BEGINNING THE THERAPEUTIC RELATIONSHIP AND OBTAINING A PROBLEM LIST AND DIAGNOSIS pdf

1: Beginning Therapy: A Primer

Obtaining a complete history from the family before talking with the client is not important in establishing a therapeutic relationship. A depressed client is very resistive and complains about inabilities and worthlessness.

American Mental Health Counselors Association: Code of Ethics Excerpt: At the outset of treatment, the patient should be made aware of the nature of psychoanalysis and relevant alternative therapies. The psychoanalyst should make agreements pertaining to scheduling, fees, and other rules and obligations of treatment tactfully and humanely, with adequate regard for the realistic and therapeutic aspects of the relationship. Promises made should be honored. See also Standards 8. Best Practice Guidelines Excerpt: They communicate information in ways that are both developmentally and culturally appropriate. Group Workers provide in oral and written form to prospective members when appropriate to group type: The principle of autonomy opposes the manipulation of clients against their will, even for beneficial social ends. Code of Ethical Conduct: Approved by the Board of Directors October 25, , Amended June 21, 5 Privacy; 15 Where the client is not capable of informed consent to treatment, interact with the legally designated substitute decision maker in such a way as to promote the greatest degree of self realization for the client; 16 Engage in mutual and ongoing negotiation with respect to therapeutic processes. Counsellors make sure that clients understand the implications of diagnosis, fees and fee collection arrangements, record-keeping, and limits of confidentiality. In this instance informed consent should be obtained from an appropriate person who is close to the patient.. In urgent circumstances, psychologists, would proceed with the assent of such persons, but fully informed consent would be obtained as soon as possible. Respect for the rights and dignity of the client. They treat as confidential all information obtained in the course of their work. As far as possible, they ensure that clients understand and consent to whatever professional action they propose. Social workers should provide clients with an opportunity to ask questions. This may include providing clients with a detailed verbal explanation or arranging for a qualified interpreter or translator whenever possible. When counseling is initiated, and throughout the counseling process as necessary, counselors inform clients of the purposes, goals, techniques, procedures, limitations, potential risks and benefits of services to be performed, and clearly indicate limitations that may affect the relationship as well as any other pertinent information. Journal of Medical Ethics, vol 39, 4, Journal of the American Medical Association, vol. In a review of informed consent documents from randomly selected US hospitals, the documents were shown to have limited educational value It is fundamental to the ethics of theraqpy and counseling. The APA ethics code sets forth specific standards for informed consent This fundamental concept can trip us up if we are not careful. The doors to our offices and clinics are wide open. The resources are all in place. But not even the most persistent patients can make their way past intimidating forms which clerks may shove at patients when they first arrive , our set speeches full of noninformative information, and our nervous attempts to meet externally imposed legalistic requirements such as the Health Insurance Portability and Accountability Act. A first step is to recognize that informed consent is not a static ritual but a useful process. Evidence-Based Practice and Psychological Treatments: The Imperatives of Informed Consent. Frontiers in Psychology, 7. Clients also have a right to be fully informed about the efficacy and effectiveness of specific techniques in therapy The point is that research must percolate into disclosure procedures: Health Psychology, , Oct , Regarding the ethical dilemma of information, informing patients about treatment benefits and modes of action in a personalized interaction might be a good strategy to buffer negative effects of informing about potential side effects, and thus to prevent nocebo side effects. International Journal of Law and Psychiatry, December, Psychologists have assumed this responsibility but may not have examined their professional capacity to fulfill this obligation. Psychologists lack the necessary legal training to fully inform the litigant of many legal ramifications of the psychological evaluation process. Even psychologists who are well informed in legal matters are not in a position to provide legal advice to litigants. Lawyers have also had the responsibility of preparing their clients

for forensic psychological evaluations, and they may be hampered in this duty by a lack of understanding of psychological testing and interview procedures, psychological ethics, and the details of forensic evaluations. In this article, we have explicated the rationale for a joint procedure for informing the litigant about the psychological evaluation. Journal of the American Medical Association, , vol. In many settings clinical informed consent involves a laundry list of potential risks recited to a patient who has already committed to a procedure, followed by the requisite signatures on a form. It is not surprising that patient comprehension is often poor. In a recent study of patients who had just provided informed consent Despite this, the general outlines of the doctrine are fairly well agreed on. Some ethicists advocate digital consent forms, delivered by computer or smart phone. Interactive forms could lead participants through the consent process, and keep them more informed during the trial. Research and Practice, June , vol. Whether they are seeking supervision to meet academic, licensure, or certification requirements or to assist in rehabilitation following an ethical violation, supervisees all benefit from having clear information about that to which they are agreeing. Many authors and specialty guidelines recommend, and ethical standards require, that informed consent be obtained in writing. The format in which the information is presented will vary with the type of supervision, the context, and the preferences and theoretical orientation of the supervisor. An insight and discussion into the law relating to consent and competence" by S. Care, Health and Development, , vol 33, 1, pages Even if both the child and parents refuse treatment, courts are reluctant to accept this, particularly if it is in the best interest of the child Recupero and Samara E. American Journal of Psychotherapy, 59 4 , , To limit liability and to protect patients, e-therapy providers should disclose material risks as well as possible benefits and engage patients in an active dialogue. A thorough informed consent procedure enables patients to make an educated decision about whether e-therapy is right for them. Military Medicine, July, , vol , 7, pages University of Alberta Press, Informed consent is the most represented value in the Canadian Code of Ethics for Psychologists British Medical Journal, vol. If we can change this mindset and view obtaining consent as an ethical duty first and foremost, one that is central to respecting the autonomy and dignity of patients, then we will have taken a major step towards first class consent and uninterrupted lunches. Cambridge University Press, Canadian Journal of Counselling, , vol. American Psychiatric Publishing, Informed consent allows patients to become partners in treatment determinations that accord with their own needs and values. Most psychiatrists find increased patient autonomy desirable in fostering development of the therapeutic alliance that is so essential to treatment. Research and Practice, April , vol. There also appears to be an overemphasis on content issues i. American Psychological Association, For example, the state of Colorado requires psychologists to present certain written information to their clients, including therapist credentials, client rights, and the State Grievance Board address Handelsman, Supervisors must be familiar with state regulations. Research and Practice, , vol. In this way they avoid risking an ethical violation, reduce their liability, and improve their informed consent process, which Handelsman suggested, can lead to better treatment outcomes. There is a misunderstanding that the federal government requires certain boilerplate language that is mandated for inclusion in these forms. Oxford University Press, Teachers and other collateral informants deserve to know, before they fill out a questionnaire or cooperate with an interview about their student, that they information they provide may be used by the court or attorneys. Even though this knowledge may affect what the teacher says, it is unethical to imply to the teacher that the information gathered will remain confidential, when, in fact, it will not. New England Journal of Medicine, November, , vol. In that regard, the presumption intrinsic to a modern democracy is that the vast majority of persons are capable of making their own decisions. Hence, only patients with impairment that places them at the very bottom of the performance curve should be considered to be incompetent. Clinical work with individuals, couples, families, and groups each presents unique challenges with regard to informed consent, as do third-party requests for services, clinical supervision, research, and teaching. Though patients did identify several important advantages of the consent process, there was substantial uncertainty about the implications of signing or not signing the consent form Many patients did not see written consent as functioning primarily in their interests

