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Chapter 1 : Treatment | Autism Spectrum Disorder (ASD) | NCBDDD | CDC

The change in tax treatment will also affect the shareholders' tax basis in their shares. To assist investors with tax-basis reporting, Form (Report of Organizational Actions Affecting Basis of Securities) has been posted on the Investor Relations section of the CenturyLink website at Form DIV Information.

There are many circumstances that motivate people to admit that their drug and alcohol use has become a problem and then find the willingness to seek help. For some, however, even in the face of dire consequences, there is a tendency to remain in denial about the magnitude of their addiction. Other people may become aware of a problem, but find it difficult to take the necessary steps to seek help and enter into recovery. Then, there are those who are able to identify the need for a change and are ready and able to take the necessary steps to find and maintain support. Precontemplation During the precontemplative stage of change, people are not considering a need for change and are therefore uninterested in seeking help. In this stage, the addicted person is likely to become defensive and rationalize drug and alcohol use. In working with an individual in the precontemplative stage, the recovery team assists the client in moving towards contemplation by helping them to adjust their locus of control i. The treatment team will also use motivational interviewing techniques to help the client consider the possibility for a change. Contemplation In the contemplative stage, people are aware of the personal consequences of their addiction and spend time thinking about their problem. In this stage, the addicted person may be open to some discussion about the consequences of their addiction; however, they remain ambivalent about making a change. In the contemplative stage, the treatment team will help the client weigh the benefits and costs of seeking help and will continue using motivational interviewing techniques to assist the client in imagining new options for their life and potential steps to break free from active addiction. Preparation During the preparation stage, people have made a commitment to make a change. Often times, clients will unconsciously attempt to skip this stage and enter directly into taking action; however, it is important that the treatment team supports the client in adequately preparing to take action. During this stage, counselors will empower the client to gather information about potential options for change, looking at recovery supports that meet their personal interests. In a holistic treatment approach, as found at Journey Pure, the treatment team will continue supporting the preparation stage of change once the client enters treatmentâ€”developing a personalized treatment plan for each client that best fits his or her individual needs. Action In the action stage, people believe they have the ability to change and are actively involved in taking steps in recovery. The client dives deep into assignments, personal inventories, and relapse prevention work to ensure a successful transition out of treatment and into recovery. People in this stage tend to remind themselves of their progress and build community supports that reinforce their recovery goals. In order to ensure ongoing recovery, a competent treatment team will assist the client in case management, helping the client to gather essential resources and supports prior to leaving the facility. Supporting our loved ones in recovery can often feel overwhelming and full of conflicting emotions. By understanding what motivates clients to change, treatment professionals can work more effectively to develop individualized treatment plans that encourage healthy progress towards recovery. Once in treatment, individuals begin to develop the tools and resources to ensure ongoing support and maintain recovery as they transition back into their day-to-day lives. Will your insurance pay for treatment?

Chapter 2 : Psychotherapy - Wikipedia

Center for Change uses a multidisciplinary approach with specialized and intensive treatment help for eating disorder patients under the care of a supportive and experienced staff. We offer comprehensive eating disorder programs â€" from acute inpatient, residential care, and day and evening programs to outpatient services and aftercare.

Eligibility[edit] In current medical practice, a diagnosis is required for sex reassignment therapy. In the International Classification of Diseases the diagnosis is known as transsexualism [9]. As of February , the most recent version of the standards is Version 7. Only some gender-nonconforming people experience gender dysphoria at some point in their lives". Gender nonconformity is not the same as gender dysphoria; nonconformity, according to the standards of care, is not a pathology and does not require medical treatment. Local standards of care exist in many countries. Persistent, well-documented gender dysphoria; Capacity to make a fully informed decision and to consent for treatment; Age of majority in a given country however, the WPATH standards of care provide separate discussion of children and adolescents ; If significant medical or mental health concerns are present, they must be reasonably well-controlled. Often, at least a certain period of psychological counseling is required before initiating hormone replacement therapy, as is a period of living in the desired gender role, if possible, to ensure that they can psychologically function in that life-role. On the other hand, some clinics provide hormone therapy based on informed consent alone. Generally speaking, physicians who perform sex-reassignment surgery require the patient to live as the members of their target gender in all possible ways for at least a year "cross-live" , prior to the start of surgery, in order to assure that they can psychologically function in that life-role. Other frequent requirements are regular psychological counseling and letters of recommendation for this surgery. It is sometimes required even before hormone therapy, but this is not always possible; transsexual men frequently cannot "pass" this period without hormones. Transsexual women may also require hormones to pass as women in society. Most trans women also require facial hair removal, voice training or voice surgery , and sometimes, facial feminization surgery , to be passable as females; these treatments are usually provided upon request with no requirements for psychotherapy or "cross-living". Some surgeons who perform sex reassignment surgeries may require their patients to live as members of their target gender in as many ways as possible for a specified period of time, prior to any surgery. Therefore, many surgeons are willing to perform some or all elements of sex reassignment surgery without a real-life test. This is especially common amongst surgeons who practice in Asia. However, almost all surgeons practicing in North America and Europe who perform genital reassignment surgery require letters of approval from two psychotherapists; most Standards of Care recommend, and most therapists require, a one-year real-life test prior to genital reassignment surgery, though some therapists are willing to waive this requirement for certain patients. The requirements for chest reconstruction surgery are different for transmen and transwomen. The Standards of Care require trans men to undergo either 3 months of Real-life-test or psychological evaluation before surgery whereas transwomen are required to undergo 18 months of hormone therapy. The requirement for trans men is due to the difficulty in presenting as male with female breasts, especially those of a C cup or larger. For very large breasts it can be impossible for the trans man to present as male before surgery. For trans women, the extra time is required to allow for complete breast development from hormone therapy. Having breast augmentation before that point can result in uneven breasts due to hormonal development, or removal of the implant if hormonal breast development is significant and results in larger breasts than desired. Eligibility of minors[edit] While the WPATH standards of care generally require the patient to have reached the age of majority, they include a separate section devoted to children and adolescents. While there is anecdotal evidence of cases where a child firmly identified as another sex from a very early age, studies cited in the standards of care show that in the majority of cases such identification in childhood does not persist into adulthood. This treatment is controversial as the use of puberty blockers involves a small risk of adverse physical effects. A study made a longer-term evaluation of the effectiveness of this approach, looking at young transgender adults who had received puberty suppression during adolescence. It found that "After gender reassignment, in young

