NEW MEXICO HIGHLANDS UNIVERSITY

COUN 634:
Practicum in Counseling Handbook

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NEW MEXICO HIGHLANDS UNIVERSITY
Counseling & Guidance
Practicum Information Sheet

Name: _____

Address: _____

Email: _____

Phone: _____

Practicum Site: _____

If this is a school site, please complete the following:

School: Elementary _____ Middle _____ High _____

District: _____ State _____

Address:

_____

_____

Phone: _____

Supervisor: _____

Supervisor Email: _____

Agency Director / School Principal: _____

Practicum Schedule:

M_____ T_____ W_____ TR_____ F_____ S_____ Su_____

Time: _____

NEW MEXICO HIGHLANDS UNIVERSITY
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Practicum Goal Statement

Name: _____

Date: _____

Site: _____

Self-Evaluation of Counseling Skills:

- Strengths:

- Weaknesses:

- Which particular counseling skills are you developing and looking to refine at this time?

- Goals for this clinical experience:

- How will you know whether or not you have accomplished these goals?

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Ethics Statement

This is to verify that I have read, understood, and will follow the American Counseling Association's *Code of Ethics* (2005) and/or the American School Counselor Association's *Code of Ethics* (2010). This includes the preamble, purpose, and all Sections.

If any ethical issues occur during my candidacy, I will immediately contact my University Supervisor, and give him/her all necessary information and process progressions as the ethical issue moves into resolution.

Additionally, I have not been coerced in any manner by my supervisor or any University employee to comply with the ACA's *Code of Ethics* (2005) and/or the ASCA's *Code of Ethics* (2010), or to sign this form. I do this by my own volition and willingness to promote professionalism in counseling.

_____

Signature of Candidate

_____

Printed Name of Candidate

_____

Date

I. Introduction

The New Mexico Highlands University Counseling Department welcomes you to the counseling practicum. We are committed to the development of counselors who will provide effective counseling services. Supervised experiential activities are vital to this development. Throughout your training you will participate in a variety of experience-based activities ranging from in-class role-plays to providing counseling services to individual clients. Your practicum experiences are your opportunity to apply your counseling training to real clients. For most counselor trainees, it means ''finally'' being able to do what you enrolled in your graduate program to do. You will conduct actual counseling sessions. You will attend class and review each case with your site-supervisor and practicum class on a regular basis. You will learn how to complete case documentation and practicum content issues. You will learn to critique yourself and become a more skillful counselor.

II. Practicum Requirements

The goals of practicum are:

1. To provide hands-on counseling experiences under the supervision of faculty and qualified supervisors.

a. Practicum students will successfully accumulate a minimum of **100** practicum hours of which **40** hours will be direct client contact hours.
b. Practicum students will participate in regular group and individual supervision.

2. To provide a safe and challenging environment conducive to self-exploration and increased self-awareness.

a. Practicum students will identify their strengths and challenges regarding their basic counseling skills and professional competence by means of self-evaluation and supervisor-evaluation.

b. Practicum students will both give and receive feedback with their peers regarding their basic counseling skills, case conceptualization, and the therapeutic relationship.

3. To provide a structure that facilitates the integration of theoretical knowledge and clinical application.

a. Students will periodically "staff" their cases in group and individual supervision.
b. Students will be required to complete case documentation as designated by site requirements and standards.

III. Ethics

Counseling Practicum students adhere to the professional ethics of the counseling professions as advocated by the American Counseling Association and the American School Counselor Association. Please familiarize yourself with those standards and consider them binding during your involvement in practicum and throughout your professional career. A copy of the current edition of the ACA Code of Ethics and Standards of Practice is included, but can also be obtained from the ACA and ASCA website, if needed (*link below*). In addition to the ACA Code of Ethics, other ethical rules for practicum are listed below. **Remember, each practicum site will have its own set of policies and procedures. It is your responsibility to obtain and understand these policies.**

*ACA *Code of Ethics* link*:*
http://www.counseling.org/Files/FD.ashx?guid=ab7c1272-71c4-46cf-848c-f98489937dda

*ASCA Ethical Standards for School Counselors link:
http://schoolcounselor.org/files/EthicalStandards2010.pdf

1. **Material from client files is never to be discussed or shown to anyone other than your supervisor, instructor, or in class as directed by your instructor.**

2. Information about clients is never requested or released without the client's specific written consent, a copy of which must be kept in the client's file. In the case of minors, a parent or guardian must authorize such action.

An exception to this rule is made when it is suspected that the client may be a harm to their self or to others. **The decision to breech the client's confidentiality is never to be made by the practicum student counselor alone.** If the need arises, discuss it in detail with your site supervisor. Clients need to be advised of these limits to confidentiality during the intake interview. **Clients who are at risk of harm to self or others are not appropriate for practicum and need to be referred to more advanced practitioners.**

3. All counseling documents must be reviewed by the site supervisor or an appropriate designee.

IV. Supervision

The supervision process is an important part of your training experience. You will receive two types of supervision, individual and group. Group supervision will be conducted during your class time and will involve reviewing cases and relating class members' counseling experiences to counseling theory. Individual site supervision will be conducted on a weekly basis and will involve a more intensive one-on-one type of instruction. The purpose of supervision is to provide you with ongoing feedback regarding your counseling skills and professional development. To prepare yourself for supervisory sessions (individual and group), review your sessions, and identify specific supervisory needs prior to your supervision sessions.

V. Liability Insurance

All students enrolled in practicum are required to carry professional liability insurance. Low cost insurance is available to student members of ACA. Contact your practicum instructor for additional information.

VI. The Therapeutic Relationship

The relationship between counselor and client is of paramount importance in determining the effectiveness of counseling (Corey, 2001). It is the key therapeutic ingredient, as well as the primary means of inspiring positive change in clients (Corey, 2001; Kahn, 1997). Effective counseling is more than a theoretical approach or a particular set of counseling skills. A high-quality therapeutic relationship is healing for the client, regardless of the counselor's theoretical orientation or use of specific counseling techniques (Corey, 2001).

Counselor ***empathy*** has been recognized as the most central dynamic in determining the quality of the therapeutic relationship (Kahn, 1997; Shea, 1998). Attending carefully to the client's thoughts, feelings, and behaviors; respecting the client's worth and dignity; and using *active listening* skills are important facets of counselor empathy and provide means to foster a high-quality therapeutic relationship. Active listening will help you to better understand the client's subjective experience and will demonstrate to the client that you are trying hard to understand his or her concerns. During your internship, your ability to be empathetic and to convey your care, concern, and respect will be healing for your client.

Counselor ***trustworthiness*** is another healing force in the therapeutic relationship. When your client trusts you, he or she will feel safe enough to explore important feelings, develop new perspectives, and try out new behaviors. Prove your trustworthiness in basic, concrete ways. Always be reliable and dependable. The following behaviors are especially helpful in developing client trust:

- Make certain that your client has your full attention and respect during sessions, and try to demonstrate you're caring in both verbal and nonverbal ways.
- Start and end sessions on time, and do your best to maintain the regularity of the appointment schedule that you and your client have agreed upon. Whenever possible, give your client plenty of advance notice if you will be on vacation/break or otherwise unavailable for regular sessions.
- Always follow through on counseling-related tasks that you have discussed with your client, such as finding a support group or a list of helpful books.

- Maintain strict confidentiality. Never discuss a client outside of the treatment setting unless you first have a signed release and have explained to your client exactly what information will be disclosed or exchanged.
- Do not mention other clients or talk about the specific details or problems of other clients. Clients may feel that their own time with the counselor is intruded upon when attention is focused on other clients during session. Clients also may worry about a breach of confidentiality if the counselor discloses certain aspects of other client's problems.
- Maintain professional boundaries at all times. It is unwise to engage in social relationships or participate in any business transactions with clients outside of the counseling setting (Corey, Corey, & Callahan, 1998). Do not disclose intimate personal information or discuss your own problems, as clients may feel obligated to take care of your needs and emotions, rather than attending to their own (Corey, Corey, & Callahan, 1998). However, an *appropriate* self-disclosure by the therapist is acceptable and sometimes necessary in the therapeutic relationship, as long as certain elements are respected. These elements include immediacy and timeliness, genuineness in self-disclosure, and being in the here-and-now moment. The predicted result is to encourage the client to self-disclose in more depth and to stimulate the development of a more egalitarian relationship with the therapist. (Ivey, Ivey, & Zalaquett, 2010).

VII. The Counseling Process

Counseling may be conceptualized as an interactive process involving a trained professional counselor (or counselor-in-training) and a client, with the purpose of enhancing the client's level of functioning. Counselor and client work together in a collaborative fashion, helping the client grow and change by identifying goals, developing new ways of understanding and coping with problems, and learning to use internal and environmental resources more effectively. When beginning to work with clients during your practicum, it is helpful to remember that the counseling process always involves the following steps, regardless of your theoretical orientation, your level or clinical experience, or the complexity of the client's problems:

- *Relationship-Building Stage* (developing trust/rapport and building a therapeutic alliance).
- *Problem identification Stage* (developing a full understanding of client and the client's concerns).
- *Goal Setting & Assessment Stage* (deciding on specific goals and strategies to achieve them).
- *Working Stage* (utilizing internal and external resources to resolve concerns).
- *Termination and Follow-up Stage* (assessing readiness to end and ensuring that progress is maintained) (Doyle, 1998).

These stages are interrelated and interlocking, rather than linear or sequential. Clients may need to move through some of them more than one time. For example, difficulties with implementation, may lead to further work on decision-making or exploration.

Adapted from, Favier, C., Eisengart, S., Colonna, R., *The Counselor Intern's Handbook*, (Belmont, CA: Brooks/Cole, Cengage Learning, 2004) pp. 66-67, and also from, Neukrug, E., *The World of the Counselor: an Introduction to the Counseling Profession*, (Belmont, CA: Brooks/Cole, Cengage Learning, 2012) pp. 170-173.

A. Building a Therapeutic Relationship

Counseling by its very nature is a process that occurs over time. Although counseling is not a linear process, it can be conceptually helpful to divide the process into three stages: *initial, working, and termination*. Various tasks and responsibilities are associated with each stage, including securing informed consent, conducting intake interviews, and record keeping. Also, different client factors, including motivation for change and responsiveness to treatment, need to be considered. Throughout the counseling process, practitioners continually work to establish and maintain a positive counseling alliance with their clients. During the first few sessions of the counseling process, counselors focus on building a therapeutic relationship and helping the clients explore issues that directly affect them. In initial sessions, counselors spend time assessing the seriousness of the concern presented, providing structure to the counseling process, and helping clients take initiative in the change process.

During the initial interview, it is important to take the steps needed to make clients feel comfortable, respected, supported, and heard. For this to occur, counselors need to set aside their own agendas and focus exclusively on the client, including listening to the client's story and presenting issues. This type of behavior, in which the counselor shows genuine interest in and acceptance of the client, helps establish rapport.