BEGINNING THE THERAPEUTIC RELATIONSHIP AND OBTAINING A PROBLEM LIST AND DIAGNOSIS pdf

nor as a way of making their wishes known Although there is no straightforward relation between knowledge of rights and ability to exercise those rights, a lack of awareness of the limits and scope of consent is clearly undesirable, potentially causing patients to feel disempowered and lacking in control. New York University Press, Discussing distinct aspects of psychotherapy at different points in time" by Andrew Pomerantz. Beahrs and Thomas G. American Journal of Psychiatry, January, , pages Where written forms are required, nonetheless, they should be constructed with therapeutic intent, be relatively simple and straightforward, be framed in ordinary language without jargon, cover the key contractual business parameters and differential responsibilities, note the relevant uncertainties, and summarize general principles and specific emergency resources for what to do whenever the therapist is unavailable Personalizing written informed consent forms has been shown to foster rapport and more constructive patient expectations Finally, written forms should not be considered a substitute for ongoing verbal consent. Koocher and Patricia Keith-Spiegel. Although a small number of states e.

BEGINNING THE THERAPEUTIC RELATIONSHIP AND OBTAINING A PROBLEM LIST AND DIAGNOSIS pdf

2: Introduction to Informed Consent In Psychotherapy, Counseling and Assessment

-- Cognitive theories and their clinical implications -- Learning theories and their clinical implications -- Emotion theories and their clinical implications -- Beginning the therapeutic relationship and obtaining a problem list and diagnosis -- Developing an initial case formulation and setting treatment goals -- Using the formulation to.

The book is terrific and I recommend reading it. This list below is not comprehensive, but provides a nice quick reference of things to remember. Yalom works from an existential and interpersonal framework â€" people fall into despair because of relationships that do not satisfy or due to the harsh facts of the human condition. The tips follow the sequence of the book â€" material is paraphrased excepting direct quotes which are his. See also 50 More Tips, coming soon. The job of the therapist is then to identify and remove obstacles, the rest following from the innate tendency of the client to grow. Therapy is an unfolding where the therapist gets to know the client over timeâ€¦a diagnosis is limiting and can act as a self-fulfilling prophecy. Think of your clients as fellow travelers, rather than dividing into healers and the afflicted â€" we are all in this together and no person has immunity to the tragedies of existence. The relationship with the client should take top priority. Each hour, check in with the client on the therapist-client relationship â€" how are we doing today? Be generous with sharing your positive thoughts and feelings about clients, but be genuine and avoid empty compliments. Have accurate empathy for your clients â€" they benefit immensely from being fully seen and understood. Use the here and now to help clients learn empathy themselves, asking clients how their statements and actions might affect others, not forgetting to include yourself, the therapist. Share your thoughts or dreams of your clients with them, if productive. Demonstrate your willingness to your client to enter into a deeply intimate relationship with them. There is an inequality in the therapeutic relationship â€" the teacher has many students and the students have but one teacher. Use the here and now as a major source of therapeutic power â€" it refers to the events of the therapeutic hour and to what is happening here in this office and relationship. The importance of using the here and now is based upon assumptions of the importance of interpersonal relationships and the idea of therapy as a social microcosm. Our interpersonal environment influences us and our self image is formulated to a large degree based upon what we perceive important figures in our lives appraise us to be. Find here-and-now equivalents of dysfunctional behavior regarding interpersonal interactions a client is concerned about. Working in the here-and-now is concrete compared to an abstract or historical focus. If a client bores you for example, then they may likely bore others as well. Clients may resist you being human and resist your disclosure. Explain it was them, not the therapist, who is the magician, who had really helped themselves. Nietzche expresses an opposing view: Harry Stack Sullivan said if the therapist develops more anxiety than the client, the client becomes the therapist. Self-disclosure is an absolutely essential ingredient in psychotherapy â€" no client profits without revelation. A disclosure has content and process. Content is the stuff revealed and process is the disclosure act itself. Vertical disclosure refers to in-depth disclosure about the content. Horizontal disclosure is disclosure about the act of disclosure itself. If the knowledge is known to our self and others, it is public. If it is known to our self and not others, it is secret. If it is not known to our self yet it is known to others, it is blind. If it is not known to self and also not to others, it is unconscious. It is the blind self that therapists target, helping clients see themselves as others see them. Especially useful in group therapy, using here and now experiences. If we focus on our own feelings, we are less likely to evoke defensiveness â€" our own feelings cannot be challenged. Introduce the idea that you wish to be closer to the client, to know them better, yet the behavior in question distances me and may distance others. Strike when the iron is cold â€" give feedback to clients about a behavior when they are behaving differently. Confront the topic of death and our defenses based on denial of death â€" cope with the awareness of death â€" that learning to live well is to learn to die well. The idea of death may save us â€" we reprioritize our values and trivialize the trivia. Heidegger spoke of two modes of existence â€" the everyday mode and the ontological mode. The first we are consumed with material

surroundings and are filled with wonderment with how things are in the world. The second we are focused on being per se, we are filled with wonderment that things are in the world. When did you first become aware of death? With whom did you discuss it? How did adults respond to your questions? What deaths have you experienced? How have your attitudes changed about death? Some preoccupied with sex have been exposed to a great threat of death. In finding meaning, may ask: What do you want on your tombstone epitaph? Schopenhauer said that willing is never fulfilled â€" as soon as one wish is satisfied, another appearsâ€¦every human life is tossed backward and forward between pain and boredom. The Buddha taugh that the question of meaning in life is not edifying and one should immerse oneself into the river of life and let the question drift away. We are in the deepest sense, responsible for ourselves and as Sarte put it, we are the authors of ourselves. Help clients assume responsibility. If they see their problems as outside of themselves, then we can commiserate, help them adapt or attain equanimity, or teach them to be more effective at altering their environment. If we hope for a therapeutic change, then we must encourage our clients to assume responsibility â€" that a client must see themselves as having a role in the sequence of events. Take advantage of here and now data. Never or almost never make decisions for a client â€" we work with unreliable data, biased by the client. Caveat â€" physical abuse situations â€" may need to discourage clients from returning to abusive settings. Making decisions for clients, especially ones they do not wish to do, is a good way to lose clients â€" they drop out of therapy. To settle for preemptive advice forgoes the opportunity for existential exploration. Decisions are expensive for they demand renunciation and cut us off from other possibilities. We are required to reduce our limitations and relinquish our myth of personal specialness, unlimited potential, imperishability, and immunity to biological laws. We help clients by dealing with difficult decision dilemmas by helping them assume responsibility and exposing them to the resistance of choosing.

BEGINNING THE THERAPEUTIC RELATIONSHIP AND OBTAINING A PROBLEM LIST AND DIAGNOSIS pdf

3: Graduation Competencies

This eagerly awaited book shows how skillful case formulation addresses a critical challenge in psychotherapy today: how to use empirically supported therapies (ESTs) in real-world clinical contexts.