adulthood, the [gender dysphoria] was alleviated and psychological functioning had steadily improved. Well-being was similar to or better than same-age young adults from the general population. Improvements in psychological functioning were positively correlated with postsurgical subjective well-being. By delaying the onset of puberty, those children who go on to gender reassignment "have the lifelong advantage of a body that matches their gender identities without the irreversible body changes of a low voice or beard growth or breasts, for example,". Hormone replacement therapy trans For trans people, hormone replacement therapy HRT causes the development of many of the secondary sexual characteristics of their desired sex. However, many of the existing primary and secondary sexual characteristics cannot be reversed by HRT. For example, HRT can induce breast growth for trans women but can only minimally reduce breasts for trans men. HRT can prompt facial hair growth for transsexual men, but cannot regress facial hair for transsexual women. HRT may, however, reverse some characteristics, such as distribution of body fat and muscle, as well as menstruation in trans men. Generally, those traits that are easily reversible will revert upon cessation of hormonal treatment, unless chemical or surgical castration has occurred, though for many trans people, surgery is required to obtain satisfactory physical characteristics. But in trans men, some hormonally-induced changes may become virtually irreversible within weeks, whereas trans women usually have to take hormones for many months before any irreversible changes will result. As with all medical activities, health risks are associated with hormone replacement therapy, especially when high hormone doses are taken as is common for pre-operative or no-operative trans patients. It is always advised that all changes in therapeutic hormonal treatment should be supervised by a physician because starting, stopping or even changing dosage rates and levels can have physical and psychological health risks. Although some trans women use herbal phytoestrogens as alternatives to pharmaceutical estrogens , little research has been performed with regards to the safety or effectiveness of such products. Anecdotal evidence suggests that the results of herbal treatments are minimal and very subtle, if at all noticeable, when compared to conventional hormone therapy. Chest reconstruction surgery[edit] Main articles: Male chest reconstruction and Breast implant For a lot of trans men chest reconstruction is desired, or required. Binding of the chest tissue can cause a variety of health issues including reduced lung capacity and even broken ribs if improper techniques or materials are used. A mastectomy is performed, often including a nipple graft for those with a B or larger cup size. For trans women , breast augmentation is done in a similar manner to those done for cisgender women. As with cisgender women, there is a limit on the size of implant that may be used, depending on the amount of pre-existing breast tissue. Sex reassignment surgery[edit] Main article: SRS may encompass any surgical procedures which will reshape a male body into a body with a female appearance or vice versa, or more specifically refer to the procedures used to make male genitals into female genitals and vice versa. Sex reassignment surgery is the most common term for what may be more accurately described as "genital reassignment surgery" or "genital reconstruction surgery. There are significant medical risks associated with SRS that should be considered before undergoing the surgery. Other procedures[edit] Facial feminization surgery FFS is a form of facial reconstruction used to make a masculine face appear more feminine. FFS procedures can reshape the jaw , chin , forehead including brow ridge , hairline, and other areas of the face that tend to be sexually dimorphic. Vocal therapists may help their patients improve their pitch, resonance, inflection, and volume. Before surgery, transsexual people often need assistance with passing in public, including help with gestures and voice modulation. Participation in support groups, available in most large cities, is usually helpful. Similar to trans women, trans men should live in the male gender role for at least 1 yr before surgery. Anatomic results of neophallus surgical procedures are often less satisfactory in terms of function and appearance than neovaginal procedures for trans women. Complications are common, especially in procedures that involve extending the urethra into the neophallus. Risk factors for return to original gender role include history of transvestic fetishism , psychological instability, and social isolation. In adolescents, careful diagnosis and following strict criteria can ensure good post-operative outcomes. Many prepubescent children with cross-gender identities do not persist with gender dysphoria. However, some successful patients who wish to blend into the community as men or women do not make themselves available for follow-up. Also, some patients who are not happy with their reassignment may be more known to clinicians as they continue clinical

