment at Project Network with her 3 year-old son Krimson. Project Network is an Alcohol and Drug residential in-treatment center for women and their children, who can receive lodging, addictions and mental health counseling, and case management while they work to stabilize themselves and maintain recovery. Celia entered into treatment at PNET last November, her drugs of choice being Alcohol and Meth. Celia has also been diagnosed with PTSD by a Mental Health therapist at PNET and works weekly with that therapist. Since then, she and I have been working together-I as her A&D clinician-to uncover her triggers and learn skills she can utilize when she finds herself in high-risk/high-stress situations. We meet twice a week for 45-60 minutes, and Celia also attends groups 5 days a week with the other clients in the center. These groups include: Relapse Prevention, MRT (Moral Reconation-Therapy), Process Group, Living in Balance, Domestic Violence, DBT (Dialectical Behavior Therapy), and weekly AA meetings. I facilitate her Living in Balance group so we work together in that context once a week as well. This group incorporates skills-training as well as time for processing, and focuses on practicing skills for sober, healthy living post treatment.

Celia identifies culturally and spiritually with the Ho-Chunk tribe and considers many of her fellow tribal members to be her family and community. Celia also identifies as having two families, her biological family, and her adopted family. Celia reports that she and her brother Clover are “the last remaining members of her biological family”. In her lifetime, her father has not been present in her life save for a few years she can remember during which he was abusive to her mother, and her bio-mother and bio-sister are dead. Celia’s relationship status is “single”. Krimson’s father, Great Horse, and she have been separated for about nine months, and were never legally married. Celia desires sole custody of Krimson and at this point there is no custody documentation in place. This is a process we are working with the state of Oregon on, filing custody papers and applications.

**Presenting problem/concern: Precipitating event**

 Until March of 2013, Celia reports having been sober for 5 ½ years, 27 months of which she was in prison for an arson and attempted murder charge. Celia says she relapsed due to her struggle to balance her full-time course load at PCC, parent her son, and manage the abusive relationship she was in with Krimson’s father. She relapsed on Meth and began using several times a week. Then, in August she was in an auto-accident which impaired her nerves severely, mainly in her feet. She was unable to walk without support of crutches and a person to assist her. She had 8 surgeries to address this nerve damage over about 3 months. During her recovery from the accident, she began abusing alcohol again in late August. Until this past November when she entered PNET she had been utilizing Outpatient services from NARA, and reports working with a NARA advocate when she decided she needed to be in a residential level setting, as Outpatient services were clearly not effective for her.

**Case goals and objectives**

Celia and I created these goals collaboratively in the first two weeks we worked together. The focus on the three problems she identified as having which were:

“I can’t manage my life, school, parenting, because of my use. And co-dependency is a big, big issue for me…I feel like I always need someone, and I know lots of my relationships have been fucked up, for me and for Krimson.”

“Parenting is really difficult for me. Even though I’ve had four kids, Krimson is the first one I’ve parented, and it’s really hard, especially because I’m a woman and he needs men to show him the ways of our people and to teach him his role in our community”.

“I know I can’t really express my emotions. I think that’s what got me here and back to using. I know I drink because of the other stuff underneath, but it’s hard for me to show how I feel without the alcohol. I use alcohol to be able to show my anger, and then I end up hurting people around me or myself”.

For these identified problems, the goals we constructed are as follows:

Goal: Ct will maintain sobriety post tx indefinitely, and create a healthy recovery environment post tx with the help of NARA and other culturally specific services.

Objective: Ct will learn 5 coping skills for addressing triggers, and avoiding high risk situations. Ct will practice these skills at least 2x a week for 90 days. Ct will work with clinician to establish her ideal recovery environment post tx, acquire housing in Portland near her closest family members, and apply to finish her final term at PCC so that she can acquire her Associates of Science degree.

Intervention: Ct will attend Relapse Prevention, Matrix, MRT groups for 6 months.

Ct will coordinate services with NARA with her A&D clinician, and meet with her clinicians 2x weekly.

Ct will smudge at least 2x a week when she meets with her A&D clinician, and more if deemed necessary.