Introduction The process of therapy has many steps, and begins before the client comes for the first appointment. Below are several steps and some tips on managing them. You should express interest in working with the client, and set up a time to meet. As clients often decide to come to therapy after matters have reached a crisis, they may expect to see you immediately, and so an appointment the same or next day is often helpful. Some will suggest at least a phone appointment for 15 to 20 minutes the same day if a face-to-face meeting is not possible in order to calm the anxious client, and assess for any risk of harm to self or others. First Appointment It is important to realize that the client may be anxious, upset, or in turmoil when they come for their appointment. You may be the therapist to see them, but you may be an intake worker or evaluator who will assess and assign them to the appropriate therapist. If you will not be able to see them for therapy, let them know at the outset i. They may need to talk a bit, and get a sense of who you are, before deciding to see you for therapy. Be sure to explain what therapy is, how it works, and answer questions about what the client can expect from therapy in general and from therapy with you. Some of this is basic HIPAA procedures as required by law, and some is basic informed consent procedures as required by our ethical code. The Start of Therapy Therapy begins with a first interview. It is a relational process, where the therapist, as a person, directs the process and communicates verbally and non-verbally what therapy is like. They "listen" to what is said and not said, what is communicated in verbal and in non-verbal ways. Different people experience "obvious" stresses and make "common sense" choices for a range of different reasons. For example, the therapist may ask "Where do you live? The client may ask "Are you married? Sullivan and others have also written about the meaning of the payment for the service of psychotherapy. Sullivan notes that the payment is all that the therapist receives from the therapy, perhaps in addition to a sense of having helped the client. He stresses this as keeping this basic element of the therapy relationship clear from the outset helps the therapist maintain a sense of clarity about boundaries and the role of the therapist. Since Sullivan, others have noted the role of the therapist as an agent for social change who helps clients step back and see their role as a part of a large and complex social and economic system; this allows them to make some choices about their behaviors and functioning which they might not recognize otherwise. Sullivan breaks up the first interview into four stages: The Inception is the beginning of the interview. The reason for referral, greeting, previously reviewed information, and ethical concerns of confidentiality and informed consent are discussed during this stage. The Reconnaissance entails gathering information about the problems and stresses that bring the client to therapy. The Detailed Inquiry entails gathering specific and detailed information from the client, separating relevant from irrelevant information, and understanding the balance of problems and stresses compared to resources and strengths. This can include, for example, knowing what the client has tried to resolve problems before, and asking what has been helpful and what has not. The final phase is Termination, the end of the interview. Two things happen in this phase. First, this is when the therapist closes the process for the client, as opening up memories of traumatic events, discussion of seemingly hopeless problems in their current life, and recalling past failures and mistakes can leave them feeling worse than when they came in. Part of what the therapist does is help them close up some of these processes and return to daily life, and part is helping them leave behind these feelings for the next session. Second, this is when the therapist in effect invites the client back to work on the issues that cause them distress and unhappiness. For some clients, the first appointment is the most difficult, as it entails considering and explaining things they would never discuss with others. For other clients, the second appointment is actually the most difficult. Coming back means committing to a process, placing trust in a stranger, and experiencing some hope that therapy and work with this therapist will be helpful. While some therapists do not try to determine how the first appointment ends, some do try to end the

first session on a "hopeful note," one that inspires the client to believe that they can make changes to be happier in their lives. Even if the client says something that is obviously distorted, do not attack or challenge their views, as you likely are pushing them to face something they are not ready to face, and telling them in effect that therapy is about being pushed to face unpleasant things Do not praise clients or give false assurances. They he may be unable to accept any praise, even if sincerely offered, and feel therapy will be a "feel good" process rather than a "working" process. There is a difference between making false promises, and offering hope that the client can and will be able to change their life. If the client is not ready for this, it can again feel as though therapy is about confronting them with things they do not feel ready to face. Even if they are ready, this can cause the client to think the therapist is quick to diagnose people or problems without knowing all the facts. Thus, for the client to view the therapist as prone to making quick judgments without all the facts is itself making a quick judgment without the facts. It is also a way for clients to avoid considering that they may not have given the therapist all the facts. This is not unusual, however. Do not join the client in attacking others. Showing them that you can be nonjudgmental of strangers, even when the "facts" seem clear, indicates you can also be nonjudgmental of them. This can be very helpful in assessing how ready he client is for therapy, and thus how "fast" the process of therapy should progress. Do not offer a diagnosis. However, consider that this may make the client feel judged in some sense i. Remember that diagnoses were designed for doctors to communicate essential information quickly and efficiently to other doctors; they were not designed to be shared with patients. Do not interrogate clients on sensitive areas of their lives. While they may talk openly with some people about their sexual desires, childhood, and work lives, they choose when and how and with whom they do this. They may need time to be sure the therapist will not judge them. Note Taking Newer therapists may feel taking notes helps them remember the content of the therapy session, and this is likely true. This, taking notes can be distracting for the therapist and client. However, taking notes allows you to record information verbatim, record important details and information without relying upon memory, and produces written proof of the session and the information it contained. Further, there is a social psychology term known as confirmatory search strategies, meaning we search for information to validate what we already think. Thus, we tend to remember information that made us think we were right, and forget information that might have made us think we were wrong. This happens for several reasons: Clients usually do not know what is and is not important to therapists. They may believe some thoughts and feelings are quite normal, or that everyone experiences the same things, and so they may not have the perspective to think otherwise. Clients may not want to reveal certain things until they are sure they can trust their therapists Some things are emotionally painful to face, or require insight and understanding to recognize. As a result, clients may not face these things not as a way to deceive their therapists, but rather as a way to deceive themselves. They may not realize patterns, triggers, or signs and so are not able to report them. Resistance Resistance is a way clients protect themselves from painful experiences. Sometimes is has been seen as an impediment to therapy that should be challenged, but other times it has been seen as a healthy and natural process in clients that therapists should work with. For example A teenager may come to therapy, but sulk and refuse to talk, as engaging in the process might feel like admitting they are psychologically flawed or damaged in some way, or the sole cause for the problems in their lives. The therapist might offer "maybe you feel angry about being sent here," or "maybe you feel you do not need to be here. The therapist might ask why he came, and be told that others told him to come to therapy. The therapist might offer that his problem seemed to be with these other people, and begin focusing on why these others see a problem and what the client wants to do about these perceptions. This avoids making the client take ownership of a problem that may or may not be their fault, but also moves the therapy toward finding some area both therapist and client can agree on and working from there. This could be resistance to the treatment, but could be an effort to determine whether the therapist can help, and whether the therapy environment is safe. The therapist can reflect back issues, and provide some information. Establishing Rapport The client may come to therapy with several needs: The therapist may be a helping authority who educates, an idealized parent who heals past hurts, an actual parent who remains constant while

the client works through resentments and unhealthy patterns, or a supportive person when lovers and friends are missing. Therapy may take anywhere from several sessions to several months to several years. It requires great initial attention but also ongoing care and maintenance. Rogers argues that reflective listening is a poor term, as it involves much more than just listening.