contact. Some satisfactory outcomes were reported, but the magnitude of benefit and harm for individual surgical procedures cannot be estimated accurately using the current available evidence. The vast majority functioned quite well psychologically, socially and sexually. Two non-homosexual male-to-female transsexuals expressed regrets. The study states that "no inferences can be drawn [from this study] as to the effectiveness of sex reassignment as a treatment for transsexualism," citing studies showing the effectiveness of sex reassignment therapy, though noting their poor quality. The authors noted that the results suggested that those who received sex reassignment surgery before had worse mortality, suicidality, and crime rates than those who received surgery on or after McHugh is a well-known opponent of sex reassignment therapy. According to his own article, [29] when he joined Johns Hopkins University as director of the Department of Psychiatry and Behavioral Science, it was part of his intention to end sex reassignment surgery there. McHugh succeeded in ending it at the university during his time. Her paper was allegedly instrumental in removing Medicaid and Medicare support for sex reassignment therapy in the US. In many areas with comprehensive nationalized health care, such as some Canadian provinces and most European countries, SRT is covered under these plans. In other countries, such as the United States , no national health plan exists and the majority of private insurance companies do not cover SRS. HHS says it will move to implement the ruling. As Medicaid and private insurers often take their cues from Medicare on what to cover, this may lead to coverage of sex reassignment therapy by Medicaid and private insurers. The Act was widely welcomed by civil society organizations.

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Chapter 3 : Moving through the 5 stages of change in recovery from addiction

The mean ARR fell from before treatment to after treatment, with a mean improvement of in EDSS score. Overall, EDSS scores improved in 14 patients, remained stable in 12, and worsened in 6.

Immediate access to this article To see the full article, log in or purchase access. She completed a family practice residency at Good Samaritan Hospital in Dayton. Address correspondence to Gretchen L. Reprints are not available from the authors. Smoking cessation in hospitalized patients. Effectiveness of physician-based interventions with problem drinkers: How to help your patients stop smoking: In search of how people change. What really drives change? Miller WR, Rollnick S. Stages of change and decisional balance for 12 problem behaviors. Assessing the stages of change and decision-making for contraceptive use for the prevention of pregnancy, sexually transmitted diseases, and acquired immunodeficiency syndrome. Use of the stages of change in exercise adherence model among older adults with a cardiac diagnosis. Stages of change in adopting healthy diets: An algorithm for smoking cessation. Brief interventions with substance-abusing patients. Med Clin North Am. Am J Public Health. Mediators of change in physical activity following an intervention in primary care: Experimental evidence for stages of health behavior change: Paraprofessional delivery of a theory based HIV prevention counseling intervention for women. A cross-national trial of brief interventions with heavy drinkers. Effectiveness of brief interventions in reducing substance use among at-risk primary care patients in three community-based clinics. The Health Belief Model: Generalized expectancies of internal versus external control of reinforcement. Enhancing motivation for change in problem drinking: J Consult Clin Psychol. Drug and alcohol review. Matching alcoholism treatments to client heterogeneity: Project Match Research Group. Motivational interviewing to improve adherence to a behavioral weight-control program for older obese women with NIDDM. Helping smokers make decisions: Miller WR, Rollnick W. Professional training videotape series. University of New Mexico, Professional responses to innovation in clinical method: Guest editors of this series are Cynthia G.

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Chapter 4 : A 'Stages of Change' Approach to Helping Patients Change Behavior - - American Family Phys

NCBI Bookshelf. A service of the National Library of Medicine, National Institutes of Health. Center for Substance Abuse Treatment. Enhancing Motivation for Change in Substance Abuse Treatment.