The counselor can help build rapport by intentionally using specific helping skills, such as reflecting feelings, summarizing, clarifying, and encouraging. It is critical for counselors to develop a repertoire of helping skills and an ability to use them appropriately throughout the counseling process. A counselor needs to focus on what the client is thinking and feeling and how the client is behaving. Establishing and maintaining rapport is vital for the disclosure of information, the initiation of change, and the ultimate success of counseling.

Inviting clients to talk about their reasons for seeking help is one way to initiate rapport. This non-coercive invitation to talk is called a d*oor opener.* Appropriate door openers include inquiries and observations such as "What brings you to see me?" "What would you like to talk about?" and "You look like you are in a lot of pain. Tell me about it." These unstructured, open-ended invitations allow clients to take the initiative in the session. In such situations, clients are more likely to talk about priority topics.

The amount of talking that clients engage in and the insight and benefits derived from the initial interview can be enhanced when the counselor appropriately conveys empathy, encouragement, support, caring, attentiveness, acceptance, and genuineness. Of all these qualities, empathy is the most important.

Taken from, Gladding, S. & Newsome, D., *Clinical Mental Health Counseling in Community and Agency Settings* (Upper Saddle River, NJ: Pearson Education, Inc., 2010) p 136 & pp. 146-147.

B. Problem Identification Stage

As the counseling relationship and trust continues to build, the next stage becomes problem identification. This stage is concerned with data and information gathering, continuing to listen to the client's story and even

helping them to draw it out and to make it more concrete. Attending carefully to verbal and non-verbal behaviors can be useful when searching for client discrepancies to confront later in the working stage. It is also important during this time to identify client strengths and assets because skillful problem definition and knowledge of the client's assets gives the session purpose and direction. "The building of a trusting relationship and the ability to do an assessment of client problems are signs that you are moving into the second stage where you and your client will validate your initial identification of the problem(s). It may be that what the client initially came to counseling for was masking other issues. Or additional issues may arise as you explore the client's situation-perhaps even issues of which the client was not fully aware. In either case during these sessions, you validate your original assessment and make appropriate changes as necessary" (Neukrug, 2012, p. 171).

C. Goal Setting and Assessment Stage

During the third stage of the therapeutic relationship, "you begin to understand your client in deeper and broader ways…where you begin to make inferences based on your theoretical orientation and about underlying themes" that have emerged or were discovered in the previous problem identification stage (Neukrug, 2012, p.172-173). During this time you will collaborate with the client in order to discover what specific goals to set and work towards. This stage entails planning therapy based on what the client is seeking and to understand, from the client's viewpoint, what life would be like without the existing problem(s).

D. Working Stage of Counseling

In the initial phase of counseling, counselors concentrate on gathering information and getting their clients involved in the helping process. The initial sessions of counseling conclude with a treatment plan (see p.33) that serves as the basis for the next phase of counseling-the action or working phase. During this phase, specific objectives are refined and interventions for achieving those objectives are implemented. It is important to remember

that the division between the *initial phase* and the *working phase* is arbitrary. For example, assessment, although associated with the initial phase of counseling, continues through all phases of counseling. Treatment plans, which usually come at the conclusion of the initial phase of counseling, also signify the beginning of the working phase of counseling.

For practicum and internship students this is a trial-and-error and retrial process between the counselor and the client. There is no-one-size-fits-all approach that faculty and clinical supervisors can give to students. Student counselors in practicum/internship simply need to try different techniques. The more you use various techniques, the more you can learn and build on your existing skill set. Here are some basic counseling techniques and interventions you will likely use:

- *Open-ended Questioning*: "What brought you in today?"
- *Reflection of Feelings*: "How did you feel when your spouse left?"
- *Paraphrasing*: "So, it sounds like you were upset at your roommate?"
- *Summarizing*: "It sounds like you believe that you are beginning to feel a sense of confidence regarding recovering from your divorce. You are reaching out to friends, attending a weekly support group, even contemplating dating again. Does that sound about right?"

Depending upon your theoretical orientation, you may also use:

- *Scaling Questions*: "On a scale of 1 to 10, with a 1 meaning you feel very depressed and 10 meaning you feel great, where would you put yourself?"
- *Gestalt Empty Chair Technique*: "Ok, let's say your father was sitting in that empty chair beside you. What would want to say to him regarding his verbal abuse?" Also, the empty chair technique can be conducted using a psychodrama approach, where the client will sit in the empty chair and play the role of the absent person (e.g. father, mother, spouse, etc.) The client will also play themselves.
- *Reframing*: "You mentioned 'I always fail'. But earlier I heard you say you just completed a college degree. It seems to me it might be more accurate to say, 'I have failures, but I'm also successful.'"
- *Homework*: "Ok, here's what I'd like you to do between now and next week's session. You have talked about a desire to make friends. Would

you be comfortable trying to speak with three new people this coming week? Then, we could discuss how that went in next week's session."

- *Artwork*: (with younger clients): "Ok Ellen, I have some paper and crayons. I'd like you to draw your family on this large sheet."
- *Role Plays*: This action-orientated technique is a form of psychodrama that is used to assist clients in creative problem solving by allowing clients to express emotional turmoil and openly talk about issues in the here-and-now with minimum directive input being provided by counselor. Clients, especially couples and families are primed for role plays. Individual counseling also should involve role plays from time to time. Role plays are often used for issues involving confrontation, asking for a date, assertiveness, setting limits (e.g. with a parent), and so forth.

Taken from, Gladding, S. & Newsome, D., *Clinical Mental Health Counseling in Community and Agency Settings* (Upper Saddle River, NJ: Pearson Education, Inc., 2010) p 136 & pp. 146-147 and from, Hodges, S., *The Counseling Practicum and Internship Manual,* (New York, NY: Springer Publishing Company, LLC., 2011) p. 65.

One of the most critical aspects of the practicum experience is learning to trust your own instincts (Gladding, 2009). Some counselor educators might call this process learning to listen to your "inner voice". Learn to heed this voice. To become a successful counselor, each counselor-in-training must learn to recognize his or her own voice and to put the suggestions of that inner voice into action. Listening to your inner voice is another path to becoming a genuine practitioner (Rogers, 1942 & 1951). Additionally, understand that the inner voice will not be perfect regarding what technique or intervention to use with a client, because counseling is not an exact science. Still, awareness of your inner voice is likely the most reliable path to take in the counseling experience.

E. Termination & Follow-up Stage

Counseling relationships vary in length and purpose. It is vital to the health and well-being of everyone involved that the subject of termination be brought up early so that the time in counseling is used effectively as possible. Individuals need time to prepare for the end of meaningful relationships. There may be some sadness even if the relationship ends in a

positive way. Thus, termination should not necessarily be presented as the zenith of the counseling experience. It is better to play down the importance of termination rather than to play it up (Cormier & Hackney, 2008).

Ideally, counselor and client should agree on when it is time to end the counseling relationship (Young, 2009). Often, verbal messages may indicate a readiness to terminate. For example, a client may say, "I really think I've made a lot of progress over the past few months". A statement of this nature suggests client recognition of growth or resolution. At other times, client behaviors signal that it is time to end the counseling relationship. Examples include a decrease in the intensity of work; more humor; consistent reports of improved coping skills; verbal commitments to the future; and less denial, withdrawal, anger, mourning, or dependence (Welfel & Patterson, 2005). With respect to these types of changes, a counselor may state, "You appear to be well on your way to no longer needing my services."

Taken from Hodges, S., *The Counseling Practicum and Internship Manual,* (New York, NY: Springer Publishing Company, LLC., 2011) p. 65-66 and from, Gladding, S. & Newsome, D., *Clinical Mental Health Counseling in Community and Agency Settings* (Upper Saddle River, NJ: Pearson Education, Inc., 2010) p. 161

There are several issues to address when considering termination (Gladding, 2009):

- Have clients achieved behavioral, cognitive, or affective goals? When both clients and counselors have a clear idea about whether particular goals have been reached, the timing of termination is easier to figure out. The key is to establish a mutually agreed-on contract before counseling begins.
- Can clients concretely show they have made progress in what they wanted to accomplish? Specific progress may be the basis for making a decision about termination. Is the counseling relationship helpful? If either the client or the counselor senses that what is occurring in the counseling sessions is not helpful, termination may be appropriate.
- Has the context of the original counseling arrangement changed? In cases where there is a move or a prolonged illness, termination (as well as a referral) should be considered. Examine whether the client's initial problem/symptoms have been eliminated or significantly reduced.

- Does the client appear capable of coping with demands in his or her life?
- Is the client better able to relate to others and to give and receive love?
- Has the client progressed in his or her ability to be productive in career and life tasks?
- Can the client "play" and enjoy life?

It is up to the counselor to explain termination clearly to the client at the earliest possible time. The initial intake is the ideal time to cover the topic, especially as essentials such as confidentiality, fees, and related topics are covered during that session. This way the client understands that at some point in the future, the counseling relationship will end. Termination should also be framed in terms of success. For example:

Counselor: Now at some point in the future, when you have met your goals for counseling, you will graduate from counseling.

Terminating with clients can be difficult for both the counselor and the client. It is natural for clients to want to "hang onto" a relationship that has been positive and growth-oriented for them. After all, for some clients, the counseling relationship may have been their closest relationship. Nevertheless, termination is necessary for continued growth and development of the client. Counselors would do well to frame termination up as "continued growth" and portray is as a "commencement" for types.

Taken from, Gladding, S. & Newsome, D., *Clinical Mental Health Counseling in Community and Agency Settings* (Upper Saddle River, NJ: Pearson Education, Inc., 2010) p. 161 and from Hodges, S., *The Counseling Practicum and Internship Manual,* (New York, NY: Springer Publishing Company, LLC., 2011)p. 157

XI. Progress Notes

Progress notes provide a means for monitoring a client's progress throughout treatment/counseling. Progress notes are also used to examine a client's progress toward treatment/counseling goals, the development of new issues and goals, and the modification of the initial treatment/counseling plan. In supervision, these notes provide a means for the supervisor to track the progress of the client and the supervisee.

Progress notes should be brief, concise, and should be written as soon as possible following the counseling session. The notes should include only relevant information; thus, in writing your progress notes "avoid labeling, judging, and using terminology that may be stigmatizing to the client" (Hansen, Rossberg, & Cramer, 1994, p. 306). Remember that clients have the right to review their case records.

Session Objectives and therapeutic interventions should relate to the overall treatment/counseling plan for the client. Progress notes should include specific client information and may be supported by behavioral observations, assessment measures, client statements, and other observations by the counselor. Progress notes also allow you to monitor changes that may result in a modification of the treatment/counseling plan for a client.