BEGINNING THE THERAPEUTIC RELATIONSHIP AND OBTAINING A PROBLEM LIST AND DIAGNOSIS pdf

4: Informed Consent in Therapy & Counseling: Standards & Guidelines, Forms, & References

A major contribution for all clinicians committed to understanding and using what really works in therapy, this book belongs on the desks of practitioners, students, and residents in clinical psychology, psychiatry, counseling, and social work.

Strategic Family Therapy The Therapeutic Relationship - Research and Theory The client-therapist relationship is important both as a primary element of therapy an effective element of therapy in and of itself and as a supportive or secondary element of therapy an effective element of therapy through secondary effects. While these studies are based on meta-analytic reviews which have their own limitations, the findings seem solid. The question of "Which is the more important, the technique or the relationship? Strupp, ; Garfield, Bowers and Clum attempted to form some answer to this question by reviewing studies which compared therapies with a technique focus, therapies with a relationship focus placebo therapy , and therapies with both. Overall they found that therapy with both relationship and technique focus had an effect size of. Thus, they concluded, that the non-specific factors of therapy, the relationship focused therapy, contributes. Thus, the question of "Which is the more important, the technique or the relationship? The therapeutic relationship has effectiveness at least as a primary element of therapy; it contributes a unique piece of variance to the effectiveness of therapy. The therapeutic relationship also has effectiveness as a secondary element of therapy. The Therapeutic Relationship in Cognitive-Behavioral Therapy Beck and Freeman , in their brief review cognitive-behavioral treatment, note that cognitive-behavioral therapy is based on therapist and client collaboration in guided discovery. Both the client and therapist work to determine goals, homework assignments, terms for success, and means for maintenance of success. The therapist is open and honest with the client, sends clear and explicit messages to the client, and gives honest feedback. The cognitive-behavioral therapist works with schemas. Given this, the cognitive-behavioral therapist must be sensitive to relationship issues and work towards building a trusting relationship early in therapy. Thus, the cognitive-behavioral therapist effects change primarily through therapeutic techniques, such as guided discovery of schema beliefs, relaxation training, graded anxiety hierarchies, dysfunctional thought recording, in vivo and imaginal exposure but also understands the importance of relationship issues as they effect these primary goals and the effectiveness of these techniques. Cognitive-behavioral therapists see the relationship as a secondary factor of therapy. There has been ample literature on the effectiveness of cognitive-behavioral therapy e. The therapist must show empathy to the client, be genuine with the client, and have unconditional positive regard for the client. Being genuine involves being open and honest with the client and sometimes self-disclosing to help the client feel the therapist has empathy. Having unconditional positive regard for the client means valuing them as people, without conditions of worth. However, this end is mostly accomplished by unconditional positive regard of the client by the therapist. Insight may also be helpful to the client. Thus, the therapeutic relationship is important as a primary factor in psychotherapy. Indeed, Frank 19XX has argued that the relationship is the most important part of therapy. It is through the relationship that the therapist provides the three critical elements of therapy: In fact all therapy, some would argue Strupp, , gains its effectiveness through the relationship. Further, the therapist could review with the client the goals and homework assignments on which the pair are working as well as the speed at which the therapist and client are currently working. This would help alleviate the "negative transference. In other words, the client is not used to having relationships that carry unconditional positive regard. Past relationships must have carried high conditions of worth. Thus, the therapist would help the client feel valued unconditionally, reflect back their feelings or anger and hurt, and help them to understand the effects these past experiences of conditioned worth have had on the client. Brief Treatment Brief psychotherapy has been referred to by many as short term anxiety provoking psychotherapy STAPP , as time limited therapy, as brief therapy, and as problem-focused therapy. Brief therapy usually lasts 20 sessions or less: Brief therapy usually does not focus on past relationships and childhood experiences or

analyze negative transference. Client ratings of improvement and therapist ratings of improvement were similar for most disorders. Most benefit occurred early in therapy. Thus, as perhaps most people benefit from the early sessions of therapy, maybe a therapist could provide only the early sessions of therapy and be very effective. Sifneos and Mann review these criteria for STAPP and note that appropriate clients usually; 2 have high initial anxiety which is important for motivation 3 have an initial problem focus to keep the therapy focused 4 have the ability to form a trusting relationship with the therapist 5 have the ability to access feelings and experiences Clients who do not meet these criteria are assumed to be inappropriate for brief therapy. Therapists who foster dependence by their clients, who have difficulty maintaining a focus in therapy, and who require detailed exploration of childhood experiences and past relationships are also assumed to be inappropriate to conduct brief therapy Mallon, 19XX. Garfield and Bergin note that there is some evidence for the effectiveness of brief therapy when such criteria as those above are used to select clients. Criteria for brief marital therapy may be drawn from this as well. Likewise, there are some family oriented therapists who believe that families and couples must change the structure of their family, a difficult task which usually can not be addressed in short term therapy. The unanswered question, however, is how much can the specific anyone benefit from brief therapy? It is possible that inappropriate clients may gain some benefit in brief therapy, but do they benefit enough from therapy to warrant treating them, both from the client, the therapist, and the HMO or PPO perspectives? Such clients may be harmed by being released from brief therapy. Thus, an understanding of clients for who brief therapy is not helpful and potentially harmful is important. Sifneos and Mann note that some clients, such as borderline clients, may not be appropriate for brief therapy as they may have impaired objects relations effecting their ability to form ego strength and positive transferences. Certainly other clients with low ego strength or poor self-schemas, such as chronic mentally ill clients, may have difficulties working in brief therapy. A suicidal client or physically abused spouse may need immediate hospitalization, followed by more time-open-ended therapy to deal with such issues and monitor their safety. Children must be considered separately, as they may or may not be able to benefit from brief therapy, depending upon the view of the problem. Some family theorists e. Coyne 87 notes that children of depressed parents are at an increased risk for poor mental health such as depression. An "inoculative" or compensating factor is a stable relationship with a supportive adult. Strategic therapists would address the referral problem alone and not address other family problems unless asked to, and thus conduct brief family therapy. The child would be expected to improve, as the behavior at school would be changed, perhaps providing a more structured environment at school and a stable relationship with a school social worker, a teacher, or a school counselor. In summary, brief therapy may clearly be very effective with some adults.

BEGINNING THE THERAPEUTIC RELATIONSHIP AND OBTAINING A PROBLEM LIST AND DIAGNOSIS pdf

5: The Case Formulation Approach to Cognitive-Behavior Therapy

The case formulation approach to cognitive-behavior therapy is a framework for pro- viding cognitive-behavior therapy (CBT) that flexibly meets the unique needs of the patient at hand, guides the therapist's decision making, and is evidence based.