Psychiatric services Academic and technical schools While you are exploring treatment options with a client, also review the concept of change as a wheel or cyclical process see Chapter 1. Each person moves through the stages of change--forward or backward--over a substantial period of time Prochaska and DiClemente, ; Prochaska et al. This cycling sometimes takes the form of an upward spiral, with gradual improvement in the spacing, length, and severity of periods of problematic behavior Miller, Because most people typically move around the cycle several times before exiting into stable recovery, let clients know that they should not become discouraged if their first treatment option does not work. Point out that, with all the possibilities, they are certain to find some form of treatment that will work. Reassure them that you are willing to work with them until they find the right choice. Clients sometimes resist the idea that change is a cyclical process and prefer to view change as "all or nothing. It is of the utmost importance to convey to your clients that they can return to see you no matter what, even after a slip. You also should be sensitive to the client who resists an idea you have found motivational for others. In this case, you might say, "It sounds like this issue is really important to you. Tell me more about that," or "It sounds like you would not want to go through that again, and I can understand why, at this point, you would not want to talk about those things. So, to help you with this, let me know how I can help you avoid the things that led to recurrence in the past, while at the same time help you avoid discussing the things that you do not think are helpful. Clinicians are accustomed to the idea that treatment success means completing a formal program and, conversely, dropping out means treatment failure. However, research has shown that a significant number of clients stop treatment because they do not need further help and can implement change on their own DiClemente and Scott, Often, they only need assistance in maximizing their readiness to change and enhancing their motivation. No further aid is wanted--no negotiating, no plan, no contract--just encouragement and reassurance that they can return if they need more help. The danger is that some clients, such as those with a long history of excessive and relatively uninterrupted substance use, may take this opportunity to run away from treatment. When these clients suggest trying to change on their own, discuss your concerns about their leaving prematurely. Several programs offer time-limited check-in modules to prepare clients for change. For example, a treatment program in Austin, Texas, periodically offers a 2-hour group for people who smoke. The program contains educational and motivational components as well as some elements of self-help through group support. Although participants are told how to access treatment if necessary, the group is designed to help participants initiate self-change. Research suggests that some people can change substance-dependent behaviors on their own without treatment DiClemente and Prochaska, ; Klingemann, ; Sobell et al. Developing a Behavior Contract A written or oral contract is a useful tool for helping clients start on their change plans. A contract is a formal agreement between two parties. Literate clients may choose to make a signed statement at the bottom of the Change Plan Worksheet or may prefer a separate document. Explain to literate clients that other people have found contracts useful at this stage and invite them to try writing one. The act of composing and signing a contract can be a small but important ceremony of commitment. Avoid writing the contract for clients and encourage them to use their own words. With some, a handshake is an adequate substitute for a written contract, particularly with the client who lacks literacy. Whom is the contract with? What parties does it involve? Other clients regard the contract as a promise to themselves, to a spouse, or to other family members. Contracts are often used in treatment programs that employ behavioral techniques. For many clinicians, contracts mean contingencies--rewards and punishments--and programs often build contingencies into the structure of their programs. For example, in many methadone maintenance programs, take-home medications are contingent on substance-free urine screens. Rewards or incentives have been shown to be highly effective reinforcers of abstinence. In a treatment program study of 40 cocaine-dependent adults Higgins et al. The other group received no vouchers. Seventy-five percent of the voucher group completed 24 weeks of treatment, compared

with 40 percent of the control group, and the duration of continuous cocaine abstinence in the voucher group was nearly twice as long as that of the control group See Chapter 7 for more discussion of incentives. In developing a contract, the client may decide to include contingencies, especially rewards or positive incentives. Rewards can be highly individual. Enjoyable activities, favorite foods, desired objects, or rituals and ceremonies can all be powerful objective markers of change and reinforcers of commitment. Rewards can be tied to duration of abstinence, to anniversaries of the quit date, or to achievement of subgoals. One client might plan to spend the afternoon at a baseball game with his son to celebrate a month of abstinence. Another might buy a pair of red shoes after attending her 50th AA meeting. Still another might light a candle at church, and another might hike to the top of a nearby mountain to mark an improvement in energy and health. Lowering Barriers to Action Identifying barriers to action is an important part of the change plan. As clients decide what options are best for them, ask whether they anticipate any problems with those options or any obstacles to following the plan and achieving their goals: What could go wrong? What has gone wrong in past attempts to change? As mentioned earlier, certain clients resist the idea that something could go wrong. Here, it is better to get the information by asking about what has gone wrong in the past. It is sometimes easier to discuss past difficulties than to acknowledge the possibility of difficulties in the future. One common barrier to action involves referring your client to another treatment program or other services following initial consultation or evaluation. When you refer clients, make sure they have all the necessary information about how to get to the program, whom and when to telephone, and what to expect during the call e. For example, you may know that the receptionist at the program is a friendly person, or that many people get lost by entering the building on the wrong side, or that a nearby lunch counter serves good food. One inpatient program takes clients on field trips to the outpatient aftercare site before discharge to ensure a smooth transition. Research has shown that giving the client a name and telephone number on a piece of paper is far less effective than more personalized referral methods Miller, b. Consider helping your client make the telephone call to set up the intake appointment at the chosen program. Some clients may want to make the phone call from your office, whereas others might wish to call the program from home and call you later to inform you that they made an appointment. Still others prefer to think things over first and make the call from your office at the next session. Let your clients know that you are interested in knowing how everything goes. Anticipating problems As suggested in the Change Plan Worksheet, one question to ask clients is, "If down the line the plan fails, what do you envision might be the cause? Do not try to anticipate everything that could go wrong; focus on events or situations that are likely to be problematic and build alternatives and solutions into the plan. Some problems may be clear from the outset. A highly motivated client sitting in your office may plan to attend an outpatient treatment program 50 miles away three times a week, even though such a plan involves both bus and train schedules and late-night travel. Referral to a less distant program may be the solution, although helping the client make some telephone calls to the program could identify a participant willing to provide a ride. Recognizing barriers to action Barriers to action are frequently encountered and should be discussed, if only briefly, when the change plan is being negotiated. Consider specific strategies and coping behaviors, and help clients explore what works best for them. Potential barriers exist in several areas. Family relations can be critical barriers to initiating and maintaining action. For example, the client may want to take back control. A wife who has made all family decisions by herself for a long time may react negatively to sharing power. A teenager who is used to coming and going unnoticed may rebel over a new curfew. Such family disruptions and crises can contribute to a return to substance use, and clients can anticipate and learn specific strategies and coping behaviors to avoid such an outcome. Some clients may decide to institute a family meeting at a certain time each week for discussing problems and averting crises; the first one can be scheduled in your office. Some families benefit from more formal family therapy, which can be incorporated into the change plan. Other clients may identify a respected older person, such as a grandfather or friend, who would be willing and capable of acting as an arbiter in family disagreements. Also, people in recovery attend frequent meetings, which decreases the time they have available for family. Clients may consider attending meetings during the lunch hour or at other times that do not reduce family time. Another important issue is the rebonding of a relationship or a marriage. Usually the male client is eager to return to a sexual relationship,