XII. Basic Counseling Skills

1. Attending Behavior

- Orienting oneself physically and psychologically
- Encourages the other person to talk
- Lets the client know you're listening
- Conveys empathy

What Does Attending Behavior Look Like?

a) "***SHOVLER***" (or "**SOLER**" – *the underlined*):

- **S**: Face the other **S**quarely
- **H**: **H**ead nods
- **O**: Adopt an **O**pen Posture
- **V**: **V**erbal Following
- **E**: Sp**e**ech
- **L**: **L**ean toward the other
- **E:** Make **E**ye Contact
- **R**: Be Relatively **R**elaxed

b) Listening:

- Listening is the **most important** skill in counseling. It is the process of 'hearing' the other person. Three aspects of listening include the following and which express the internal state of the counselee and can be 'listened' to by the attentive counselor.
  - *Linguistic:* actual words, phrases and metaphors used to convey feelings.
  - *Paralinguistic:* not words themselves but timing, accent, volume, pitch, etc.
  - *Non-verbal:* 'body language' or facial expression, use of gestures, body position and movement, proximity or touch in relation to the counselor (see observation).

2. Types of Counseling Interventions

- **Open-ended Questions**:

  - Questions that clients cannot easily answer with "Yes", "No" or one - or two-word responses.
  - "Tell me about your family while you were growing up"
  - "Why is that important to you?"
  - How did you feel when that happened?"
  - "What did you do when she said that?"
  - "What are your reasons for saying that?"

  Purposes of Open-Ended Questions:

  - To begin an interview
  - To encourage client elaboration
  - To elicit specific examples
  - To motivate clients to communicate

- **Closed-Ended Questions**:

  - Questions that the other can easily answer with a "Yes," "No," or one- or two-word responses
  - "Are you going to have the test done?"
  - "Did you drink before you got into the car?"
  - "Do you drink often?"
  - "Do you exercise?"

- "Do you like your job?"

Purposes of Closed-Ended Questions:

- To obtain specific information
- To identify parameters of a problem or issue
- To narrow the topic of discussion
- To interrupt an over-talkative client

➢ **Confronting**:

- "Confrontation is a gentle skill that involves listening to the client carefully and respectfully; and, then, seeking to help the client examine self or situation more fully. Confrontation is not "going against" the client; it is 'going with' the client, seeking clarification and the possibility of a creative *New*, which enables resolution of difficulties" (Ivey A., Ivey B., & Zalaquett C., 2010, p. 241).

Steps in Confrontation:

a) Listen and identify conflict in client's mixed messages, discrepancies, and incongruity.

b) Clarify and clearly point out issues to clients and help them work through conflict to resolution.

c) Listen, observe, and evaluate the effectiveness of your intervention on client change and growth.

➢ **Paraphrasing**:

- The counselor rephrases the content of the client's message:

  Client: "I know it doesn't help my depression to sit around or stay in bed all day."

  Counselor: "It sounds like you know you should avoid staying in bed or sitting around all day to help your depression."

Purposes of Paraphrasing:

- To convey that you are understanding him/her

- Help the client by simplifying, focusing and crystallizing what they said
- May encourage the client to elaborate
- Provide a check on the accuracy of your perceptions

When to use it:

- When you have an hypothesis about what's going on with the client
- When the client is in a decision making conflict
- When the client has presented a lot of material and you feel confused

Steps in Paraphrasing:

Example - Client, a 40-year-old woman: "How can I tell my husband I want a divorce? He'll think I'm crazy. I guess I'm just afraid to tell him."

a) Recall the message and restate it to yourself covertly
b) Identify the content part of the message
c) Wants divorce, but hasn't told husband because he will think she's crazy
d) Select an appropriate beginning: E.g., "It sounds like," "You think," "I hear you saying,"
e) Translate the key content into your own words: Want a divorce= break off, split; E.g., "It sounds like you haven't found a way to tell your husband you want to end the relationship because of his possible reaction. Is that right?"
f) Confirm the accuracy of the paraphrase

- **Interpretation**:

  - This common but carefully used skill is "a verbal technique that focuses on helping clients gain insights into the inner significance or meaning of their past or present patterns of behavior, feelings, or thoughts." (Gladding, 2006, p.77). It is beneficial to frame an interpretation in a way that can be perceived as a question or as an exploratory suggestion rather than a direct statement or a matter of fact.

- **Summarizing**

- A collection of two or more paraphrases or reflections that condenses the client's messages or the session
- Covers more material than a paraphrase
- Covers a longer period of client's discussion

Purposes of a Summary:

- To tie together multiple elements of client messages
- To identify a common theme or pattern
- To interrupt excessive rambling
- To start a session
- To end a session
- To pace a session
- To review progress
- To serve as a transition when changing topics

Steps in a Summary:

Example - Client, a young girl

At the beginning of the session: "I don't understand why my parents can't live together anymore. I'm not blaming anybody, but it just feels very confusing to me." [Said in a low, soft voice with lowered, moist eyes]
Near the middle of the same session: "I wish they could keep it together. I guess I feel like they can't because they fight about me so much. Maybe I'm the reason they don't want to live together anymore."

a) Recall key content and affect messages.

Key content: wants parents to stay together

Key affect: feels sad, upset, responsible

b) Identify patterns or themes.

She is the one who is responsible for her parents' break-up

c) Use an appropriate sentence stem and verbalize the summarization response.

e.g., "I sense," or "You are feeling"

d) Summarize.

e.g., "Earlier today you indicated you didn't feel like blaming anyone for what's happening to your parents. Now I'm sensing that you are feeling like you are responsible for their break-up

e) Assess the effectiveness of your summarization.

XIII. Developing Competencies

Your practicum can be viewed as a time to build a framework of new professional relational skills on a foundation of the material that has been presented to you throughout your counseling program, your own life experiences, and your personal values and philosophies. This framework is composed of new perspectives, understandings, abilities, and skills added gradually and with care. Your goal is to construct a strong framework over a solid foundation, working diligently but patiently and often standing back to look at the work you have accomplished so far.

During your practicum you will begin to develop some of the specific personal attributes and competencies that you will use during your professional counseling career. To help you delineate your goals, the following is a list of skills for graduate-level practicum and intern students to work toward building. It is important to remember that practicum is just the beginning of your professional development; you will continue to add competencies throughout your career.

Suggested Competencies for Practicum Students:

I) Communication Skills

A. Verbal Skills

1. Students will be able to express themselves clearly and concisely in daily interactions.
2. Students will be able to communicate pertinent information about clients and to participate effectively in interdisciplinary treatment team meetings and case conferences (including case presentations, which may involve videotaping and/or audio taping), while

maintaining their identities as counselors within a multidisciplinary group.

3. Students will be able to educate clients and to provide appropriate information on a variety of issues (such as parenting, after-care and other support services, psychotropic medications, stress management, sexuality, or psychiatric disorders) in an easily understandable manner.
4. Students will be able to communicate with clients' families, significant others, and designated others, and designated friends in a helpful fashion. They will be able to provide, as well as to obtain, information concerning the client, while respecting the client's rights concerning privacy, confidentiality, and informed consent.
5. Students will be able to communicate effectively with referral sources, both inside and outside the agency, concerning all aspects of client needs and well-being (for example, housing, legal issues, healthcare, Twelve Step programs, and psychiatric concerns).

B. Writing Skills

1. Students will be able to prepare a complete, written initial intake assessment, and recommended treatment modalities.
2. Students will be able to write progress notes, to chart, and to maintain client records according to agency standards and regulations.
3. Students will be able to prepare a written treatment plan, including client concerns, therapeutic goals and specific interventions to be utilized. This plan is concrete, behaviorally specific, and individualized to the client.
4. Students will be able to prepare and present a formal, written case study.
5. Students will be able to use computer skills to work with word processing programs and to maintain and search databases.

C. Knowledge of Nomenclature

1. Students will thoroughly know professional terminology pertaining to counseling, psychopathology, treatment modalities, and psychotropic medications.

2. Students will be able to understand professional counseling jargon and will be able to participate in professional dialogue.

II) Interviewing Skills

A. Students will structure the interview according to a specific theoretical perspective (for example, psychodynamic, humanistic, or behavioral theory) because a theory base provides the framework and rationale for all therapeutic strategies, techniques, and interventions.

B. Students will be able to use appropriate counseling techniques to engage the client in the interviewing process, to build and maintain rapport, and to begin to establish a therapeutic alliance. This may include using attending behaviors, active listening skills, and a knowledgeable and professional attitude to convey empathy, genuineness, respect, and caring, and to be perceived as trustworthy, competent, helpful, and expert (Cormier & Cormier, 1998).

C. Students will be able to use appropriate counseling techniques to increase client comfort and to facilitate collection of data necessary for clinical assessment, such as evaluating mental status, taking a thorough psychosocial history, and eliciting relevant, valid information concerning the presenting problem, in order to formulate a diagnostic impression. Specific interviewing competencies may include observation, use of open-ended and closed-ended questions, the ability to help the client stay focused, reflection of content and feeling, reassuring and supportive interventions, and the ability to convey an accepting and nonjudgmental attitude.

D. Students will develop a holistic approach toward interviewing by assessing psychological, biological, environmental, and interpersonal factors that may have contributed to the client's developmental history and presenting problems.

E. Students will strive to see things from the client's frame of reference and to develop a growing understanding of the client's logical perspective.

F. Students will be aware at all times of the crucial importance of understanding the client from a multicultural perspective and will be aware that sociocultural heritage is a key factor in determining the client's unique self, worldview, values, ideals, patterns of interpersonal communication, spiritual/religious views, family structure, behavioral norms, and concepts of wellness as well as pathology.

III) Diagnosis

A. Students will understand the most commonly used assessment instruments, such as personality and intelligence tests, anxiety and depression scales, and interest inventories.

1. Students will become familiar with the validity and reliability of these instruments.
2. Students will be able to interpret data generated by these instruments and understand the significance of these data in relations to diagnosis and treatment.
3. Students will be able to determine which assessment instruments would be most helpful in evaluating specific client problems or concerns.
4. Students will be aware of the limitations of assessment instruments when used with ethnic minority populations.

B. Students will develop a working knowledge of the most current edition of the *Diagnostic and Statistical Manual of Mental Disorders.*

1. Students will be familiar with the organization of the DSM and will be able to use this classification system effectively (for example, to find diagnostic codes or to trace clients' behaviors, affects, or cognitions along the decision trees to ascertain potential diagnoses).
2. Students will be able to understand the DSM diagnostic classification of disorders and will be able to identify particular constellations of client problems as specific DSM diagnostic categories.

C. Students will be able to review and consider all pertinent data, including interviews, medical records, previous psychiatric records, test

results, psychosocial history, consultations, and DSM classifications, in formulating a diagnostic impression or preliminary diagnosis.

IV) Treatment

A. Students will be able to conduct therapy using accepted and appropriate treatment modalities and counseling techniques based on recognized theoretical orientations and outcome research.