Ethical or Unethical Definitions Before this paper proceeds to discuss the different forms of consent, following are some basic definitions of some of the above-mentioned terms as identified by Apple Inc. Expressed Convey a thought or feeling in words or by gestures and conduct: Presumed [With clause] suppose that something is the case on the basis of probability: I presumed that the man had been escorted from the building [trans. Or take for granted that something exists or is the case. Explicit Stated clearly and in detail, leaving no room for confusion or doubt: Implicit consent includes non-verbal and other forms of consents. Implied consent is given when clients engage in behaviors that reasonable people would interpret as informed choice. Written Mark letters, words, or other symbols on a surface, typically paper, with a pen, pencil, or similar implement: Verbal Relating to or in the form of words: Spoken rather than written; oral. Verbal consent can be implicit or explicit, depending on the extend and type of words and language used to give the consent. Not involving or using words or speech. May involved gestures or other non-verbal cues. It is important to remember that neither explicit nor written consent necessarily guarantees that the concern is informed or valid. The notion of implicit consent is rarely discussed in the psychotherapy literature, even though it is probably the most common form of consent given. As a result, the poorly or rarely defined is often misunderstood. Consistently, there is little practical guidance as to the extent and depth of explanation that is needed. Needless to say, what is reasonable is highly debatable, and as a result, the degree of implicit consent is not clear and is set by the courts and professional bodies on a case-by-case approach. In these situations one may make the argument that what seems like an affirmative nod was a head bob stemmed from an involuntary muscle spasm or a Tourette twitch. It seems unrealistic and, some may say, ludicrous or counter clinical to have a client sign an informed consent for touch prior to a simple supportive touch on the shoulder. Requiring such consent is likely to be detrimental to the therapeutic alliance, as the client will, most probably, view the therapist as rigid and scared rather than supportive and caring. Another example of a consent that is neither explicit, in writing nor verbal is when a client shows up to a session with his or her spouse and tells the therapist that he or she would like the spouse to join them for that session. Implied in this situation is that the client authorizes the therapist to reveal, at the very least, confidential information that the therapist uses in treating the client. In this situation it is not clear how much information the therapist is authorized to reveal. The most cited concern is, what if the therapist reveals to the spouse that the client has or had a sexual extramarital affair that the spouse was not aware of. While in an ideal world the therapist would have discussed what information he or she is authorized to reveal and whether the affair or other issues should be brought up. In some situations it is advisable to have a written consent that summarizes the communication regarding the joint session. However this options is not always possible or realistic.

BEGINNING THE THERAPEUTIC RELATIONSHIP AND OBTAINING A PROBLEM LIST AND DIAGNOSIS pdf

6: 50 Tips for Counselors: A Compilation of Irvin Yalomâ€™s Advice | Renee Baker, www.enganchecuban

A therapeutic relationship must be developed so the client can trust the nurse to provide a safe environment and aid her emotional recovery. A nurse is writing a plan of care in the medical record of a paranoid male client who has unjustifiably accused his wife of having many extramarital affairs.

This chapter describes the constellation of barriers deterring use of mental health treatment by people who are either suicidal or who have major risk factors for suicidality: A close examination of barriers to treatment is warranted by several striking findings: Nearly 20 percent make contact with primary care providers in the week before suicide, nearly 40 percent make contact within the month before suicide Pirkis and Burgess, , and nearly 75 percent see a medical professional within their last year Miller and Druss, Among older people, the rates are higher, with about 70 percent making contact within the month before 1 Page Share Cite Suggested Citation: The National Academies Press. However, suicide victims are three times more likely to have difficulties accessing health care than people who died from other causes Miller and Druss, These findings underscore the importance of sifting through reasons why people escape detection or fail to receive adequate diagnosis and treatment for risk factors and suicidality. They also underscore the importance of taking a broad view of barriersâ€”focusing on suicidality, as well as on risk factorsâ€”because their treatment is so intertwined. The barriers discussed in this chapter collectively weigh against treatment. Each barrier is unlikely to act in isolation, but likely interacts with and reinforces the others. The complex relationship of various precipitative, exacerbative, and maintenance effects of barriers is unique in each clinical case. Deeper and more nuanced understanding of the multiple barriers to treatment is essential for design, development, and implementation of preventive interventions. Prospective longitudinal studies can help to elucidate relationships among barriers as they change across the life-span and across the development of suicidality. The chapter works its way from general to more specific barriers. It first looks broadly at barriers to treatmentâ€”such as stigma, cost, and the fragmented organization of mental health services. It then covers barriers raised within a range of therapeutic settingsâ€”by both clinician and patient. Finally, the chapter focuses on barriers for groups at greatest risk for suicide: About two-thirds of people with diagnosable mental disorders do not receive treatment Kessler et al. Stigma toward mental illness is pervasive in the United States and many other nations Bhugra, ; Brockington et al. Stigma refers to stereotypes and prejudicial attitudes held by the public. These pejorative attitudes induce them to fear, reject, and distance themselves from people with mental illness Corrigan and Penn, ; Hinshaw and Cicchetti, ; Penn and Martin, The stigma of mental illness is distinct from the stigma surrounding the act of suicide itself. The stigma of mental illness deters people from seeking treatment for mental illness, and thereby creates greater risk for suicide. The stigma surrounding suicide is thought to act in the opposite directionâ€”to deter Page Share Cite Suggested Citation: In some situations, however, the stigma of suicide acts to increase suicide risk because it may prevent people from disclosing to clinicians their suicidal thoughts or plans. Studies cited later in this chapter clearly indicate that patients often do not discuss their suicidal plans with their clinician. This, in turn, leads to their under-treatment and thus increases their likelihood of suicide. The existence of stigma surrounding mental illness is best supported by nationally representative studies of public attitudes. Studies find that about 45â€”60 percent of Americans want to distance themselves from people with depression and schizophrenia. The figures are even greater for substance use disorders Link et al. Stigma leads the public to discriminate against people with mental illness in housing and employment Corrigan and Penn, It also discourages the public from paying for treatment through health insurance premiums Hanson, Public attitudes toward mental health treatment are somewhat contradictory: For people with mental illness, the consequences of societal stigma can be severe: The National Comorbidity Survey, one of the only nationally representative studies to investigate why individuals with mental illnesses do not seek treatment, found that almost 1 in 4 males and 1 in 5 females with Posttraumatic Stress Disorder cite stigma as their reason Kessler, While the majority with