and the female is cautious because of the past pain and mistrust. The male then reacts to the tension that develops from not having a commitment for sexual activity from his partner. In some cases, sexual behavior is used as a device to control the recovering person, and when the expectations of the recovering person are not met, tension builds. Health problems present obstacles to recovery for many clients with serious physical or mental health disorders. Some become sick after entering treatment; others have chronic conditions that require monitoring and treatment and can produce periodic health crises e. Clients may be in chronic pain from injuries or self-neglect e. Medications taken for physical and mental health problems may cause distressing side effects. All of these conditions and situations can increase the risk of returning to substance use. Although some of these problems cannot be anticipated, clients may have to build health supports and improvements into the plan. Some clients, especially those with strong concerns about their health, may wish to include a schedule for physical and dental checkups or arrangements with specific physicians and clinics for ongoing care of chronic problems. Subgoals for acquiring medical care may involve applying for entitlement programs or checking insurance coverage. A depressed client, for example, may plan to see a mental health worker for an evaluation if she is still feeling depressed after 30 days of abstinence, or she may decide to see one sooner if her symptoms increase the risk of returning to substance use. It should be reemphasized that some clients e. System problems in the treatment program itself can be obstacles to immediate and sustained recovery. For example, many facilities have long waiting lists. Some programs require a great deal of paperwork to enter, which may put off clients with poor literacy skills.

Chapter 5 : How Addiction Treatment Enhances Motivations for Change

The Treatment Center Can Aid in the Six Stages of Change in Addiction Recovery Everyone experiences the Six Stages of Change differently, which is why individualized care is necessary for the addiction recovery process.

Close Prochaska and DiClemente? The individuals working through their substance abuse disorders experience a number of changes both during and after treatment. Most of the time, these changes reflect a pattern that has since become a model for the addiction recovery process. An Overview of the Transtheoretical Model A. This biopsychosocial model offers a unique insight into the process of purposeful behavior adjustments and reformation of poor habits? Rather than focusing only on specific aspects of change, the Six Stages focus more on the big picture. In fact, the Six Stages model of behavioral change: The flexibility of this theory? Still, most professionals use this model to examine cases of substance abuse and recovery. In order, these stages are pre-contemplation, contemplation, preparation, action, maintenance, and termination. Pre-Contemplation During the first stage, addicts will typically make excuses? Those who get stuck in this stage may be fully aware that their addiction is a problem. Still, they may also try to justify their choices to continue reaping the? The transition into the next stage of change usually occurs when addicts begin to feel shame, embarrassment, or guilt. Contemplation The second stage of change begins when addicts recognize the problem. However, people at this stage don? Instead, they weigh their options about how to address their substance abuse? Preparation The third stage marks the actual initiation of change. This is the stage where addicts truly begin to show commitment to getting sober. Most people in this stage will make the decision to quit drugs, stop drinking, and get professional help. As the name of this stage suggests, people looking to conquer addiction take the time to prepare for treatment and plan their next move. Then they take action.

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Chapter 6 : The Six Stages of Change | The Treatment Center

The cognitive model of social phobia predicts that estimated social cost is an important mediator of treatment change (Clark & Wells, ; Foa et al., ; Rapee & Heimberg,). Furthermore, an intervention that specifically targets cognitions to reduce the patients' overestimation of social cost should be more effective than a treatment.