1. Students will work toward identifying their own theoretical frameworks based on their own philosophy of humankind.
2. Students will know how to make treatment recommendations, formulate a treatment plan, establish a treatment contract, implement therapy, and terminate the therapeutic relationship at an appropriate time.
3. Students will be familiar with the following types of therapy and will understand the underlying principles, issues, dynamics, and role of the counselor associated with each type of treatment or treatment-related activity:

a. Conjoint therapy
b. Crisis intervention
c. Family therapy
d. Group therapy
e. Individual therapy
f. Marital/couples therapy
g. Brief models of therapy
h. Play therapy
i. Mental health consultation

B. Students will understand that different client populations and different types of problems may respond best to varying therapeutic approaches and techniques.

1. Students will be knowledgeable about various types of client populations and their particular problems and concerns, including but not limited to the following:

a. Adult children of alcoholics
b. Adults
c. Chemically dependent individuals
d. Children and adolescents
e. Clients of varied ethnic, cultural, and religious backgrounds
f. Dual-diagnosed clients (for example, chemically dependent with a psychiatric disorder)
g. Individuals with eating disorders
h. Elders/Geriatric
i. Gay, lesbian, bisexual, and transgender clients
j. Physically or cognitively impaired clients
k. Any other individual who may be included under the Americans with Disabilities Act

2. Students will be flexible and knowledgeable in determining population-appropriate counseling techniques and therapeutic interventions. Students will have as many therapeutic tools available for use as possible (for example, play therapy, art therapy, behavioral techniques, role-playing, Gestalt techniques, directive versus nondirective techniques, stress management techniques, and experiential therapy).

C. Students will be sensitive to the impact of multicultural issues and diversity on the counseling relationship and on treatment, and will modify therapeutic approaches and techniques to respect multicultural differences and to meet multicultural needs.

D. Students will be able to direct clients to appropriate sources of information, such as books, Web sites, and so forth.

V) Case Management

"Case management is being developed as an essential part of local mental health service delivery systems throughout the nation. The concept is intuitively appealing as a system to reduce inappropriate use of state mental hospitals, to improve continuity of care by linking the client with needed services, and to improve the client's quality of life in the community. Case management varies in form and function according to the system within which it is developed but the central theme of case

management is that responsibility for meeting the needs of the client is with one individual or team whose purpose is to link the client with services required for a successful outcome" (Franklin, Solovitz, Mason, Clemons, & Miller, 1987, p. 674).

A. Students will understand the functions and goals of all departments, programs, and services within the agency and will be able to network with appropriate personnel throughout the social service system.

B. Students will understand the roles, responsibilities, and contributions to client care of members in each department or program within the agency. The student will know which individual(s) to contact to help resolve various client problems.

C. Students will acquire a thorough knowledge of community resources and will understand the agency procedures for referring clients to outside sources for help.

D. Students will consider continuity of care to be a most important goal, beginning with the:

1. Students will act as an advocate for the client in ensuring continued quality of care and access to social services. Advocacy will include, but not be limited to, exploring possible funding sources, for care, such as mental health coverage on insurance policies, Medicaid, or Medicare.
2. Students will collaborate with other agencies or institutions, which also serve the client.
3. Students will be able to participate in all areas of discharge planning, including arranging follow-up visits with a mental health professional, communicating with insurance companies, and providing help with housing, transportation, vocational guidance, legal assistance, support groups, medical care, and referral to other services of agencies.

VI) Agency Operations and Administration

A. Students will be familiar with the organizational structure, including the table of organization of the agency, and will understand the responsibilities and functions of administrative staff.

B. Students will understand the philosophy, mission, and goals of the agency and will thoroughly know the agency's policies and procedures, which are usually delineated in a comprehensive manual.

C. Students should be aware of immediate and long-range strategic plans for the agency (for example, to hire an art therapist, to develop a chemical abuse program, or to add an additional building, as well as to evaluate and eliminate ineffective programs).

D. Students will understand the business aspects of the agency (for example, funding sources and managed care budget allowances). Productivity is the catch word.

E. Students will be aware of legal issues concerning agency functions, such as state or national licensure/certification requirements or safety regulations.

F. Students will understand agency standards that ensure continued quality of care, including quality assurance and peer review processes.

G. Students will avail themselves of the latest technology in order to better assist clients.

VII) Professional Orientation

A. Students will know all ethical and legal codes for counselors, provided by professional counseling associations as well as by state law, and will adhere to these standards at all times.

B. Students will be familiar with agency regulations and policies regarding ethical and legal issues and will adhere to these standards at the placement site.

C. Students will be knowledgeable concerning legislation protecting human rights.

D. Students will seek guidance from the on-site supervisor and the academic program supervisor with any questions concerning ethical or legal issues or professional behavior.

E. Students will consider the four basic R's for counselors (Carkhuff, 1993) whenever acting in a professional helping capacity; the right of the counselor to intervene in the client's life, the responsibility the counselor assumes when intervening, the special role of the counselor plays in the helping process, and the realization of the counselor's own resources in being helpful to the client.

Taken from, Favier, C., Eisengart, S., Colonna, R., *The Counselor Intern's Handbook*, (Belmont, CA: Brooks/Cole, Cengage Learning, 2004) pp. 66-67

Appendix A: Counseling Forms

1) Practicum Activity Log pg. 32
2) Individual Treatment/counseling Plan pg. 33
3) Session Summary pg. 34
4) Progress Notes (SOAP/DAP) pg. 35
5) Intake Form pg. 39
6) Child & Adolescent Intake Form pg. 41
7) Consent to Audio Tape Form pg. 44
8) Consent Form pg. 45
9) Discharge Summary pg. 46

NEW MEXICO HIGHLANDS UNIVERSITY

Counseling & Guidance

Practicum Activity Log

Name: _____ Semester: _____

DATE	ACTIVITY	TIME

TOTAL HOURS: _____

Individual Treatment/Counseling Plan

Client Name/Code: _____ Date: _____

Counselor-in-training: _____

Treatment/counseling Focus:

_____

_____

_____

_____

Diagnostic Information:

_____

_____

_____

_____

Long-term Goals:

1) _____ 3) _____

2) _____ 4) _____

Short-term Objectives:

1) _____ 3) _____

2) _____ 4) _____

Therapeutic Intervention(s):

1) _____ 3) _____

2) _____ 4) _____

Changes to Treatment/counseling Plan (please note reason and type of modifica

1) _____

2) _____

3) _____

Treatment/counseling Plan Evaluation (note session and date):

1) _____

2) _____

3) _____

Session Summary

Counseling Practicum 634

To be completed electronically for each client session and turned in to supervisors weekly.

Supervisee: _____

Client ID: _____ Session #: _____

Supervisor: _____

1) Goals: What specifically did you and the client agree to accomplish in this session?
2) What progress was made toward the goal(s)?
3) Did anything happen during the session that led to a reconsideration of goals? How did you resolve this?
4) What was the major theme of this session? What was the important content related to the theme?
5) Describe the interpersonal dynamics between you and the client.
6) What did you learn about the client in this session?
7) What did you learn about yourself as a counselor? What specific strengths did you display? What specific weakness or area for improvement do you wish to address in supervision?
8) Based on what happened in this session and the overall goal(s) for treatment, what do you wish to accomplish in the next session?
9) What information, resource, or practice do you need in supervision this week to accomplish what you described in question number 8?
10) What question do you have or what feedback do you wish to receive from your supervision about the portion of the tape you have marked for him or her to review?

PROGRESS NOTES
(SOAP Format)

Client: _____ **Session #**: _____

Counselor: _____ **Date**: _____

(*S*) **Subjective**: *(What the client tells you, what pertinent others tell you about the client; how the client experiences the world)*

_____

_____

_____

_____

_____

_____

(*O*) **Objective**: *(Factual, what is observed/witnessed; quantifiable)*

_____

_____

_____

_____

_____

_____

(*A*) **Assessment**: *(Clinical impressions, a synthesis & analysis of subjective & objective)*

_____

_____

_____

_____

_____

_____

(*P*) **Plan**: *(Describe intervention(s), action plan, and prognosis)*

_____

_____

_____

_____

_____

_____

Counselor Signature: _____ Date: _____

SOAP NOTES
Counseling Summary and Critique Form
(*Case Conceptualization*)

Part 1 – The Client

Client Description:

Demographic and background data, including age, gender, race, marital status, family status (children, siblings, parents, etc.), current living situation, manner of dress, illnesses, physical impairments, energy level, general self-presentation. Only update after first session.

(*S*)ubjective Complaint:

Presenting problem(s) or issue(s) from the client's perspective. What the client says, including illustrative quotes (e.g., "She states…," "He identifies…,"), causes, duration, and seriousness of issue. If more than one issue, order of importance in client's view.

(*O*)bjective Findings:

Counselor's observation of client's behavior during the session. Verbal and nonverbal; including eye contact, voice tone and volume, body posture, etc. Especially note any changes and when they occurred (e.g., "When the client said she was ready to burst, yell at her father, her face became bright red and she clenched her hands into tight fists"). Especially include congruent and/or incongruent verbal and nonverbal behavior (e.g., "When client said he was feeling better about his girlfriend he slumped down and his voice was barely audible.").

(*A*)ssessment of Progress:

Counselor's view of the client beyond what he/she said or did. What happened for the client during the session? Since the last session? Evaluate cognitive, affective, and/or behavioral functioning. Changes in thoughts, feelings, and behaviors? Is the client's main concern the same or does it change between sessions or during the session? What themes or trends in issues and patterns of behavior are you beginning to identify? What needs are motivating the client? Developmental hypotheses, interpretations, wonderings about the client belong in this section. NOTE: Support for this assessment will be apparent in previous sections; this assessment is a conclusion of the above.

(*P*)lans for Next Session:

A - *Plans for Client*.

Short and long-term goals, steps to goals. Follow-up for homework assigned (purpose, desired outcome, how you will use in session). Will you focus on thoughts, feelings, and/or behavior? Why? How/give specific skills, technique, or strategy you plan to use and your rationale.

B - *Plans for Counselor*

What reading or research do you need to do in preparation? Practice? What help do you need from the supervisor?

Part 2 – The Counselor and the Session

General Approach or Strategy:

What modality did you use in this session? For what purpose? (e.g., Client-centered to build initial rapport, behavioral homework assignment to practice assertiveness).

Sample Responses or Techniques-Rationale-Example:

Label the response (e.g., empathy, self-disclosure, two-chair exercise, RET, metaphor); give rationale, purpose, intention of response; quote a direct example from the tape. Include at least four examples.

Assessment of Session:

Evaluation of counselor's performance. What went well? What felt uncomfortable? What could be improved? What was effective or ineffective? What shows progress in your counseling skills? Be honest!

Need for Supervision:

Area(s) of concern to you. Confusion or questions (e.g., client incongruence). Help with particular counseling skills(s)? Help to deal with particular issues (e.g., death, sex, abuse? Ask for what you need!

Date of nest session.