mental illness do not seek treatment, there is wide demographic variability: If they make contact with primary care providers, stigma inhibits them from bringing up their mental health concern. Patients may instead report more somatic symptoms of 2 Both stigmas can feed into the emotional burden in the wake of a suicide attempt by someone with mental illness. They may experience the stigma of mental illness, as well as the stigma of having tried to die by suicide. Page Share Cite Suggested Citation: Even if patients begin treatment for mental illness, stigma can deter them from staying in treatment. These problems are especially relevant for older people Sirey et al. These groups are discussed later in the chapter because they are at high risk for suicide. Stigma also extends to family members. Family members of people with mental illness have lowered self-esteem and more troubled relationships with the affected family member Wahl and Harman, Families of suicidal people tend to conceal the suicidal behavior to avoid the shame or embarrassment, or to avoid the societal perception that they are to blame especially with a child or adolescent suicide. After suicide, family members suffer grief as well as pain and isolation from the community PHS, Financial Barriers The cost of care is among the most frequently cited barriers to mental health treatment. About 60â€”70 percent of respondents in large, community-based surveys say they are worried about cost Sturm and Sherbourne, ; Sussman et al. Economic analyses of patterns of use of mental health services clearly indicate that use is sensitive to price: Rises in co-payments of mental health services are associated with lower access Simon et al. The demand for mental health services is more responsive to price than is demand for other types of health services Taube et al. Having health insurance, through the private or public sector, is a major determinant of access to health services Newhouse, People without health coverage experience greater barriers to care, delay seeking care, and have greater unmet needs Ayanian et al. Overall, about 16 percent of Americans are uninsured, but rates are higher in racial and ethnic minorities Brown et al. Having health insurance, however, does not guarantee receipt of mental health services because insurance typically carries greater restrictions for mental illness than for other health conditions US DHHS, Over the past decade, during the growth of managed care, disparities in coverage have led to a 50 percent decrease in the mental health portion of total health care costs paid by employer-based insurance Hay Group, Not surprisingly, insured people with mental disorders in a large United States household survey in were twice as likely as those without disorders to have reported delays in seeking care and to have reported being unable to obtain needed care Druss and Rosenheck, The consequences of the disparities in insurance coverage for mental illness have led to legislative proposals at the state and federal level for parityâ€”coverage for mental illness equivalent to that for other health conditions US DHHS, While there do not appear to be any studies directly examining cost as a barrier to treatment for suicidal people, most researchers believe that cost does play a role. The vision, beginning in , of the community support reform movementâ€”an integrated, seamless service system that brings mental health services directly to the communityâ€”has not fully materialized. People with mental illness frequently report their frustrations and waiting times as they navigate through a maze of disorganized services Sturm and Sherbourne, ; Sussman et al. The disorganization is a product of historical reform movements, separate funding streams, varying eligibility rules, and disparate administrative sourcesâ€”all of which have created artificial boundaries between treatment settings and sectors Ridgely et al. Among the hardest hit are people with co-occurring substance abuse and mental health problems, a group at higher risk of suicidality. Co-occurring disorders are the rule rather than the exception in mental health and substance abuse treatment US DHHS, Linkages between different settings are critical for detection and treatment of mental disorders and suicidality Mechanic, They include linkages between primary care and specialty mental health care; emergency department care and mental health care; substance abuse and mental health care; and, for adolescents, school-based programs with mental health or substance abuse care. The transition from inpatient care to community-based care is an especially critical period for suicidality in light of studies finding that a large proportion of completed suicides come after recent inpatient discharge, often before the first outpatient appointment Appleby et al. In addition to improved linkages between different settings, many new programs strive to integrate mental health and primary care, through a variety of service configurations e. Its utility for

suicidality is being studied through ongoing trials Mulsant et al. Services research has focused for the past decades in developing better models of care that bridge these different sectors of care to deliver more integrated mental health care. Several successful models have been developed, most notably wraparound services including multisystemic treatment, for children and adolescents with serious emotional problems and assertive community treatment, a form of intensive case management for people with serious mental illness, combined services for people with mental and substance abuse disorders, and management programs for late life depression in primary care settings US DHHS, One major problem, however, is lack of availability to these state-of-the-art services. Many communities simply do not provide them, and, when they do, there are often waiting times for treatment US DHHS, Low availability of mental health services of any kind is a major problem in rural areas Beeson et al. People in rural areas report significantly more suicide attempts than their urban counterparts, partly as a result of lower access to mental health services Rost et al. Another major problem is adapting model services to the unique needs of different communities or populations. Programs found successful for some populations may not translate into other settings. For example, a new primary care program for veterans designed to expand access to specialty mental health failed to do so Rosenheck, , despite the success of similarly designed gateway programs for other populations. Tailoring programs to the needs of distinct populations, including minority groups, is essential, given that they are less likely to access mental health treatment than are whites US DHHS, Its promise has been to improve access to health care by lowering its cost, reducing inappropriate utilization, relying on clinical practice guidelines to standardize care, promoting organizational linkages, and by emphasizing prevention and primary care. The impact of managed care on mental health services has been profound in terms of costs: The study cited above by the Hay Group indicated that during the growth of managed care, there was a 50 percent reduction in the mental health portion of total health care costs paid by employer-based insurance. Whether these cost reductions have lowered access to, and quality of, mental health services for people who need them is a critical topic for research, but one for which answers have been elusive. Research has been stymied by the dramatic pace of change in the health care marketplace, the difficulty of obtaining proprietary claims data, and the lack of information systems tracking mental health quality or outcome measures Fraser, ; US DHHS, Most concerns center on potentially poorer quality and outcomes of care from limited access to mental health specialists, reduced length of inpatient care, and reductions in intensity of outpatient mental health services Mechanic, ; Mechanic, The impact of managed care expressly on detection or treatment of suicide has been largely unstudied. The limited body of relevant research has focused on depression treatment, spotlighting problems in quality of care and outcomes. The first major studies of prepaid managed care versus traditional fee-for-service care found generally no overall differences in outcome, but poorer outcomes for patients with the most severe mental illness Lurie et al. Later studies, focusing exclusively on primary care, found that less than 50 percent of depressed patients in staff-model health maintenance organizations received antidepressant medication that met practice guidelines Katon et al. One of few managed care studies to have addressed suicide, at least tangentially, was of outpatients with depression receiving care from seven managed care organizations of varying organizational structures Wells et al. Using patient questionnaires, the study found that about 48â€”60 percent of patients with depressive disorder received some sort of mental health care. Two findings of the study are particularly relevant to suicide prevention: A largely unstudied question is whether reductions in intensity of outpatient services, or in length of stay in inpatient care, contribute to suicide risk. Reduction in care was defined by the study as one or more of the following: While this study was not of managed care per se, it raises questions about cost containment strategies used by managed care to reduce intensity or frequency of services for people at risk of suicide. In related findings, initial results from a study of all hospital discharges in Pennsylvania found a 25 percent reduction in length of stay during a 3-year period for inpatient treatment of depression. Preliminary results suggest that the reduction in length of stay was accompanied by an increase in readmission rates, a finding that the study investigators interpreted as suggesting that caution should be used when implementing practice guidelines for length of stay personal

communication, J. Quality improvement guidelines have been demonstrated to be successful at improving productivity and outcomes of depression in managed care, according to a randomized controlled trial Wells et al.

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Thus, building a therapeutic relationship is a dynamic process is different for different people, and changes over time as people's needs change. It requires great initial attention but also ongoing care and maintenance.