Top of Page Behavior and Communication Approaches According to reports by the American Academy of Pediatrics and the National Research Council, behavior and communication approaches that help children with ASD are those that provide structure, direction, and organization for the child in addition to family participation. ABA has become widely accepted among health care professionals and used in many schools and treatment clinics. ABA encourages positive behaviors and discourages negative behaviors in order to improve a variety of skills. There are different types of ABA. Following are some examples: Lessons are broken down into their simplest parts and positive reinforcement is used to reward correct answers and behaviors. Incorrect answers are ignored. Positive changes in these behaviors should have widespread effects on other behaviors. Other therapies that can be part of a complete treatment program for a child with an ASD include: It also focuses on how the child deals with sights, sounds, and smells. For example, picture cards can help teach a child how to get dressed by breaking information down into small steps. Occupational Therapy Occupational therapy teaches skills that help the person live as independently as possible. Skills might include dressing, eating, bathing, and relating to people. Sensory Integration Therapy Sensory integration therapy helps the person deal with sensory information, like sights, sounds, and smells. Sensory integration therapy could help a child who is bothered by certain sounds or does not like to be touched. Some people are able to learn verbal communication skills. For others, using gestures or picture boards is more realistic. The person is taught to use picture symbols to ask and answer questions and have a conversation. Visit the Autism Speaks or Autism Society website to read more about these therapies. Dietary Approaches Some dietary treatments have been developed by reliable therapists. But many of these treatments do not have the scientific support needed for widespread recommendation. An unproven treatment might help one child, but may not help another. Many biomedical interventions call for changes in diet. Dietary treatments are based on the idea that food allergies or lack of vitamins and minerals cause symptoms of ASD. Some parents feel that dietary changes make a difference in how their child acts or feels. Or talk with a nutritionist to be sure your child is getting important vitamins and minerals. But there are medications that can help some people with related symptoms. For example, medication might help manage high energy levels, inability to focus, depression, or seizures. Top of Page Complementary and Alternative Treatments To relieve the symptoms of ASD, some parents and health care professionals use treatments that are outside of what is typically recommended by the pediatrician. These types of treatments are known as complementary and alternative treatments CAM. They might include special diets, chelation a treatment to remove heavy metals like lead from the body , biologicals e. The National Institute of Dental and Craniofacial Research has a website to help health professionals with the oral health care needs of patients with an ASD. Gov lists federally funded clinical trials that are looking for participants. ATN is also developing a shared national medical database to record the results of treatments and studies at any of their five established regional treatment centers. Preschool Education Programs for Children with Autism 2nd ed. Educating Children with Autism. National Academy Press, Complementary and Alternative Medicine. Pediatric Habilitation, volume News release, Health Behavior News Service.

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Chapter 7 : AIDS Treatment | Conditions & Treatments | UCSF Medical Center

The "stages of change" or "transtheoretical" model is a way of describing the process by which people overcome addiction. The stages of change can be applied to a range of other behaviors that people want to change, but have difficulty doing so, but it is most well-recognized for its success in treating people with addictions.

By Jessica McConnan, M. Nothing could be further from the truth as addicts tend to go through what they feel are their lowest points over and over again without being able to break the cycle on their own no matter how much heart they put into trying. Another mistaken and foregone conclusion is that the addict must be highly motivated and committed to the treatment as a prerequisite to enrollment. Motivation is now viewed from a totally different perspective. It involves recognizing a problem, searching for a way to change , and then beginning and sticking with that change strategy. There is now irrefutable evidence that drug addiction is a disease and one that is treatable in the manners that other chronic conditions such as asthma or diabetes may be. Working with the patient in a collaborative partnership to promote positive changes versus the historically, confrontational, all or nothing, and argumentative atmospheres of past treatment practices proves to be more effective for these individuals. The belief that recovery is real provides the essential and motivating message of a better futureâ€"that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them. Addicts like the way that drugs make them feel and whether or not they are prepared to deal with any barriers that would prevent them from seeking, obtaining, or using drugs, the alternative is to procrastinate about making any healthy lifestyle changes. Ambivalence about substance abuse is normal, but, can be resolved by working with the client toward essential changes. The Nature of Motivation We now know that motivations to change will waver repeatedly throughout the course of any addiction treatment regardless of how well or poorly motivated the person is in the beginning. Initial motivations to stop using drugs and recover from the consequences is fleeting at best without ongoing management for negative connotations of addiction. Internal urges and desires felt by the client External pressures and goals that influence the client Perceptions about risks and benefits of behaviors to the self Cognitive appraisals of the situation There are many issues that empower the ambivalence to change and prolong recovery contemplations when they are deeply rooted in the core inner self of a person, but, even the most ambivalent addict has a chance to succeed given the right set of service components with a focus on positivity. Why Enhancing Motivations in Addiction Treatment is Important When people are faced with the important decision of whether or not to participate in an addiction treatment program, they almost always find themselves frustrated, confused, intimidated, lacking confidence or inadequately equipped in some way to comply with what they imagine will be the treatment demands. These programs impose environmental schedules and controls and require a substantial amount of emotional work and behavioral change on the part of the client. Because motivation is of central importance to any recovery from addiction, a higher priority has been placed on enhancing and maintaining client motivations as essential to greater treatment participations, retentions, and positive outcomes. Benefits of Motivational Enhancement Techniques When addiction treatment is in line with what is most concerning to the individual and in the best of their self interest, motivational enhancement techniques instill motivation by helping clients become ready, willing, and able to change what needs to be changed in order to successfully recover. Being able involves having the right resources, support, and self efficacy to change and being willing is having the desire to change, but, many are willing and able, yet still not ready, the final step which involves deciding to change. Keeping the client responsible for their treatment progression, some of the most promising treatment approaches use motivational enhancement techniques such as Motivational Interviewing as a counseling style and Contingency Management as a behavioral intervention to promote positive behaviors and enhance recovery motivations. The benefits of these techniques include: Inspiring motivation to change Preparing clients to enter treatment Engaging and retaining clients in treatment Increasing participation and involvement Encouraging a rapid return to treatment if symptoms recur To learn more about enhancing motivations in addiction treatment, call us today at