Adapted from Purdue University's Graduate Counseling Program

PROGRESS NOTES
(DAP Format)

Client Name: _____ **Counselor**: _____

DATE / TIME	THERAPY NOTES / LOCATION
	(*D*) Data: *(presenting problem, therapist interventions, targeted treatment, goals, or objective)*
	Treatment Goals Addressed: **(*A*) Assessment**: (include mental status issues, progress/lack of progress, clinical concerns)
	(*P*) Plan:

Counselor Signature: _____ **Date**: _____

NEW MEXICO HIGHLANDS UNIVERSITY
Counseling & Guidance
Confidential Intake Form

- Date:
- Name:
- Phone Number(*s*): (*Home*) (*Work*)
- Emergency Contact(*s*): (*Name, Phone, Relationship*)

- Current physician(*s*) name and phone number:

- Date of Birth:
- Gender:
- Education Level:
- Current Occupation:
- Partnership Status:
- Place of Birth:
- Cultural Assessment:
- Referred by:
- Children:

- If living at home, list the names and ages of family members:

- Reason(*s*) for seeking counseling:

- Have you had or are you currently receiving counseling or services from another agency or program?

  For what reason(*s*)?

  For how long, and by whom?

- Are you currently or have you had difficulties with substance abuse?

- Has any member of your family had problems with substance abuse?

- Have you been told that you have a chronic medical, psychological, or learning disorder?

- Do you or any else in your family have a history of physical, emotional or sexual abuse? If yes, please specify.

- List of medications you are currently taking or have taken in the last few years?

- Have you ever been hospitalized for emotional problems? If so, when and where?

NEW MEXICO HIGHLANDS UNIVERSITY
Counseling & Guidance
Child & Adolescent Intake Form

Client Name/Code: _____ Date of Intake Interview: _____

Counselor Name: _____

Identifying Information:

- Age: _____
- Sex: _____
- Ethnicity: _____
- Grade Level: _____
- Teacher's Name: _____
- Principal's Name: _____
- School: _____

Treatment/Counseling History:

- Prior Counseling Received: _____
- Extent of Prior Treatment/Counseling: _____

Family History:

Parent(s)/Guardian(s)

- Father's Age: _____
- Occupation: _____
- Living? _____
- Biological Father (or) Step Father?

_____
_____

- Mother's Age: _____
- Occupation: _____
- Living? _____
- Biological Mother (or) Step Mother?

_____
_____

Sibling(s)/Step-Siblings:

- Brother(s): _____
- Age(s): _____
- Grade Level(s): _____
- Occupation: _____
- Sister(s): _____
- Age(s): _____
- Grade Level(s): _____
- Occupation: _____

- Familial Medical/Psychological History:

_____

_____

_____

_____

- Additional Relevant Family Information (e.g., marital status, current living arrangements):

_____

_____

_____

_____

- Physical Illness/Accident History:

_____

_____

_____

_____

Educational History:

- Assessment Results:

IQ: _____ Verbal: _____ Quantitative: _____

Other Psycho-educational Assessments (achievement, ability, vocational interests):

_____

_____

_____

- Grade Retention:

If the child has ever been retained, indicate grade(s): _____

- Special Education Status:

Does the child presently qualify for or receive any special education services? _____

If so, provide additional information:

_____

Information Regarding Student Support:

Results of Discussion with Parent(s)/Guardian(s) Regarding this Referral:

Results of Discussion with School Staff (e.g., principal, teachers) Regarding this Referral:

NEW MEXICO HIGHLANDS UNIVERSITY
Counseling & Guidance
Consent to Audio Tape

The practicum/internship is required for graduate students in the final phase of their training as counselors. The students are required to audio tape or video tape their counseling sessions. Consequently, all counseling sessions in the center are audio taped. These recordings are used by the teaching staff to insure that you receive the services requested and to provide supervision of your counselor trainee. Counseling services are provided by practicum or intern students who have completed the prerequisite courses for admission into clinical training. They will be supervised by doctoral level faculty.

The contents of your counseling sessions will be held in the strictest of confidence and will not be revealed to any person or agency except under the following circumstances.

1. If you, or if you are a minor, your parents, give written permission to release information.
2. If you are involved in a bonafide medical emergency, information may be given to medical personnel.
3. If research, management audits, financial audits, or program evaluation are conducted, information may be revealed but you will not be identified either directly or indirectly.
4. If you reveal information which, in your counselor's judgment, indicated that you intent to harm yourself or someone else.
5. If you reveal information that indicates the existence of child abuse, as required by New Mexico Law.

I have read and understand the above statements and I agree to the following:

1. Counseling sessions will be audio or video taped. Tapes will be erased after supervisory review or at termination of counseling.
2. Teaching staff and the supervising group may listen to the tapes.

Client's Signature: _____ Date: _____

Parent's Signature (if client is a minor): _____ Date: _____

Counselor / Witness: _____

NEW MEXICO HIGHLANDS UNIVERSITY
Counseling & Guidance
Consent Form

I, _____, understand there are limits to confidentiality in this therapeutic setting. My counselor has explained these limits. I understand that if my counselor decides that I present an imminent danger to myself or others (e.g., suicidal or homicidal intent, child abuse or neglect, elder abuse), appropriate personnel will be contacted for my own protection and the protection of others. Personnel may include the Supervisor (professor/clinician), social service agencies, hospital personnel, and law enforcement.

I also understand that information I present during the course of my counseling may be discussed with the Clinic supervisor and other counselors (involved in the Practicum Clinic) for the purposes of instruction and supervision. Please understand, too, that your privacy will be respected (outside of the limitations explained above) and that you can expect the information you share to be treated with sensitivity and professionalism.

_____ _____

(Name of Client) *(Date)*

_____

(Counselor/Witness)

DISCHARGE SUMMARY

Client: _____ **Date of Closing**:_____

Counselor: _____ First/Last Session: _____

Presenting Problem (from intake):

_____

_____

_____

_____

Original Goals/Objects of Treatment Plan:

_____

_____

_____

_____

Summary of Treatment Approach/Highlights:

_____

_____

_____

_____

Goal/Objective Outcomes:

_____

_____

_____

_____

Recommendations for Further Counseling:

_____

_____

_____

Appendix B: Resource Guide

CRISIS PHONE NUMBERS:

- Agora (UNM Suicide & Crisis Counseling: 277-3013
- Albuquerque Family Advocacy Clinic: 243-2333
  www.abqfamily.org
- ASOP – UNM Alcohol and Substance Abuse: 925-2400
- Albuquerque Bar Association Volunteer Lawyers: 256-0417
- Alcoholics Anonymous: 266-1900
- Children's Psychiatric Hospital (CPH): 272-2890
- Crime Victims Reparation Commission:
  http://www.cvrc.state.nm.us/index.html
  "Coordinates services to victims of violent crimes including;
  Counseling, medical, dental, funeral costs etc."
- CYFD: 841-6100
- Domestic Violence Victim's Assistance: 768-2104
- Hogares: 345-8471
- Gang Intervention Unit APD: 875-3500
- Gang Intervention/Prevention YDI: 343-1918
- Grief – Children's Grief Center: 323-0478
- Grief-Compassionate Friends (Parental loss of child): 344-5564
- Homeless Resources: *http://homeless.samhsa.gov/*
- Juvenile Probation: 841-7300
- PFLAG-Parents & Families of Lesbians & Gays: 873-7373
- My Community – online, bilingual resources:
  www.mycommunitynm.org
- Poison Control Center: 272-2222
- Presbyterian Kaseman Hospital: 291-2000
- Rape Crisis Center: 266-7711
- Resources Inc. Counseling & Legal: 884-1241
- Runaways-Amistad: 877-0371
- Runaways-New Day Shelter: 938-1060
- Safe House Domestic Violence: 247-4219
- Safe Ride for Medicaid recipients: 255-4238
- Strength of Us: *www.strengthofus.org*
- Tools for young adults living with mental illness
- UNM Mental Health Services 272-2800
- United Way Info Line 247-3671

EMERGENCY ROOMS & HEALTH CLINICS:

Presbyterian Hospital
1100 Central Ave SE
(505) 841-1163 ·

Presbyterian Urgent Care
401 San Mateo Blvd SE
(505) 462-7333

Concentra Urgent Care/Walk In Clinic
3811 Commons Ave NE 505-345-9599

First Choice Alamosa
6900 Gonzales SW
831-2534

First Nations Community Healthcare
5608 Zuni SE 87108
262-6590

NM DOH NE Heights PHO
8120 La Mirada Pl. NE 87109 332-4850

Lovelace Medical Center
601 Dr. Martin Luther King Jr. Ave NE
Albuquerque, NM 87102
505.727.8000

Lovelace Urgent Care Center
5150 Journal Center Blvd NE
(505) 262-3233

UNM Family Practice Clinic
2400 Tucker NE 87131
272-1734

Young Children's Health Center
306 A San Pablo SE 87108
272-9242

Albuquerque Healthcare for the Homeless
1217 1st Street NW 87102
242-4644

COMMUNITY RESOURCES FOR PARENTS & FAMILIES:

Advocacy Inc.	266-3166	Non-profit sliding scale legal services for youth
Autism Society	332-0306	Monthly meetings for support & educational information
AMCI –Central Intake	272-9033	Assessment & Vouchers for drug & alcohol programs
CFAR	842-8932	Free services for alcohol & drug abuse recovery, includes parent group when teens decline services.
Children's Grief Center	323-0478	Free group counseling
Children's Treatment Center	296-3965	Outpatient treatment with parent & child training medicaid only

Depression & Men
http://www.rcpsych.ac.uk/mentalhealthinformation/mentalhealthproblems/depression/mendepression.aspx

La Familia	766-9361	Outpatient therapy
Medicaid Enrollment	855-9817	
New Day Teen Shelter	938-1060	Safe place for teens to live, case management, counseling, school coordination etc.
NM Child Safety Seat	332-7707	Free car seats for low income distribution program
Outcomes	243-2551	United Way funded: social skills groups, grandparents raising grandchildren & therapy
NM Family Network	265-0430	Advocacy, support & resources for parents of children who are behaviorally different
PFLAG-Parents Families & Friends of Lesbians & Gays	873-7373	Support group for family and friends whose loved ones are gay or lesbian
Programs for Children UNM	272-2190	Outpatient therapy
Psych Emergency Services	272-2920	24 hour psychiatric emergency
Public Health Office	332-4850	Immunizations/checkups for minors without insurance
RAISE	925-7492	UNM program for early psychosis ages 15-40
Rape Crisis	266-7711	Support for victims of sexual assault
Safe Ride	255-4238	Medicaid recipients can use this for transportation to medical & mental health appointments
Shelter for Domestic Violence	247-4219	Safe House for women & children of domestic violence
UNM Crisis	247-1219	24-hour-a-day crisis intervention

Low/No Cost Counseling:

Samaritan:
http://www.samaritancc.com/scc/index.html

YDI:
http://www.ydinm.org/PIT/clinical.aspx

Catholic Charities Counseling Services:
http://www.catholiccharitiesasf.org/abq-counseling.htm

Uninsured Counseling Services:

Children's Medical Services (for uninsured children who are not Medicaid eligible and have a chronic medical condition)
North Valley office 841-8211
Southwest office 873-7481