So what should you expect from your first appointment with a counselor, social worker or psychologist? The answer is simple: You should expect easy, brain-expanding questions, questions and more questions. Here are 10 of the more typical questions a psychotherapist will ask to prime your mental pump for positive change during the counseling process. Following the question is an example of what it might sound like. What brings you here? People who show up here have courage galore, perhaps even a tad bit of exasperation. Oh, and feel free to interrupt me at any time or steer the conversation to where you need it to go. In your mind, what brings you here today? Have you ever seen a counselor before? If so, how many meetings did you attend and for what issues? The point of counseling is to create positive changes as rapidly as possible without feeling hurried. How do you see the problem or how do you define it? Which difficult people in your life are causing problems for you? How do you get along with people at work? How would you describe your personality? What are three of your biggest life accomplishments? Who or what is most important to you in your life? What is the problem from your viewpoint? Are you an optimist or a pessimist? How do you feel when a problem pops up unexpectedly? So, how does this problem typically make you feel? Do you feel sad, mad, hopeless, stuck or what? What do you think causes the problem to worsen? Have you ever not had the problem or noticed that the problem went away altogether? Have you tried certain tools, read books or pursued avenues in the past that have worked well to solve the problem? How does the problem affect your self-esteem or your sense of guilt? Do you regularly set positive goals for your work life, love life and fun life? What is your attitude about change? What are your positive change goals? How would you like to improve your life to be more satisfied and happy? If we can find ways to make the problem better, perhaps we can find ways to greatly reduce or even eliminate the problem. Still others are pretty thick-skinned about emotional events. In your case, what makes you feel anxious? Is your mood like a roller coaster, or is it pretty steady? What brings you down or makes you feel blue? How do you get yourself out of a bad mood? What have people close to you told you about your moods? I believe you are paying me to help you achieve your positive goals as quickly as possible. Some people like to receive homework, some clients like to vent and have me listen, and others want a high level of interaction. How do you think you learn best? Do you think of me as your communications and relationships coach? What do you expect from the counseling process? How many meetings do you think it will take to achieve your goals? How might you undermine achieving your own goals? Do you blame anyone for your problem? Do you use good advice to grow on? How will you know when we are done? What keeps happening repeatedly that frustrates you? What do people keep doing that you dislike, and what do you wish they would change? How do you typically handle irritations, aggravations and frustrations? Do you get mad easily? How does your anger come out? What baggage or resentments do you carry from the past? What changes could someone make that would really make you happy? What has been a major life disappointment? Who is pulling your strings, and why? How well do you get along with your life partner? Do you love your life partner? What positive relationship rules do you follow? How would you describe your relationship with your kids or grandkids? Do you get along with your siblings? How would you best describe your relationship with your parents? What family conflicts have you been embroiled in recently? What relationship have you been in that you judged to be a failure? Who do you call upon when your heart is hurting to mentor you? Have you put time and money into improving your communication skills lately? What is your biggest vulnerability or Achilles heel in relationships?

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8: 10 Introductory Questions Therapists Commonly Ask

Modern counseling models and techniques are as varied and diverse as the counselors and clients who use them. Most counselors have a particular theory, method or school of thought that they embrace, whether it is cognitive behavior therapy, solution-focused therapy, strength-based, holistic health.

Like most people, counselors become upset or angry when they hear about children getting hurt or being abused. Some counselors are recovering from substance abuse disorders and were themselves abused or neglected as children, and they may find themselves in a professional situation where they have to confront their own abuse experience and its impact on their lives. As a consequence, counselors who were abused or who had substance-abusing parents may experience feelings that interfere with their efforts to work effectively with adult survivors. For example, counselors may find it difficult to relate to clients effectively and to reach a balance of providing enough--but not too much--support and distance. Survivors of abuse may pose many relational challenges to the counselor. These clients are often mistrustful at the same time that they need a trustworthy relationship, and a "push-pull" dynamic may result. Counselors must be mindful of these possible reactions and develop appropriate strategies to ensure effective care of the client. Because child abuse and neglect reflect the ultimate violation of trust, it is critical that counselors maintain a professional relationship with appropriate boundaries and limitations in place. This chapter reviews some of the challenges posed by transference and countertransference issues with this treatment population and discusses possible secondary traumatization in counselors. The Consensus Panel recommends that counselors establish and maintain clear boundaries from the outset, as well as establishing a "treatment frame. Transference, Countertransference, and Secondary Traumatization The counselor-client relationship is a crucial component of all therapy. Its importance is highlighted in work with abuse survivors because of the nature of the injury caused by the abuse--it was often caused by someone in close relationship to the client, on whom she was dependent, and from whom she should have received care and protection. The counseling relationship is therefore instrumental in providing the client with the necessary support to address and work through issues related to abuse including substance abuse while modeling a healthy, nonexploitive relationship. Transference Transference generally refers to feelings and issues from the past that clients transfer or project onto the counselor in the current relationship. When clients interact with other persons, they are likely to respond in ways that repeat old patterns from their past. These transference reactions have specific implications for survivors of childhood abuse, who may perceive the counselor as threatening or abandoning in the same way as the perpetrator of the abuse. Conversely, clients may idealize the counselor, seeing him as the warm and loving parent they always wanted. Many survivors have enormous shame and low self-esteem and feel responsible and guilt-ridden about the abuse. This may lead to attempts to distract the counselor from abuse-related issues so that they are not discussed or examined, or to respond to the counselor in ways that replicate the past e. The counselor must be aware of and prepared for possible responses of this sort and must work to bring them to clients, attention for discussion. The counselor must also avoid replicating relational patterns from the past even if clients expect them and act in ways to encourage them. For example, the counselor should not allow clients to be overly caretaking toward him, nor should he be so overinvolved with clients that objectivity is lost. These issues are discussed in more detail below in the section "Establishing the Treatment Frame and Special Issues. Although countertransference occurs in all therapy and can be a useful tool, an unhealthy countertransference occurs when the counselor projects onto clients her own unresolved feelings or issues that may be stirred up in the course of working with the client. For example, if clients act seductively, the counselor may feel uncomfortable or threatened. Counselors must pay close attention to their own feelings to protect their clients and to learn more about them. At the same time, the counselor should keep in mind that the feelings clients evoke in a counselor are likely to be feelings that clients are evoking in their daily interactions with others. For the same reason, a counselor might discourage the client from talking about