Chapter 8 : Sex reassignment therapy - Wikipedia

Implementing Change in Substance Abuse Treatment Programs TAP 31 31 Technical Assistance Publication Series U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES.

We recommend that you consult with your doctor to discuss any side effects you may experience. The following is a list protease inhibitors and their possible side effects: Amprenavir Agenerase, APV â€" Side effects include nausea, diarrhea, vomiting, rash, numbness around the mouth and abdominal pain. About 1 percent of people have serious skin reactions, including Stevens-Johnson syndrome. Atazanavir Reyataz, ATV â€" Side effects include headache, rash, stomach pain, vomiting, depression, increased cough, trouble sleeping, tiredness, back pain, joint pain, as well as numbness, tingling or burning of the hands or feet. More serious side effects include yellowing of the eyes or skin, change in heart rhythm, diabetes and high blood sugar, diarrhea, infection, nausea and blood in the urine. Indinavir Crixivan, IDV â€" Side effects include change in sense of taste, diarrhea, nausea, vomiting, dizziness or drowsiness, general feeling of weakness, headache, stomach pain and trouble sleeping. More serious side effects include kidney stones, changes in body fat, increased bleeding in patients with hemophilia, high sugar and fat levels in the blood, and onset or worsening of diabetes. In addition, patients taking Lopinavir should be monitored for possible liver problems. People taking the drug who have liver disease, such as hepatitis B or hepatitis C, may experience a worsening of their liver condition. A small number of patients have experienced severe liver problems. Nelfinavir Viracept, NFV â€" Side effects include diarrhea, weakness, headache, nausea and abdominal pain. Ritonavir Norvir, RIT â€" Ritonavir often is used in combination with other protease inhibitors â€" an approach called "Ritonavir boosting. The disadvantage is that Ritonavir interacts with many drugs, both prescription and over the counter. It is important that you speak with your doctor about all your medications before taking Ritonavir. Side effects include general weakness, burning or prickling sensation in the hands and feet, stomach pain, diarrhea, constipation, indigestion, flatulence, nausea, vomiting, loss of appetite, change in sense of taste, headache, dizziness, drowsiness, insomnia, fever, throat irritation, abnormal thinking, rash, sore throat and sweating. More serious effects include pancreas disease, changes in body fat, increased bleeding in patients with hemophilia, high sugar and fat levels in the blood, and onset or worsening of diabetes. Saquinavir Fortovase, Invirase, SQV â€" Side effects are related to the stomach and intestinal system, including diarrhea, nausea, stomach-intestinal pain, heartburn, rectal gas, vomiting, altered taste sensation, headache, fatigue, depression, sleep disturbance including insomnia, anxiety, sex drive disorder, muscle aches, rash, hepatitis and abnormal fat redistribution. The group of drugs includes Enfuvirtide, also known as Fuzeon or T HAART â€" often referred to as the anti-HIV "cocktail" â€" is a combination of three or more drugs, such as protease inhibitors and other anti-retroviral medications. The treatment is highly effective in slowing the rate at which the HIV virus replicates itself, which may slow the spread of HIV in the body. The goal of HAART is to reduce the amount of virus in your body, or the viral load, to a level that can no longer be detected with blood tests. These drugs may be prescribed in combination with other anti-retroviral drugs.

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More serious side effects include yellowing of the eyes or skin, change in heart rhythm, diabetes and high blood sugar, diarrhea, infection, nausea and blood in the urine. Fosamprenavir (Lexiva, FOS) â€" Side effects may include rash, nausea and diarrhea.