First Nations Healthsource (for health and mental health issues for native folks, but they also see uninsured folks too, especially our undocumented families)
5608 Zune Rd. SE
262-2481

Journey's Inc. (Counseling services in WMHS area)
2929 Coors Blvd. NW
(Lovelace building)
314-7012

Mando de Ayuda (Counseling services in WMHS area)
2929 Coors Blvd. NW Suite 102 I
306-3008

Beatrice Boles (therapist in private practice in WMHS area. Sees children and adults mostly. 2929 Coors Blvd. NW Suite 201-C
480-5241

St. Joseph Center for Children and Families (Counseling for insured, uninsured and Spanish speaking children, adolescents, couples and families. They are on a sliding scale that used to slide all the way down to $5 per session.)
7401 Copper Ave. NE
232-9803

Enlace Comunitario (Free services for Spanish speaking women and their children who are victims of domestic violence)
310 Valverde Dr. SE
246-8972

NM Guard Family Readiness Program:

Resources for NM Guard and Families for: Deployment readiness; Family readiness; Military family life consultants; transitions advisors; substance abuse; and other resources. Call: 264-9705 or 853-5668 Also Beth Mann Kirtland AFB School Liaison Officer 846-6477

Respite Care for Young People:

- Alta Mira: 262-0801
- Hogares: 345-8471
- High Desert TFC: 823-4530
- La Familia TFC: 766-9361
- Namaste: 232-8708
- NM Solutions: 268-0701
- Peak Developmental Agency: 266-0489

SOCIAL SERVICES - MEAL SITES, FOOD PANTRIES, RENT & UTILITIES ASSISTANCE AND SHELTERS:

Meals

243-4887	Barrett House
243-5646	First United Methodist Church
243-2527	Good Shepard Center
877-6967	Joy Junction
823-8060	Meals on Wheels
246-8001	Noon Day Ministry
242-5677	Project Share
255-7579	Restoration Ministries
843-9405	St. Martins Hospitality Center
242-3112	Salvation Army

Food Pantries

268-4418	Albuquerque Indian Center (Priority to Native Americans)
275-9623	Glory Christian Fellowship
761-9818	Salvation Army

Food Banks

The Storehouse 106 Broadway Blvd SE 842-6491

Rio Grande Presbyterian Church 600 Coors NW 831-3778

Salvation Army 4301 Bryn Mawr NE

St. Vincent de Paul Society 714 4th SW 242-3434

Emergency Food Assistance/Food Stamps 1011 Lamberton Pl NE 841-7954 NE Section, 841-7700 NW Section 1401 Williams SE 841-2600 1401 Old Coors Rd SW 841-2300

Jewish Family Services Food Pantry 5520 Wyoming NE 291-1818

Calvary Chapel 4001 Psuna Rd. NE 344-0880

Echo, Inc. 1301 Broadway NE 242-6777

Roadrunner Food Bank 2645 Bavior Dr. SE 247-2052

Rent & Utilities Assistance

247-0442/724-4670	Catholic Charities Court Advocacy Program
265-3714	Help Transitional Housing/METRO Care
800-244-1111	LITAP (Low income telephone bill assistance)
246-8001	Noon Day Ministry
843-9405	St. Martins
247-284	Salvation Army
800-283-4465	LIHEAP
265-3714	H.E.L.P

Rental Programs

265-3717	HELP Transitional Housing

Clothing & Furniture

836-8800	Alamosa Center
344-7481	Bernalillo County PTA Clothing Bank

Domestic Violence Shelters

247-4219	Women's Community Association
246-9240	New Mexico Coalition Against Domestic Violence
266-7711	Rape Crisis Center
884-1241	Resources Inc.

Day Shelters

242-3171	Albuquerque Rescue Mission
246-8001	Noon Day Ministry
843-9405	St. Martins Hospitality Center

Single Women & Family Shelters

877-6967 Joy Junction

Single Women & Women with Children Shelters

243-4887 Barrett House
883-8870 Casa Milagros
247-9521 Catholic Charities
243-6055 Salvation Army
884-8856 Women's Housing Coalition

Teen Shelters

877-0371 Amistad Runaway Facility
831-6038 Youth Development

Single Men Shelters

243-2527 Good Shepard Center

Counseling & Therapy Agencies:

- *Accelerated Family Counseling* 888-1686

  Nancy Romero Director Family, Individual, crisis, case management, Outpatient substance abuse- 6 therapists

- *Agape Counseling Services* 836-5335

  They are located on the west side 5415 Fortuna rd NW. The counselors there are *bilingual* and they do individual, marriage, elderly counseling as well as children. They accept payments on a sliding scale and accept Medicaid and Presbyterian.

- *Age to Age* 291-6314

  - Rhonda Newald-Potter – Owner
  - Self Injury Groups; Teen Girl Issue Groups, Anger Issues, Child, Teen & Family, GLTBQ knowledgeable. 2530 Virginia NE Suite 400 Albuquerque, NM 87110 agetoagecounseling@yahoo.com

- *Albuquerque Behavioral Health* 830-6500

  - Linda Zobrist, MC, LCC
  2403 San Mateo, NE Suite W-10

- *Albuquerque Family Mental Health Clinic* 256-0065

- Children & Teens: LD, CD, ADD, ODD
Separation Anxiety, Family, Weight Loss

- *Albuquerque Play Therapy* 307-1059

  - Solution focused, play based therapy for ages 3-13 620-8768
  1420 Carlisle NE sliding scale no insurance
  Works with classroom difficulties, grief, divorce, trauma, ADHD, and other common childhood difficulties using multi-modalities.

- *Kaseman Behavioral Medicine* 291-5300

  - Susan Dantato M.D; Also additional therapists

- *Bodin Exchange* – California 310-806-9655

  - Consults across USA
  Adolescent crisis intervention consultation for placement for inpatient alcohol or drug recovery: $6,500! www.bodinassociates.com

- *Children's Grief Center* 323-0478

  - Support Groups for ages 5-18

- *Children's Treatment Center* 296-3965

  - Leslie Dozzo – Director; Research based child/teen day treatment program for attachment disorders, history of abuse, multiple placements, emotional or behavioral Difficulties. Medicaid only

- *Counseling World* 404-0717

  - 2601 Wyoming NE Suite 101 www.counselingworld.com
  20 contract therapists providing a wide range of services

- *Family Therapy of Albuquerque* 821-3628

  - Based in Heights Cumberland Church
  8600 Academy, NE Accepts many 3rd party insurance, Medicaid and sliding scale; 17 Therapists including: Dr. Deborah Good, Ph.D.

- *Gambling Recovery Center* 242-6988

  - Integrity Recovery; ext.112; www.walkingwithintegrity.com

- *Girard and Indian School Professionals* 255-8682
  Ext. 105 / 440-3226

  - Christy Tackwell, LPCC, LPAT EMDR, PTSD, Depression, Anxiety, CBT, Anger Management, Art Therapy, Children, Adolescents, Families

- *Guhl Center for Children & Adolescents* 505-842-5300

  - Meeting the specialized counseling and therapy needs of children and teenagers John Harlow, PhD, licensed psychologist; children and adolescents;

ADD/ADHD evaluations; Leah Rudnick, MD, child, adolescent and adult psychiatry

- *Girard Professional Offices* 255-8682

  - David Ewing M.D. Rene Silleroy PhD

- *Mindful Counseling* ~ Patti Smith 480-1201

  - Teen issues of depression, anxiety, addictions. She also adults, families and couples. www.mindfulcounseling.org

- *New Mexico Solutions* 268-0701

  - Outpatient therapy takes Medicaid & Other insurance

- *Outcomes* 243-2551

  - United Way Funded including low income Families; Play & Sand Tray therapy; Psych Evals; Family, Couple & Group Therapy

- *Rio Grande Counseling* 246-8700

  - IOP-Intensive Outpatient Program Teen Substance Abuse Group Counseling.

- *Samaritan Counseling Center* 842-5300

- *Sandia Counseling Center* 822-8223

  - Marriage & Family, divorce recovery Classes for adults, EMDR, music and Art therapy, anxiety & depression group Therapy, grief & loss located at Sandia Church at Eubank & Paseo

- *St Josephs* - an extension of Samaritan specifically 232-9803

  - Serving Spanish or bilingual speaking only clients. Parenting training & therapy.

- *Remuda Ranch* ~ Out of state Eating Disorder 1-800-445-1900

  - Inpatient Treatment ~ Arizona www.remudaranch.com

- *Rubin Cohen Educational Services* 505-690-7180

  - Finding therapeutic environments for troubled teens and children http://www.rubinedu.com/ Santa Fe

- *Southwest Family Institute* 830-1871

  - Suicide Assessments Only Call; 410-1871

- Dr. Craig Pierce – Director
  Family, Individual, crisis, case management, out patient Substance abuse, Sand tray & Play therapy Multi-systemic Family Therapy free for Medicaid; 2612 Texas St NE is a brown building with a tree out front on the right (east).

- *UNM*
  - Mark Pedrotty PhD Therapy for children 272-4244
  - Robert Annet PhD Pediatric Neuropsychology 272-5551
  - UNM Neuropsychology Pediatrics Clinic 272-0331

- *Youth & Family Counseling* 841-7374
  - District Court Mandated Counseling

Individual Practices:

- Jane Brandt, MA, LPCC 239-3555
  Children, teens & families

- Krista Barrett 888-1121
  Wellness Center Gibson & Yale
  Sand Tray Training, young children 3-12, takes Medicaid. Has experience with autism.

- David Brault LISW, Father & Family Center 266-9233

- Ann Buck, 506-5831; Michael Ollom, 270-6700; Melinda Martinez 306-2277; 4233 Montgomery Suite 240 in Granada Square. These 3 counselors share offices and specialize in sand-tray and play therapy, grief, and trauma, children and teens as well as parenting skills.