abuse issues, saying it is not the right time. However, it is very important to let the client determine when and at what pace to work on the issues, especially when dealing with child abuse and neglect. Effective treatment will be severely diminished if the counselor is unaware of her countertransference feelings toward a client. In these cases, the counselor should be closely supervised, or the client may need to be referred to another counselor. Counselors must also be cautious not to see signs of childhood abuse in every symptom. Not everyone in treatment has been abused, and counselors should be aware of the possibility of clients recovering nonexistent repressed memories, especially from clients who are eager to please their counselor. This is especially important for counselors who are themselves survivors of childhood abuse or neglect. Secondary Traumatization Many counselors find the level of violence and cruelty they are exposed to in working with adult survivors of abuse upsetting and incomprehensible. The counselor who is repeatedly confronted by disclosures of victimization and exploitation, especially between parent and child, may experience symptoms of trauma, such as disturbing dreams, free-floating anxiety, or increased difficulties in personal relationships. He may also experience anger or helplessness, which are detrimental to both the counselor and the client. Or, after a day of dealing with intense material in client sessions, a counselor may seem unaffected until strong emotions emerge--seemingly out of nowhere. The stress and "burnout" that may result from working with such clients can even produce symptoms similar to those of posttraumatic stress disorder PTSD e. Counselors can have these reactions even if they have no personal history of childhood abuse. Counselors experiencing these symptoms may lose perspective and become either over- or underinvested in a client Briere, ; Pearlman and Saakvitne, Counselors who are underinvested may become numb to feelings that would otherwise cause anxiety, anger, or depression. This reaction represents an attempt to avoid and distance oneself from the uncomfortable issues raised by the abuse. He may respond to the client coldly and clinically. Those counselors who overinvest, on the other hand, become extremely involved with their clients, going beyond the appropriate boundaries of the relationship. They may respond by becoming parental and doing problematic things such as lending their clients money, trying to solve their problems for them, or seeing them too frequently. They may also fail to confront clients when they behave inappropriately or destructively. When working with a client who was abused as a child, an overinvested counselor may have rescue fantasies or feel inappropriate anger directed at former therapists, child protective services CPS workers, and parents or caretakers. In extreme cases, the relationship can cease to be beneficial as it becomes overly personal, with the attendant loss of objectivity that is necessary in a professional relationship Briere, Burnout As mentioned above, working with clients who have chronic mental health disorders, severe substance abuse disorders, or a history of childhood abuse and neglect can often lead to "burnout. These secondary trauma responses have been called "compassion fatigue" Figley, , referring to the toll that helping sometimes has on the helper. Burnout affects many counselors and can shorten their effective professional life Grosch and Olsen, If the counselor sees a large number of clients many with trauma histories , does not get adequate support or supervision, does not closely monitor her reactions to clients, and does not maintain a healthy personal lifestyle, counseling work of this sort may put her at personal risk Courtois, This situation is even more serious in the current financially focused managed care atmosphere that requires health care workers to assume larger and more complex caseloads. These complex cases often involve previously traumatized clients who present the counselor with many personal and treatment challenges Grosch and Olsen, Counselors can minimize the likelihood of burnout. As much as possible, they should not work in isolation and should seek to treat a caseload of individuals with a variety of problems, not only those who have experienced childhood trauma. Discussing feelings and issues with others who are working with similar clients can decrease isolation through a process of shared responsibility Briere, Counselors also should try to keep a manageable caseload. They should deliberately set aside time to rest and relax, keep personal and professional time as separate as possible, take regular vacations, develop and use a support network, and work with a supervisor who can offer support and guidance. Some treatment settings have established in-house support groups for counselors who work with abuse and trauma survivors. Working as part of a treatment team can be a natural way to facilitate

support and reduce stress. In some cases, counselors may want to seek personal help through therapy that will allow them to work more successfully with this population. Among its other potential benefits, psychotherapy can help counselors come to terms with their own limitations. Counselors who are satisfied with their personal and professional lives are less likely to experience secondary trauma symptoms. Establishing the Treatment Frame and Special Issues Counselors should develop and maintain a treatment frame--those conditions necessary to support a professional relationship. Setting and maintaining boundaries is especially critical in treating survivors of childhood abuse and neglect. Several parameters of the treatment frame are discussed below, as well as special issues that may arise. Because childhood abuse is a profound violation of personal boundaries, adult survivors of abuse or neglect may never have developed healthy and appropriate boundaries, either for themselves or in their expectations of others. They often need a great deal of affection and approval, and counselors must make clear that they are not responsible for directly meeting all of those needs. The counselor must maintain a calm, optimistic interest in his clients, recognizing that getting overly involved will rob clients of the opportunity to identify and build upon their own inner resources. Other parameters of the counseling relationship, or treatment frame, set by many mental health professionals Briere, include Making regular appointment times, specified in advance Enforcing set starting and ending times for each session Declining to give out a home phone number or address Canceling sessions if the client arrives under the influence of alcohol or psychoactive drugs Not having contact outside the therapy session Having no sexual contact or interactions that could reasonably be interpreted as sexual Terminating counseling if threats are made or acts of violence are committed against the counselor Establishing and enforcing a clear policy in regard to payment These are general guidelines, and the specific arrangements between a counselor and client will vary according to a number of circumstances. For example, a client may arrive under the influence of drugs or alcohol. Also, for some clients, telephone contact outside the therapy session is necessary and fosters a working alliance between client and counselor. Some clients may need ongoing support for dealing with difficulties with their children or suicidal feelings. A rigid rule stating no contact outside of therapy may be harmful for very needy clients. Clients may feel abandoned if a telephone call is not returned, damaging the therapeutic alliance. In smaller communities, a counselor may expect to encounter clients in public places. It is wise to discuss in advance with clients the confidentiality and boundary issues that could arise in these situations. Clients may prefer that the counselor not acknowledge them or may wish to be greeted with a simple hello. Building Trust Building trust has been described as the earliest developmental task and the foundation on which all others are built Erikson, Establishing trust is broadly accepted as fundamental to the development of a therapeutic relationship. However, because adults who were abused or neglected by their parents have experienced betrayal in their most significant relationships, they often find it difficult to trust others. Clients who were not abused by persons close to them also experience problems with trust, but for those who have been betrayed by people on whom they were dependent, issues of confidentiality and privacy are especially critical. Trust makes an individual vulnerable to criticism, abandonment, and rejection. Clients may therefore be mistrustful and suspicious of the counselor, making the development of a trusting relationship a potentially long and difficult task. Reflecting the transference discussed above, they may fear the counselor or see him as abusive, manipulative, or rejecting. The counselor must not personalize these feelings but be consistent and reassuring, never taking trust for granted Courtois, As clients deal with childhood abuse and neglect issues, they may face a series of crises. These crises give the counselor opportunities to build trust. Many tenets of a good therapeutic relationship unconditional positive regard, a nonjudgmental attitude, and sincerity are also essential for establishing a foundation of trust. When the Client "Falls in Love" With the Counselor Because of the difficulties many abused clients have with intimacy, the new experience of having someone who listens and whom they can trust can sometimes lead them to believe that they are in love with the counselor. Sadly, many survivors of abuse are so accustomed to negative feelings shame, fear, guilt, anger that positive feelings joy, trust, contentment, playfulness are unfamiliar to them. Such clients may not understand their own feelings, and they may not have the skills to differentiate them. In some

cases, if a client has recently stopped abusing drugs or alcohol, romantic obsession or sexual fantasies can substitute for the substance addiction as a way of reducing tension. Powerful romantic feelings may be directed toward the counselor, threatening the therapeutic relationship. The counselor must, above all, avoid transgressing the boundaries of the relationship and continue to emphasize the guidelines discussed when the counselor established the treatment frame. He should not consent to personal requests, even if they seem innocent e. Second, even if he only suspects a client of harboring sexual feelings for him, he should immediately bring the matter to the attention of a colleague.

9: - NLM Catalog Result

Chapter 4â€"Therapeutic Issues for Counselors Alcohol and drug counselors, along with other mental health professionals, face a number of challenges and special issues when working with people who have suffered abuse or neglect as children.

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