The Oxford English Dictionary defines it now as "The treatment of disorders of the mind or personality by psychological methods Freudian methods, namely psychoanalysis , in contrast with other methods to treat psychiatric disorders such as behavior modification. Delivery[edit] Psychotherapy may be delivered in person one on one, or with couples, or in groups , over the phone, via telephone counseling , or via the internet. That means that many users do not "stick to" the program as prescribed. They may uninstall the app or skip days, for instance. Psychiatrists are trained first as physicians, andâ€"as suchâ€"they may prescribe prescription medication ; and specialist psychiatric training begins after medical school in psychiatric residencies: Clinical psychologists have specialist doctoral degrees in psychology with some clinical and research components. Other clinical practitioners, social workers , mental health counselors, pastoral counselors, and nurses with a specialization in mental health, also often conduct psychotherapy. Many of the wide variety of psychotherapy training programs and institutional settings are multi-professional. Such professionals doing specialized psychotherapeutic work also require a program of continuing professional education after the basic professional training. There is a listing of the extensive professional competencies of a European psychotherapist, developed by the European Association of Psychotherapy EAP. Europe[edit] As of , there are still a lot of variations between different European countries about the regulation and delivery of psychotherapy. Several countries have no regulation of the practice, or no protection of the title. Some have a system of voluntary registration, with independent professional organisations. The titles that are protected also varies. Given that the European Union has a primary policy about the free movement of labour within Europe, European legislation can overrule national regulations that are, in essence, forms of restrictive practices. In Germany, the practice of psychotherapy for adults is restricted to qualified psychologists and physicians including psychiatrists who have completed several years of specialist practical training and certification in psychotherapy. As psychoanalysis, psychodynamic therapy, and cognitive behavioral therapy meet the requirements of German health insurance companies, mental health professionals regularly opt for one of these three specializations in their postgraduate training. For psychologists, this includes three years of full-time practical training 4. Counseling and psychotherapy are not protected titles in the United Kingdom. Counsellors and psychotherapists who have trained and qualify to a certain standard usually a level 4 Diploma can apply to be members of the professional bodies who are listed on the PSA Accredited Registers. United States[edit] In some states, counselors or therapists must be licensed to use certain words and titles on self-identification or advertising. In some other states, the restrictions on practice are more closely associated with the charging of fees. Licensing and regulation are performed by the various states. Presentation of practice as licensed, but without such a license, is generally illegal. History of psychotherapy and Timeline of psychotherapy Psychotherapy can be said to have been practiced through the ages, as medics, philosophers, spiritual practitioners and people in general used psychological methods to heal others. Called Mesmerism or animal magnetism, it would have a strong influence on the rise of dynamic psychology and psychiatry as well as theories about hypnosis. However following the work of his mentor Josef Breuer â€"in particular a case where symptoms appeared partially resolved by what the patient, Bertha Pappenheim , dubbed a " talking cure "â€"Freud began focusing on conditions that appeared to have psychological causes originating in childhood experiences and the unconscious mind. He went on to develop techniques such as free association , dream interpretation , transference and analysis of the id, ego and superego. His popular reputation as father of psychotherapy was established by his use of the distinct term " psychoanalysis ", tied to an overarching system of theories and methods, and by the effective work of his followers in rewriting history. Sessions tended to number into the hundreds over several years. Behaviorism developed in the s, and behavior modification as a therapy became popularized in the s and s. Skinner in the United States. Behavioral therapy approaches relied

on principles of operant conditioning , classical conditioning and social learning theory to bring about therapeutic change in observable symptoms. The approach became commonly used for phobias , as well as other disorders. Some therapeutic approaches developed out of the European school of existential philosophy. Laing , Emmy van Deurzen attempted to create therapies sensitive to common "life crises" springing from the essential bleakness of human self-awareness, previously accessible only through the complex writings of existential philosophers e. The uniqueness of the patient-therapist relationship thus also forms a vehicle for therapeutic inquiry. A related body of thought in psychotherapy started in the s with Carl Rogers. Based also on the works of Abraham Maslow and his hierarchy of human needs , Rogers brought person-centered psychotherapy into mainstream focus. The primary requirement was that the client be in receipt of three core "conditions" from his counselor or therapist: This type of interaction was thought to enable clients to fully experience and express themselves, and thus develop according to their innate potential. Others developed the approach, like Fritz and Laura Perls in the creation of Gestalt therapy , as well as Marshall Rosenberg, founder of Nonviolent Communication , and Eric Berne , founder of transactional analysis. Later these fields of psychotherapy would become what is known as humanistic psychotherapy today. Self-help groups and books became widespread. Independently a few years later, psychiatrist Aaron T. Beck developed a form of psychotherapy known as cognitive therapy. These approaches gained widespread acceptance as a primary treatment for numerous disorders. However the "third wave" concept has been criticized as not essentially different from other therapies and having roots in earlier ones as well. Postmodern psychotherapies such as narrative therapy and coherence therapy do not impose definitions of mental health and illness, but rather see the goal of therapy as something constructed by the client and therapist in a social context. Systemic therapy also developed, which focuses on family and group dynamicsâ€”and transpersonal psychology , which focuses on the spiritual facet of human experience. Other orientations developed in the last three decades include feminist therapy , brief therapy , somatic psychology , expressive therapy , applied positive psychology and the human givens approach. A survey of over 2, US therapists in revealed the most utilized models of therapy and the ten most influential therapists of the previous quarter-century.