- Dr. Joseph Cardillo 255-7016
  APS consultant, works well with children

- Dr. Martha Carmody ~ Older children 266-0025
  Teens, marriage & consultation with parents for early childhood concerns

- Nettie Rose–Drug & Alcohol Intervention 265-0753

- Dr. Mary Ann Conley 888-4445
  5800 Mc Cloud, NE Specializing in Biofeedback anxiety concerns and stress management for teens and adults
- Betsy Davis, PhD 977-1766
  PTSD, Pain Management, CBT

- Georgina Felicia, LPCC, LMFT 856-9661
  Children, teens, adults & couples; Mood Disorders, anxiety, Bipolar; Short term Solution based, Cognitive, Sandplay www.georgenafelicia.com

- Dr. Jean Flannigan 266-3981
  Family Therapist

- Carol Frank, LISW, RN 821-6056
  3727 Academy, Suite B
  Grief & Loss, PTSD, EMDR & Affect Regulation Depression, anxiety, chronic illness, family caregivers GLBTQ issues

- Debbie Gee, M.D. 837-9782
  Works well with meds regulation, teen Issues, schizophrenia & other complex issues

- Theresa Kestley PhD Sand Tray therapy 898-1177
  Currently writing a book not taking referrals 2011-2012

- Dr. Leslie Kurtz 291-5300
  Pediatrician: Developmental/Behavioral & Meds Specialty

- Mary LeCaptain 255-8682
  Neuropsychologist, works with OCD Children, worked with APS

- Susan Lane, MA, LPCC 830-1200
  Children & Adolescents
  2001 Mountain Rd NW, Suite B
  Albuquerque, NM 87104

- Emily Driver Moore PhD 259-1414
  Mean girls, media literacy, friendship groups, family therapy, self image, social, resiliency, www.socialempowermentnm.com

- Amy O'Brien 822-8223
  Teens, adults & Families Eubank & Paseo
- Dr. Pentz 883-9580
  Holistic Psychiatry & Amino Acid Therapy

- Margie Polito 884-8040
  CBT & Sandtray for children
  Recommended by Ann Buck

- Michael Rodriguez 275-6405
  Experienced Psychologist/bilingual

- Dr. Elizabeth Roll 266-2631

- Rene Silleroy, PhD 255-5522
  Child psychology, sand tray, families Cognitive Behavior Therapy

- Mae Lynn Spahr MA, LNHC 268-0421
  ADHD/LD/Trauma alternative treatment With Light & Sound Therapy
  www.abcwellness.com

- Mary Ann Shinnick LISW 459-7565
  Individual & Family Counseling
  Good with teen boys
  4004 Carlisle Blvd. Sutie J

- Jane Smith PhD 277-2650
  Eating Disorders

- Christy Tackwell 255-8682 X105
  Art Therapy, Trauma & Sexual Trauma
  2741 Indian School, NE

- Dr. Betsy Williams 872-2828
  Neuro-behaviorist, licensed diagnostician. Knowledgeable about brain damage.

Practicum/Internship Sites:

Community & Private:

A New Awakening Counseling Services
600 1st NW Suite 200
Albuquerque, NM 87102
(505)224-9124
Tanya Miller, LMFT
www.anewawakening.com

Age to Age Counseling
2530 Virginia St NE Suite 400
Albuquerque, NM 87110
(505)291-6314
Rhonda Neswald-Potter, Ph.D, ACS, LPCC
www.agetoagecounseling.com

Counseling World
2601 Wyoming NE Suite 101
Albuquerque, NM 87112
(505)404-0717
Kristen Choubard, LISW
www.counselingworld.com

Counseling and Psychotherapy Institute
803 Tijeras Ave NW
Albuquerque, NM 87102
(505) 243-2223
Dr. Kenneth Wells

Mando de Ayuda
2929 Coors Blvd NW Suite 102
Albuquerque, NM 87105
(505) 836-1303
Andrea Marrufo, LPCC

New Mexico Solutions
707 Broadway NE Suite 500
Albuquerque, NM 87102
(505) 268-0701
David Ley, Ph.D

Outcomes, Inc.
1503 University Blvd. NE
Albuquerque, NM 87102
Phone: (505) 243-2551
Bob Stice, LPCC
www.outcomesnm.org

Samaritan Counseling Center of Albuquerque
1101 Medical Arts Ave NE Bldg 3
Albuquerque, NM 87102
(505)842-5300
Dr. Sarah Brennan
www.samaritancc.com

Southwest Family Guidance Center and Institute
2612 Texas St NE
Albuquerque, NM 87110
(505) 830-1871
Susan Smith
www.swfamily.com

Team Builders
541 Quantum Rd NE
Rio Rancho, NM 87124
(505) 994-9178
Alfredo Lujan, LPCC
www.teambuilders-counseling.org

The Evolution Group, Inc
218 Broadway Blvd SE
Albuquerque, NM 87102
(505) 242-6988 ext 129
Daniel Blackwood
www.theevolutiongroup.com

Child, Adolescent and Young Adult

Desert Hills
5310 Sequoia Rd NW
Albuquerque, NM 87120
(505) 836-7330
Melinda Heller-Nellos, LPCC
www.deserthills-nm.com

Hogares, Inc.
1218 Griegos Rd NW
Albuquerque, NM 87109

(505) 345-8471
Audrey Mitchell, HR Director
www.hogaresinc.com

Youth Development, Inc.
1710 Centro Familiar SW
Albuquerque, NM 87105
(505) 270-5373
Jomo Thomas, LPCC
www.ydinm.org

Substance Abuse

First Nations
5608 Zuni Rd SE
Albuquerque, NM 87108
(505) 262-2481

Lanaeda Ortiz, Human Resources
www.fnch.org

New Mexico Women's Recovery Academy
6000 Isleta Blvd SW

Albuquerque, New Mexico 87105
(505)873-2761
Bonnie Evans, LPCC
www.cecintl.com/facilities_rr_nm_002.html

New Mexico Mens' Recovery Academy
1000 Main St Bldg 23
Los Lunas, NM 87031
(505) 866-0590
Bonnie Evans, LPCC
www.cecintl.com/facilities_rr_nm_001.html

Children & Families

All Faiths Receiving Home
1709 Moon St NE
Albuquerque, NM 87112
(505) 271-0329
Donna Lucero
www.allfaiths.org

La Familia, Inc
707 Broadway NE #103
Albuquerque, NM 87102
(505) 766-9361
Beverly Nomberg, LISW
www.la-familia-inc.org

Peanut Butter & Jelly Family Services
1101 Lopez Rd. SW
Albuquerque, NM 87105
(505) 877-7060
Jennifer Thompson, LMSW
www.pbjfamilyservices.org

Sexual Assault

Rape Crisis Center of Central New Mexico
9741 Candelaria NE
Albuquerque NM 87112
(505) 266-7712
Sage Rupp, LPCC
www.rapecrisisnm.org

Domestic Violence

Enlace Comunitario
PO Box 8919
Albuquerque, NM 87198
(505) 246-8972
www.enlacenm.org

S.A.F.E.House
PO Box 25363
Albuquerque, NM 87125
(505) 247-4219
Michelle Fuller
www.safehousenm.org

Resources, Inc
625 Silver SW Suite 185
Albuquerque, NM 87102
(505)268-8565
Rusita Avila, Clinical Director

Christian Counseling

Christian Counseling Professionals
8605 Spain Rd Suite 106
Albuquerque, NM 87109
(505) 856-0300
Gary Webb, LPCC
www.nmccc.net

Legacy Church
7201 Central Ave NW
Albuquerque, NM 87121
(505) 831-0961
Denise Smith, LMSW
www.legacychurch.com

Homeless Agencies

Barrett Foundation
10300 Constitution Ave NE
Albuquerque, NM 87112
(505) 246-9244
www.barrettfoundation.org

Health Care of the Homeless
1217 1st NW
Albuquerque, NM
(505) 767-1126
Terri Ellis, LMSW
www.abqhch.org

Appendix C: Crisis Intervention

Crisis Defined in Three Parts:

1. A precipitating event
2. A perception of the event that causes subjective distress
3. The failure of the person's usual coping methods

- Perception of the event is the most critical part of identify – most easily changed
- The focus of crisis intervention is on increasing the client's functioning.

The Process of Crisis Formation:

a) Precipitating Event Occurs
b) Perception of Event Leads to Subjective Distress
c) Subjective Distress Leads to Impairment in Functioning
d) Coping Skills Fail to Improve Functioning

Formula to Increase Functioning:

1. Alter / Change Perception of the Precipitating Event and Offer Coping Strategies
2. Subjective Distress will be lowered
3. Functioning Level returns to previous level or higher.

- The overall goal is to change the client's cognitions and perceptions of the event, offer referrals to other agencies and suggest other coping strategies.
- Remember, crises are a part of life and need not be considered abnormal – it is more about people having difficulty coping with stress.

The Crisis Prone Person:

- If a person does not receive adequate crisis intervention during a crisis state but instead comes out of the crisis by using ego defense mechanisms such as repression, denial or dissociation, the person is likely to function at a lower level than he or she did prior to the stressing event.
- Experiences a stressor perceived as threatening which leads to subjective distress and impairment in functioning. Coping methods fail.
- State of disequilibrium ensues for 4-6 weeks.
- If no intervention or help is sought, the individual will use ego strength to deny, repress, dissociate from the meaning of the precipitating event and subjective distress and functions at a lowered level.
- Individuals unprepared emotionally to cope with future stressors can easily enter into crisis states when faced with potential precipitating events.
- This takes away the individual's strength to deal with future stressors so that another crisis state may develop the next time a stressor hits. This next crisis might be resolved by more defense mechanism after several weeks, leading to an even lower level of functioning if the person does not get needed interventions.
- A crisis prone person is more susceptible to committing suicide, harm others, or have psychotic breakdowns. The person's ego is no longer able to deal with reality – personality disorders are not uncommon – suffering from emotional instability, an inability to master reality, poor interpersonal and occupational functioning and chronic depression.

Other determining Factors (follows Maslow hierarchy of needs):

- Material Resources: money, shelter, transportation, food, clothing
  Resources make coping easier
- Personal Resources: ego strength, personality traits, physical well-being, intelligence and education

- Once material needs are met clients can begin to work through the crisis.

- Personal resources will help determine how well he/she copes on their own and how they accept and implement the intervention.

- What is Ego Strength? The ability to understand the world realistically and act on that understanding to get one's needs and wishes met. "Many times a crisis worker will be called on to be the client's ego strength temporarily until the client can take over for himself or herself. They need someone to structure their behavior until the crisis is managed successfully, often with medication, family intervention and individual counseling. When someone has coped successfully in the past with various stressors, then usually his or her ego strength is high.

- Please take into account personality traits, physical well-being, a person's level of intelligence and education—well educated people are more able to use cognitive reframes and logical arguments to help them integrate traumas psychologically.

- Social Resources: friends, family, school mates, co-workers, church, clubs

- A person with strong social resources and a strong support system are more likely to cope better.

Precipitating Events:

- Can be new adjustments in the family, loss of a loved one, loss of one's health, contradictions and stresses involved in acculturation, normal psychological development, or unexpected situational stressors.

- The most important determinant is how the person perceives the crisis/situation. The meaning given to the event or adjustment determines whether the person can cope with the added stress. This meaning is termed *the cognitive key*. Steps involved cognitive meaning ascribed to the situation, reframing the cognitions. New perception leads to reducing subjective distress and increasing coping abilities.

- Differentiation between stress and crisis: If people cope with precipitating events without suffering subjective distress and experiencing a state of psychological disequilibrium, they will experience stress but not a crisis.

Types of Crisis:

- *Developmental:* normal, expected, transitional phases as people move from one stage of life to another. People who are often unable to cope with evolving needs of family members.

- *Situational:* uncommon, extraordinary events. No way of forecasting or controlling them. Typically an emergency. Examples include: crime, war, rape, death, divorce, community disaster; Characterized by sudden onset, unexpectedness, emergency quality, and potential impact on the community.