Goal: Ct will become a more knowledgeable and effective parent.

Objective: Ct will develop 3-5 parenting skills within 90 days. Ct will practice using these skills with Krimson, and be able to identify at least 3 situations/behaviors for which she has applied these skills, with a focus on discipline and healthy communication.

Intervention: Ct will attend Parenting group and Healthy U group for 6 months.

Ct will contact two male-identified community members within the next three weeks to discuss practices she can engage in with Krimson to continue her Native teachings with him.

Goal: Ct hopes to become more comfortable with discussing and/or processing her trauma. Ct hopes to learn skills which will assist her in handling stress, anger, and co-dependent behaviors.

Objective: Ct will learn 5 skills within 90 days which help her manage her stress. Ct will prevent herself from acting on anger 5-7 times within 90 days, instead using tools like identifying her thinking errors, expressing her feelings, and creating boundaries to address her frustrations.

Intervention: Ct will attend Seeking Safety, Processing Group, and Living in Balance for 6 months.

Ct will meet with herMental Health clinician 1x a week for 6 months to connect her history of trauma to her use in a way that is productive and enlightening.

**Practice Model**

Strengths-based: Acknowledge Celia’s inherent strengths and focuses on building them in her journey towards recovery

Cultural Empowerment: Celia’s perspective is shaped heavily by her cultural and spiritual values/beliefs. Recognizing these beliefs and how they work with or contrast with the mainstream models of Addictions Counseling/Therapy is a major part of our work together. Focusing on the strengths and assets that her cultural framework brings to her treatment process is a priority.

CBT: Six phases:

Assessment or psychological assessment;

**Reconceptualization**; (this is where most of our CBT work comes into play via minimizing negative or self-defeating thoughts, changing maladaptive beliefs about pain, and goal setting)

Skills acquisition;

Skills consolidation and application training;

Generalization and maintenance;

Post-treatment assessment follow-up.

**Issues/dilemmas/questions**

1. Acknowledging that Celia’s recovery environment and community offers support while also being a high-risk environment. Particularly with regards to using NARA’s services, as Celia expresses often that because she is acquainted with so many people who are NARA service users, and because many of these acquaintances are people with whom she’s had tense interactions or knows in the context of her use, it is difficult sometimes to attend NARA’s AA meetings or cultural events due to it being such a close-knit space. Process of finding other resources that are just as culturally relevant and responsive??
2. Celia acknowledges that she minimizes the gravity of her addiction, and we have just gotten to a place where she is able to appreciate how much power her addiction has over her. Must work needs to be done to prevent this realization from evolving into a sense of powerlessness. How to reinforce that Celia absolutely can be in control, as long as she approaches her addiction with “a sense of humility” (for lack of a better phrase)?
3. One big dilemma has to do with the fact that as clinicians, everyone at this agency has their own facilitation style. In our work together, Celia and I center our discussions from as culturally responsive of a perspective as we can in a clinical framework that is not necessarily built to meet the needs of every cultural group. Several times, Celia has commented the material in her groups not being applicable or being contradictory to her cultural beliefs and values. A few times she has had interactions with clinicians that she feels were disrespectful on their behalf, and has expressed her frustrations with having to justify her needs and perspective to therapists/counselors. Once, a colleague was speaking in a staff meeting about Celia’s demeanor in her Domestic Violence group, and stated that Celia was “…hiding behind her cultural practices so that she doesn’t have to engage fully in the exercises” that this counselor provides. I felt helpless in my role as Celia’s clinician, and wanted to listen to what this counselor was saying to best be able to advocate for Celia. What I recommend to Celia is to self-advocate and explain her perspective to her therapists as best she can in order to open lines of communication so that she’s not frustrated and unable to benefit from the groups. That being said, this advice contrasts with my personal belief/value that People of Color should never have to teach their authority figures/teachers/counselors how to do their jobs when working with People of Color. Unfortunately I’m not in a position of experience or authority at this agency or in this field, and I don’t feel as though my perspective is valued as much as that of the other clinicians.