Curvilinear Model of Anxiety:

- *Subjective Distress:* A rise in anxiety is a typical reaction to the initial impact of a hazardous event. A person may experience shock, disbelief, distress, and panic. If this initial anxiety is not resolved, the person may experience a period of disorganization, feelings of guilt, anger, helplessness, dissociation, confusion, and fatigue, leaving her in a vulnerable state.

  - Too much anxiety is overwhelming and paralyzing
  - Too little anxiety leaves very little motivation to change or accept interventions.
  - Moderate anxiety is optimal in motivating people to change and allowing them to utilize personal resources.
  - Sometimes an individual needs medication to reduce anxiety to the point where a person can respond to intervention.
  - Other times anxiety is encouraged to increase motivation.

The "ABC" Model of Crisis Intervention:

- Method for conducting very brief mental health interviews with clients whose functioning level has decreased following a psychosocial stressor.
- It is problem-focused and is most effectively applied within 4 to 6 weeks of the stressor.
- The central focus is identifying the cognitions of the client as they relate to the precipitating event and then altering them to help decrease unmanageable feelings.
- Three Phases: **1)** *Developing and maintaining contact*, **2)** *Identifying the problem and providing therapeutic interaction*, and **3)** *Coping.*

A. *DEVELOPING AND MAINTAINING RAPPORT*

- Basic attending skills
  - Attending behaviors: good eye contact, attentive body language, verbal following, soothing calm voice, warmth

- Questioning

  - Open-ended questions allow for exploration of what the client just said
  - Begin with "how" and "what"
  - Attach the question with something the client just said
  - Don't ask "why" questions
  - Avoid "have you" questions, they are usually forms of hidden advice

B. *IDENTIFYING THE PROBLEM*

- Counselors need to identify the nature of the crisis:

  a. *Precipitating events*: What happened that made you call for an appointment? If no answer from the client, do probing. Explain that understanding the trigger of a client's crisis aids in relieving the crisis state. Identify when the client started to feel bad; this helps pinpoint the triggering event.
  b. *Cognition about the event(s):* What are his/her beliefs or meanings attached to these events?

     - It is the client's perceptions of stressful situations that cause them to be in a crisis state as well as the inability to cope with the stress.
     - Four areas of origin of stress: 1) loss of control, 2) loss of self-esteem, 3) loss of nurturance or forced adjustment to a change in life or role
     - What do you think about this? What does it mean to you? What are you telling yourself? What assumptions are you making?
     - Need to use cognitive reframing

  c. *Emotional Distress:* Explore each area affected during the crisis state in as much detail as possible. Understanding one's feelings and behaviors is the first step in coping with them.

C. *COPING:*

- *How the client is functioning socially, academically, occupationally, and behaviorally since the crisis:*

- Assess the client's pre-crisis level of functioning in order to compare the two. This helps the counselor determine the level of coping the client can realistically achieve and gives the counselor an idea of the severity of the crisis for the person. This serves as the basis for evaluating the outcome of crisis intervention.

- Ethical Issues:

- Counselor must assess for the following:

    a. suicide
    b. child abuse
    c. elder and disabled adult abuse
    d. danger to others
    e. medical or organic illness, substance abuse

Therapeutic Interaction Statements:

- *Validation and support statements:* these make clients feel that their point of view and subjective experiencing is valid and that the counselor empathizes with their plight. Counselor lets clients know that their feelings are normal and difficult.

- *Educational statements:* counselor offers information based on counselor knowledge about various aspects of the client's crisis. This helps normalize the experience or corrects false ideas the client might hold.

- *Empowering statements:* these comments help the client feel more powerful and in control. Counselor points out choices available and how client can overcome feelings of helplessness. (e.g. You didn't have a choice in being raped, but now you do have a choice of what to do. You can call the police, go to the counseling, tell a friend, or not do any of these things. Let's talk about your feelings and thoughts on each of these checks.)

- *Reframing statements:* Counselor helps the client view the situation from a slightly different point of view using the client's frame of reference. Sometimes a positive perspective is changed into a negative one, sometimes a negative perspective is changed into a positive one.

Crisis Debriefing as an Acute Preventive Intervention for those Exposed to a Traumatic Experience:

1. **Introductory Phase: (spells out confidentiality)**

    a. Introduction of the CDT team
    b. Give a brief description of the debriefing process and its purpose
    c. Establish ground rules

2. **Fact Phase:** Participants are asked to introduce themselves and to give a description of what they heard, witnessed and did during the incident. Each participant is included in turn by completing the circle.

a. Asked to describe their roles and tasks during the incident

b. Provide some facts about what happened from their own perspective

3. **Thought Phase:** At what point did the individual realize this was an unusual situation? Ask to identify their first thoughts during the stressful incident.

   Question: When did you realize this was an unusual situation?

   Question: What did you think at the time?

4. **Reaction Phase:** Sharing of the feelings at the scene, now, and in past situations, if possible. Seeks to explore the worst part of the experience and hence to encourage people to acknowledge their emotional reactions and express their feelings.

   Question: What were your reactions (feelings) at the scene or in relation to past situations?

   Question: What was the worst part of the incident?

   Question: If there was one thing you could have left out of the event, what would it have been?

5. **Symptom Phase**: Perceived unusual experiences at the time of and/or since the incident. Expression of the individual's stress response syndromes. The purpose is to review their symptoms of cognitive, physical, emotional, and behavioral distress at the scene and subsequently, up to and including the time of debriefing.

   Question: What symptoms let you know that this was different from other situations?

   Question: What was your most intense reaction at the scene?

   Question: What were your reactions later?

   Question: What is not going away?

6. **Teaching Phase:** Team discusses stress response syndrome and normal signs, symptoms, and emotional reactions. Gives information about the management of them and about general health issues. Handouts are given now.

7. **Reentry Phase:** Wrap up loose ends, answer additional questions, provide final assurances, and establish a plan of action.

   Question: What was your moment of strength?

   Question: What did you feel good about in yourself?

   Question: What was positive about your response?

   Question: What will be valuable in the future?

8. **Referrals for additional help**

- This model is based on the critical incident stress debriefing model (CISD) which was developed by Mitchell during the 80s. This is identified as a psychological debriefing rather than didactic. Didactic debriefing is an informational model: participants are educated about stress, ways to recognize it, and techniques of self-management. Psychological debriefing is based on the conception that ventilation or catharsis facilitates the healing process.

- The debriefing should be led by at least one and preferably two specially trained mental health professional and to be supported by peer support personnel who have been previously trained in CISD. The aim of this process is to support people through a normal reaction to an abnormal event. Sessions may last 1 to 3 hours.

- Efficacy: Mitchell and Bray (1990) claim from anecdotal evidence that CISD significantly diminished the problems experienced by emergency personnel, including job turnover, early retirement, and mental and other health problems. They suggest that following a critical incident, 3-10% of emergency personnel will have no adverse effects; 80-85% will have acute or delayed effects; and 3-10% will have acute will develop chronic severe PTSD.

Assessing Suicide Thoughts and Plans:

A. Use the direct approach –"Have you ever had thoughts of hurting yourself or killing yourself?"

B. Inquire about potential suicide plans – "When you were really upset and wanted to die, how did you think you might make yourself die?

C. Assessing critical components of suicide plans: **SLAP**

- ***S****pecificity*: Details of the plan, the more specific and clear the higher the threat.
- ***L****ethality*: If the plan is implemented would it bring about death – the higher the lethality, the higher the risk.
- ***A****vailability* of suicidal means
- ***P****roximity:* Proximity of helping resources

D. Assessing Suicidal Intent

1. Evaluate lethality of previous attempts or potential suicide plans
2. Evaluate desires or consequences associated with suicidal behavior
    - What does he/she want or expect to have happen as a result of killing him/herself?

- Does she or he mainly intend to die?
- Is there anyone with whom she or he would like to get even?
- For example, does she want to make her parents sorry for
- Something they have or have not done?

E. Management and Treatment of Suicidal Young Clients

1. Use a checklist: Assess risk factors. Ask about suicidal thoughts, Assess suicide plans, Assess client intent or goals associated with suicidal behavior, Obtain psychiatric or collegial consultation.
2. Determine appropriate intervention
3. No Suicide Agreement or contract – implement either verbally or in written form

4. Decision Making:

    a. First responsibility is to determine the extent of the risk and to take measures to protect the youth from killing himself
    b. Second, determine effective interventions within the constraints of the situation, the family structure, and the individual youth.
    c. Always err on the side of caution

F. Levels of Risk

Low: Those clients who have never tried suicide, have adequate support systems, and make commitments such as "I thought about it, but I'm not sure.

Can be treated as outpatients and should be encouraged to make an appointment with a therapist if the crisis counselor cannot continue to see them.

Use reframes: The fact that you came here is evidence you don't truly want to kill yourself. People who truly want to die usually don't go to a mental health worker.

The part of you that sought help is obviously very strong and you can take comfort in knowing you have this inner strength that helps you choose to cope with your problems actively.

Middle: These are the most common cases you are likely to see. They are still functional in their work but not feeling well and are often difficult to evaluate.

They feel there is no way out of the situation. Family does not take their threats seriously.

You may need to see the client daily or hospitalize them because they might carry out the act just to get a reaction from their family.

High: I'm going to kill myself and you cannot stop me. Have a history of suicide attempts and lack support from loved ones. They will admit to having a viable plan and the means for killing themselves. They usually require hospitalization.

No Suicide Contract

I_____agree not to harm myself, and I promise to contact_____ when my suicidal feelings get too strong to control.

Client's signature_____ Date_____ Crisis worker_____

Shake hands to seal the pact. Clients who live alone and lack a support network should be monitored daily with a phone call. Get the family involved—ask them to conduct a suicide watch. This tells the client that the family cares about him.

Ask the client to bring in items that the client has planned to use for committing suicide and give them to the counselor. The counselor should destroy or lock these away.

Address the client's ambivalence and focus on the parts that want to live. Try to elicit from the client ideas for future plans and explore the things that have never happened to make life no longer worth living.

Suicide Assessment, Risk Level, and Strategy

Factor:	*Response:*	*Risk:*	*Strategy:*
Ideation:	NO	LOW	Supportive Crisis Intervention.
	YES	Go to next factor to decide	
Plan:	NO	LOW	Crisis Intervention Verbal No-Suicide Contract
	YES	Go to next factor to decide	
	Factor: **Response:**	Risk:	Strategy:
	Means: **NO**	LOW	Regular Contact, C.I.
	YES	MIDDLE	Written no-suicide contract, increase contact, family watch, turn in the means to counselor.
	Can anything stop You? **YES**	MIDDLE	Encourage clients to live for the reasons given; help them find meaning in life
	NO	HIGH	Possible involuntary hospitalization.
	Severe Depression **NO**	MIDDLE	Refer to physician for a physical and possible medication.
	YES	HIGH	Possible voluntary hospitalization.

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